Calendar No. 539

103D CONGRESS
2D SESSION

S. 2351

[Report No. 103–323]

A BILL

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

AUGUST 2 (legislative day, JULY 20), 1994

Placed on the calendar

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[Report No. 103–323]

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

IN THE SENATE OF THE UNITED STATES

AUGUST 2 (legislative day, JULY 20), 1994

Mr. MOYNIHAN, from the Committee on Finance, reported the following original bill; which was read twice and placed on the calendar

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A BILL

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

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

SECTION 1. SHORT TITLE; PURPOSE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Security Act''.

(b) UNIVERSAL COVERAGE AS PURPOSE.—It is the purpose of this Act to achieve universal health insurance coverage through—

(1) subsidies for the purchase of health insurance;

(2) affordable standardized health insurance;

(3) elimination of exclusionary practices by health insurance companies;

(4) a permanent National Health Commission which, beginning in 1996, will make recommendations every two years to the Congress on how to increase the number of people covered by health insurance;

(5) reduction of health costs through more open competitive markets and continued advances in medical education and research; and

(6) health care provided under the medicare and medicaid programs and health programs of the Department of Defense, Department of Veterans Affairs, and Indian Health Service.

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

TITLE I—HEALTH INSURANCE AND DELIVERY SYSTEMS REFORM

Subtitle A—Federal Standards for State Regulatory Programs

SEC. 101. STATE PLAN FOR CERTIFICATION AND REGULATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking ''and'' at the end of paragraph (61), by striking the period at the end of paragraph (62)

and inserting ''; and'', and by inserting after paragraph (62) the following new paragraph:

''(63) provide that the State is a participating State under title XXI.''

(b) PARTICIPATING STATE PLAN FOR CERTIFICATION AND REGULATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE PLAN FOR CERTIFICATION AND REGULATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS

''TABLE OF CONTENTS

''Sec. 21825. Nondiscrimination in federally assisted programs.

''Subtitle A—Participating State Program

''PART I—GENERAL RESPONSIBILITIES

''Subpart A—Access to Coverage

''SEC. 21001. ESTABLISHMENT OF PARTICIPATING STATE PROGRAMS.

''A State shall be a participating State for purposes of this title if such State establishes an accreditation, certification, enforcement, and information program (in this title referred to as a 'State program') to carry out participating State responsibilities specified in this title.

''SEC. 21002. ACCESS TO STANDARDIZED HEALTH CARE COVERAGE.

''(a) ACCESS TO STANDARDIZED COVERAGE.—

''(1) IN GENERAL.—A State program shall require that each health plan (whether insured or self-insured) or long-term care policy issued, sold, offered for sale, or operated in the State shall be certified by the appropriate certifying authority as one of the following:

''(A) A certified standard health plan.

''(B) A certified supplemental health benefits plan.

''(C) A certified long-term care policy.

''(D) A certified nonstandard health plan.

''(2) FEDERAL CERTIFICATION OF MULTISTATE SELF-INSURED PLANS.—For Federal certification of multistate self-insured health plans, see section 21051.

''(3) TAX QUALIFICATION.—For favorable Federal income tax treatment which is available only to certified health plans, see sections 213(f) and 4521 of the Internal Revenue Code of 1986.

''(b) ACCESS TO AFFORDABLE COVERAGE.—A State program shall require the following:

''(1) COMMUNITY RATING.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), all health plans shall be community-rated health plans which cover only community-rated individuals.

''(B) EXPERIENCE-RATED HEALTH PLANS.—Subparagraph (A) shall not apply to any health plan which—

''(i) is a self-insured health plan of an experience-rated employer, or

''(ii) is an insured health plan which is experience-rated,

but any such plan may cover only experience-rated individuals.

''(C) RESTRICTION ON SELF-INSURED HEALTH PLANS.—A self-insured health plan may be established or maintained only by an experience-rated employer.

''(2) SUBSIDIZED COVERAGE.—Individuals shall be entitled to such premium and cost-sharing assistance as is provided under the program described in part B of title XIX.

''(c) ACCESS THROUGH EMPLOYERS AND PURCHASING COOPERATIVES.—

''(1) EMPLOYERS.—

''(A) IN GENERAL.—Subject to the requirements of part I of subtitle D, a State program shall require each employer—

''(i) to make available to each employee of the employer the opportunity to enroll through the employer in one of at least three certified standard health plans which provide the standard benefits package established under subtitle C, including, if available, a fee-for-service plan and a health plan with a point-of-service option, and

''(ii) to provide, upon request, payroll withholding of the employee's premiums.

''(B) SPECIAL RULES.—

''(i) PURCHASING COOPERATIVE.—An employer other than an experience-rated employer may meet the requirements of subparagraph (A)(i) through a purchasing cooperative.

''(ii) EXPERIENCE-RATED EMPLOYER.—An experience-rated employer shall meet the requirements of subparagraph (A)(i) only through offering self-insured or experience-rated health plans.

''(2) PURCHASING COOPERATIVES.—A participating State shall meet the requirements of part II of subtitle D with respect to the establishment or sponsorship of purchasing cooperatives.

''(d) ACCESS TO ENROLLMENT OPTIONS.—A State program shall require that all certified standard and nonstandard health plans and certified supplemental health benefits plans offer the classes of enrollment described in section 21113(b)(2)(B)(ii).

''SEC. 21003. OTHER STATE PROGRAM RESPONSIBILITIES.

''(a) SUMMARY OF RESPONSIBILITIES.—The participating State responsibilities under this title include—

''(1) the accreditation and certification of standard health plans and nonstandard health plans,

including the enforcement of the insurance and delivery system reform standards for such plans under part II of subtitle B;

''(2) the accreditation and certification of supplemental health benefits plans, including the enforcement of standards for such plans under part III of subtitle B;

''(3) the accreditation and certification of long-term care policies, including the enforcement of standards for such policies under part IV of subtitle B;

''(4) providing for the collection and provision of consumer information regarding health plans as specified under section 21013;

''(5) the establishment of community rating areas under section 21021 and State service areas under section 21022;

''(6) providing under section 21023 for—

''(A) reinsurance pools,

''(B) a risk adjustment program, and

''(C) a cost-sharing adjustment program;

''(7) the specification of an annual general enrollment period under section 21024;

''(8) providing for a premium approval process for long-term care policies under section 21025;

''(9) providing for the certification of workplace wellness programs in accordance with rules established by the Secretary under section 21053, including the receipt of employer self-certification forms, enforcement of compliance, and dispute resolution;

''(10) enforcing employer responsibilities under part I of subtitle D;

''(11) the oversight of purchasing cooperatives under part II of subtitle D;

''(12) supporting the program quality assurances under subtitle E;

''(13) supporting the development of community health networks and plans to the extent required under subtitle F;

''(14) providing coordination between health plans and automobile medical liability policies under subtitle G;

''(15) the development of program remedies and enforcement described under subtitle H; and

''(16) conforming State laws and procedures to the rules regarding fraud and medical malpractice under title XI.

''(b) DEADLINES.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), each participating State shall es-

tablish a State program under this section by not later than January 1, 1996.

''(2) SUPPLEMENTAL INSURANCE.—Each participating State shall establish such State program with regard to supplemental health benefits plans by not later than January 1, 1997.

''(3) LONG-TERM CARE INSURANCE.—Each participating State shall establish such State program with regard to long-term care policies by not later than April 1, 1997.

''(c) SECRETARIAL APPROVAL, PERIODIC REVIEW, AND FUNDING OF STATE PROGRAMS.—

''(1) IN GENERAL.—The Secretary—

''(A) shall initially determine and approve the compliance of State programs with the Federal guidelines under this title; and

''(B) shall periodically review such State programs to determine if such programs continue to comply with such guidelines.

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

''(3) FUNDING.—

''(A) AVAILABILITY OF TRUST FUND AMOUNTS.—There shall be available to the Secretary, from the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986, $100,000,000 in fiscal 1995 and $300,000,000 in each of the fiscal years 1996 through 2004 to support participating States that have submitted applications in accordance with subparagraph (C) to develop State programs. The Secretary shall develop a formula for determining the appropriate awarding of funds to participating States submitting such applications.

''(B) PAYMENTS FOR INDEPENDENT REVIEW.—The Secretary shall develop a supplemental payment schedule for participating States that establish independent review committees to provide recommendations concerning health plans that fail certification.

''(C) APPLICATION.—For purposes of subparagraph (A), an application is in accordance with this subparagraph if the applicant submits the application to the Secretary at such time, in such manner, and containing such information

and assurances as the Secretary may reasonably require.

"SEC. 21004. GENERAL DEFINITIONS RELATING TO HEALTH PLANS.

''(a) HEALTH PLAN.—For purposes of this title—

''(1) IN GENERAL.—The term 'health plan' means any plan or arrangement which provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

''(A) Coverage only for accidental death or dismemberment.

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

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) Coverage issued as a supplement to liability insurance.

''(E) Worker's compensation or similar insurance.

''(F) Automobile medical-payment insurance.

''(G) A long-term care policy, including a nursing home fixed indemnity policy (unless the

Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health plan).

''(H) An equivalent health care program.

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

Such term includes any plan or arrangement not described in any preceding subparagraph which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

''(2) INSURED HEALTH PLAN.—

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

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

''(i) a licensed insurance company,

''(ii) a prepaid hospital or medical service plan,

''(iii) a health maintenance organization, or

''(iv) any other similar entity,

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

''(3) SELF-INSURED HEALTH PLAN.—The term 'self-insured health plan' means an employee welfare benefit plan, church plan, government plan, or other arrangement which—

''(A) provides health benefits funded in a manner other than through the purchase of one or more insured health plans, but

''(B) does not include any coverage or insurance described in subparagraphs (A) through (I) of paragraph (1).

''(b) STANDARD HEALTH PLAN.—For purposes of this title, the term 'standard health plan' means a health plan which provides for the standard benefits package or the alternative standard benefits package established under subtitle C.

''(c) SUPPLEMENTAL HEALTH BENEFITS PLAN.—For purposes of this title, the term 'supplemental health

benefits plan' means an insured or self-insured health plan which provides health benefits which consist of supplemental services or cost-sharing described in part IV of subtitle B. Such term does not include a plan which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

''(d) LONG-TERM CARE POLICY.—For purposes of this title, the term 'long-term care policy' has the meaning given such term by section 21158.

''(e) TERMS AND RULES RELATING TO COMMUNITY AND EXPERIENCE RATING.—For purposes of this title—

''(1) COMMUNITY-RATED HEALTH PLAN.—The term 'community-rated health plan' means a health plan which meets the requirements of section 21113.

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

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

''(B) who is an experience-rated individual (determined without regard to this subparagraph) who is not a full-time employee of an experience-rated employer and who does not enroll

in a certified standard health plan offered by the employer.

''(3) EXPERIENCE-RATED INDIVIDUAL.—The term 'experience-rated individual' means an individual who is an employee of an experience-rated employer.

''(4) EXPERIENCE-RATED EMPLOYER.—

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

''(B) SPECIAL RULE FOR LEASING BUSINESSES.—In the case of an employer the primary trade or business of which is employee leasing—

''(i) all of the employees which such employer leases to other employers shall be treated as community-rated individuals unless treated as employees of an experience-rated employer other than the leasing trade or business, and

''(ii) this title shall be applied separately with respect to its other employees.

''(5) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to any month, an employee who normally performs at least 24 hours of service per week for an employer in the month (not including the month which includes the hiring date of such employee).

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

"Subpart B—Accreditation, Certification, Enforcement, and Information

"SEC. 21011. ACCREDITATION AND CERTIFICATION OF HEALTH PLANS AND LONG-TERM CARE POLICIES.

''(a) CERTIFIED HEALTH PLANS.—

''(1) IN GENERAL.—Each State program shall provide for the accreditation and certification of health plans as certified standard health plans, certified nonstandard health plans, and certified supplemental health benefits plans.

''(2) CERTIFIED STANDARD HEALTH PLAN.—For purposes of this title, the term 'certified standard health plan' means a health plan which—

''(A) provides for the standard benefits package or the alternative standard benefits package established under subtitle C, and

''(B) is certified by the appropriate certifying authority as meeting the other applicable requirements of this title.

A standard health plan shall not fail to be treated as a certified standard health plan if such plan offers a medicare-eligible benefits package to medicare beneficiaries under a medicare risk contract entered into with the Secretary under section 1876.

''(3) CERTIFIED NONSTANDARD HEALTH PLAN.—For purposes of this title, the term 'certified nonstandard health plan' means a health plan which—

''(A) is certified by the appropriate certifying authority as meeting the applicable requirements of this title for a standard health plan, except that a plan does not provide the benefits packages established under subtitle C; and

''(B) is not a certified supplemental health benefits plan.

''(4) CERTIFIED SUPPLEMENTAL HEALTH BENEFITS PLAN.—For purposes of this title, the term 'certified supplemental health benefits plan' means a health plan which is certified by the appropriate certifying authority as meeting the applicable requirements of part III of subtitle B.

''(b) CERTIFIED LONG-TERM CARE POLICIES.—

''(1) IN GENERAL.—Each State program shall provide for the accreditation and certification of long-term care policies as certified long-term care policies.

''(2) CERTIFIED LONG-TERM CARE POLICY.—For purposes of this title, the term 'certified long-term care policy' means a long-term care policy which is certified by the applicable certifying authority as meeting the applicable requirements of part IV of subtitle B.

''(c) USE OF PRIVATE ACCREDITATION ENTITIES.—A State program may provide for the use of private accreditation entities in carrying out all or part of the duties under subsection (a) or (b).

''(d) CERTIFICATION FEES.—A State program may impose appropriate certification fees on health plans and long-term care policies seeking certification.

"SEC. 21012. CERTIFICATION ENFORCEMENT.

''(a) IN GENERAL.—A State program shall provide for the monitoring and enforcement of the certification of health plans and long-term care policies.

''(b) COMPLAINT PROCESS.—

''(1) IN GENERAL.—A State program shall provide for—

''(A) procedures for individuals and entities to file written, signed complaints with the appropriate certifying authority respecting alleged violations of the standards; and

''(B) responding to and investigating such complaints within 90 days.

''(2) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

''(A) IN GENERAL.—A State program shall provide for consumer access to complaints filed with the appropriate certifying authority with respect to health plans and long-term care policies.

''(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of individual enrollees and policyholders.

''(c) ENFORCEMENT RESPONSE.—

''(1) IN GENERAL.—In the case of any health plan or long-term care policy which fails, in whole or in part, to maintain its certified status, the State program may provide for—

''(A) the imposition of a corrective program;

''(B) State operation of the plan or policy to provide transitional access;

''(C) the suspension of new enrollment of individuals;

''(D) the penalty-free withdrawal of enrollees or policyholders from the plan or policy;

''(E) other intermediate sanctions; and

''(F) withdrawal of certification after the plan or policy has been given a reasonable opportunity to make corrections.

''(2) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—In the case of any supplemental health benefits plan or long-term care policy which fails, in whole or in part, to maintain its certified status, the State program shall impose a civil money penalty of not more than 50 percent of gross premiums received for the sale of such plan or policy. The State program shall include rules similar to the rules of section 1128A (other than subsections (a) and (b))

which shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"SEC. 21013. CONSUMER INFORMATION PROGRAM.

''(a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Each State program shall establish and operate a consumer information program to provide consumers in the State with comparative value information on the performance of all health plans in each community rating area in the State.

''(2) FUNCTIONS DESCRIBED.—The consumer information program established under paragraph (1) shall conduct annual surveys described in subsection (b)(1), annually publish comparative value information described in subsection (b)(2), and perform the additional functions described in subsection (b)(3).

''(b) FUNCTIONS.—

''(1) ANNUAL SURVEYS.—The consumer information program shall conduct annual surveys (in accordance with a national standard survey design and sampling strategy to be determined by the Secretary under subtitle E) of health care consumers in the

participating State concerning access to care, use of health services, health outcomes, patient satisfaction, and other quality measures of local interest that a State may designate.

''(2) PUBLICATION OF COMPARATIVE VALUE INFORMATION.—

''(A) IN GENERAL.—The consumer information program shall annually publish the following comparative value information collected pursuant to section 21123 on all health plans offered in the participating State, listed by community rating area, in a standard format to be determined by the Secretary:

''(i) Descriptive data, including—

''(I) the certification status of the plan;

''(II) benefits offered under the plan;

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

''(IV) risk and referral arrangements under the plan;

''(V) health care providers used under the plan;

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

''(VII) other appropriate information as determined by the Secretary.

''(ii) Data regarding the national measures of quality performance developed under section 21501(b) and adjusted for case-mix (as the Secretary determines appropriate).

''(iii) Data from the annual surveys described in paragraph (1).

''(iv) A subset of quality measures for each health care provider.

''(B) INTERSTATE COMPARATIVE VALUE INFORMATION.—The participating State may join with one or more other State programs to prepare comparative value information for a geographic area approved by the Secretary that includes adjoining portions of contiguous participating States.

''(C) DISTRIBUTION OF COMPARATIVE VALUE INFORMATION.—Comparative value information prepared by the consumer informa-

tion program shall be distributed by the program in a manner that ensures access to such information by health care consumers and that is in accordance with standards established by the Secretary. The program shall distribute the comparative value information through various entities, including employers.

''(3) ADDITIONAL FUNCTIONS.—The consumer information program shall—

''(A) educate consumers about comparability of health plan characteristics and quality;

''(B) provide information and make referrals to assist in health plan enrollment and receipt of subsidies, including the availability and specific eligibility schedules regarding pregnant women and children;

''(C) conduct outreach to underserved and at-risk populations to educate such populations on consumer responsibilities and rights to ensure full participation of such populations in the health care system; and

''(D) receive and seek to resolve complaints, and have appropriate access to relevant information to resolve the complaints.

''(c) USE OF NONPROFIT ORGANIZATIONS.—A State program may operate the consumer information program through a contract with a nonprofit organization selected by the State in a competitive process.

''(d) ADDITIONAL REQUIREMENTS.—Each State program shall meet the requirements specified under subtitles B and C of title XI with respect to certified health plans.

''Subpart C—Other State Responsibilities

''SEC. 21021. ESTABLISHMENT OF COMMUNITY RATING AREAS.

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

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

''(1) no metropolitan statistical area or primary metropolitan statistical area in a State may be divided into more than 1 community rating area in such State;

''(2) the number of individuals residing within a community rating area may not be less than 250,000; and

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

''(c) BOUNDARIES.—In establishing boundaries for community rating areas, a participating State may not discriminate on the basis of, or otherwise take into account, disability, health status, or perceived need for health services of a particular population. Such restrictions shall not prohibit participating States from establishing such boundaries to ensure that underserved and vulnerable populations are better served.

''(d) INTERSTATE AREAS.—Two or more contiguous participating States may provide for the establishment of a community rating area that includes adjoining areas of the States so long as all areas of any metropolitan statistical area or primary metropolitan statistical area within such States are within the same community rating area.

"SEC. 21022. DESIGNATION OF HEALTH PLAN SERVICE AREAS.

''(a) STATE SERVICE AREAS.—Pursuant to guidelines developed under subsection (b), each participating State under the State program shall designate, by not later than January 1, 1996, health plan service areas for purposes of sections 21127 and 21128 and subtitle F.

''(b) GUIDELINES.—The Secretary shall establish guidelines for the designation of health plan service areas—

''(1) which prevent the isolation of low-income and vulnerable populations by preventing the division of governmental boundaries of counties, towns, or cities; and

''(2) which include adjacent designated urban or rural underserved areas.

"SEC. 21023. REINSURANCE AND RISK ADJUSTMENT PROGRAM.

''Each State program under this part shall provide for—

''(1) a reinsurance pool for community-rated standard health plans and a reinsurance pool for self-insured standard health plans (other than multistate self-insured health plans) by January 1, 1996;

''(2) a risk adjustment program for community-rated standard health plans by January 1, 1997; and

''(3) a cost-sharing adjustment program for all standard health plans, except multistate self-insured health plans, by January 1, 1997,

which meet the standards developed by the Secretary under section 21101(b)(2).

''SEC. 21024. SPECIFICATION OF ANNUAL GENERAL ENROLLMENT PERIOD.

''Each participating State under the State program shall specify for the State (or for each community rating area) an annual period, of not less than 30 days, during which individuals in the State (or area) may enroll in health plans or change the health plans in which the individual is enrolled.

''SEC. 21025. PREMIUM APPROVAL PROCESS FOR LONG-TERM CARE POLICIES.

''(a) IN GENERAL.—Each State program shall provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care policies.

''(b) APPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), this section shall not apply to a group long-term care policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the Secretary, in consultation with the NAIC, provide notice to policyholders and certificate

holders of any premium change under such group policy.

''(2) EXCEPTION.—Paragraph (1) shall not apply to—

''(A) group conversion policies;

''(B) the group continuation feature of a group policy if the carrier separately rates employee and continuation coverages; and

''(C) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting such premiums to the carrier.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care policies.

''(d) ACCESS TO OTHER INFORMATION.—The State program shall provide for consumer access to actuarial memoranda, including financial information, provided under this section.

"SEC. 21026. REQUIREMENTS RELATING TO POSSESSIONS OF THE UNITED STATES.

''(a) IN GENERAL.—A possession of the United States shall be a participating State meeting the requirements of this title only if there is an agreement in effect between the United States and such possession pursuant to which—

''(1) the laws of such possession impose a part B premium recapture assessment (as defined in subsection (b));

''(2) nothing in any provision of law, including the law of such possession, permits such possession to reduce or remit in any way, directly or indirectly, any liability to such possession by reason of such assessment;

''(3) any amount received in the Treasury of such possession by reason of such assessment shall be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the Federal Supplementary Medical Insurance Trust Fund;

''(4) such assessment is coordinated with the assessment imposed by section 59B of the Internal Revenue Code of 1986 such that, for any period, an individual would be required to pay (in the aggre-

gate) not more than the applicable amount for such period; and

''(5) the possession complies with such other requirements as may be prescribed by the Secretary and the Secretary of the Treasury to carry out the purposes of this paragraph, including requirements prescribing the information individuals to whom such assessment may apply shall furnish to the Secretary and the Secretary of the Treasury.

''(b) QUALIFIED PART B PREMIUM RECAPTURE ASSESSMENT.—In subsection (a), the term 'qualified medicare part B premium recapture assessment' means an assessment imposed and collected by such a possession that is—

''(1) equivalent to the assessment imposed under section 59B of the Internal Revenue Code of 1986; and

''(2) imposed on all individuals who are bona fide residents of the possession, to the extent such individuals have not paid the assessment imposed under such section 59B to the United States by reason of subsection (d)(5) of such section.

''PART II—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

''SEC. 21031. SINGLE-PAYER SYSTEM DESCRIBED.

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

''(1) meets the requirements of section 21032; and

''(2)(A) in the case of a system offered throughout a State, meets the requirements for a Statewide single-payer system under section 21033; or

''(B) in the case of a system offered in a single community rating area of a State, meets the requirements for an area specific single-payer system under section 21034.

''SEC. 21032. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS.

''Each single-payer system shall meet the following requirements:

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

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

''(3) ENROLLMENT OF INDIVIDUALS.—

''(A) MANDATORY ENROLLMENT OF ALL COMMUNITY-RATED INDIVIDUALS.—The system shall provide for the enrollment of all community-rated individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area) who are not medicare-eligible individuals.

''(B) OPTIONAL ENROLLMENT OF MEDICARE-ELIGIBLE INDIVIDUALS.—At the option of the State and if the Secretary has approved an application submitted by the State, the system may provide for the enrollment of medicare-eligible individuals residing in the State (or, in the case of an area-specific single-payer system, in the community rating area).

''(C) OPTIONAL ENROLLMENT OF EXPERIENCE-RATED INDIVIDUALS.—

''(i) IN GENERAL.—Except as provided in clause (ii), at the option of the State, a single-payer system may provide for the enrollment of experience-rated individuals residing in the State (or,
in the case of an area-specific single-payer system, in the community rating area).

''(ii) PARTICIPATION BY CERTAIN MULTISTATE PLANS.—The system shall not require participation by any experience-rated individual who is enrolled in a certified multistate self-insured standard health plan which is a multiemployer plan described in section 21435(c)(2), or which is sponsored by an experience-rated employer sponsor with at least 5,000 full-time employees.

''(4) DIRECT PAYMENT TO PROVIDERS.—

''(A) IN GENERAL.—With respect to providers who furnish items and services included in the standard benefits package established under subtitle C to individuals enrolled in the system, the State shall make payments directly, or through fiscal intermediaries, to such providers and assume (subject to subparagraph (B)) all financial risk associated with making such payments.

''(B) CAPITATED PAYMENTS PERMITTED.—Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from re-

ceiving payments on a capitated, at-risk basis based on prospectively determined rates.

''(5) PROVISION OF STANDARD BENEFITS PACKAGE.—

''(A) IN GENERAL.—The system shall provide for coverage of the standard benefits package established under subtitle C, including the cost-sharing provided under the package (subject to subparagraph (B)), to all individuals enrolled in the system.

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

''(6) FEDERAL PAYMENTS.—The system shall provide for mechanisms to ensure, in a manner satisfactory to the Secretary, that Federal payments to a single-payer State or community rating area shall be limited to the payments that would have been

made in the absence of the implementation of the single-payer system.

''(7) INCREASED COVERAGE OR IMPROVED COST CONTAINMENT.—The system, when fully implemented, shall be expected by the State to—

''(A) reduce the number of residents of the State (or, in the case of an area-specific single-payer system, the community rating area) who are without health insurance coverage (as defined in section 2202(b)(2)) by at least 10 percent, or

''(B) decrease the rate of growth of per capita health care spending in the State (or, in the case of an area-specific single-payer system, the community rating area),

compared to baseline projections developed by the State on the basis of the most recent data, including data provided by the National Health Care Commission established under section 2201.

''(8) REQUIREMENTS GENERALLY APPLICABLE TO STANDARD HEALTH PLANS.—The system shall meet the requirements applicable to a standard health plan, except that—

''(A) the system does not have the authority provided to standard health plans under sec-

tion 21111(e) (relating to permissible limitations on the enrollment of community-rated eligible individuals on the basis of limits on the plan's capacity); and

''(B) the system is not required to meet the requirements of sections 21113 (relating to rating limitations for community-rated market) and 21122 (relating to capital requirements).

"SEC. 21033. SPECIAL RULES FOR STATES OPERATING STATEWIDE SINGLE-PAYER SYSTEM.

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

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

''(2) except as provided in subsection (b), the State shall meet the requirements for participating States under part I.

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

''(1) ESTABLISHMENT OF COMMUNITY RATING AND SERVICE AREAS.—The requirements of sections 21021 (relating to the establishment of community

rating areas) and 21022 (relating to the designation of health plan service areas).

''(2) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not appropriate to apply to a State single-payer system.

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

"SEC. 21034. SPECIAL RULES FOR COMMUNITY RATING AREA-SPECIFIC SINGLE-PAYER SYSTEMS.

''(a) IN GENERAL.—In the case of a State operating a community rating area specific single-payer system—

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

''(2) the community rating area in which the system is operated shall meet the requirements of subsection (c).

''(b) OTHER REFERENCES INAPPLICABLE.—Any requirement which the Secretary determines is not appropriate to apply to a community rating area specific single-payer system.

''(c) REQUIREMENTS FOR COMMUNITY RATING AREA IN WHICH SYSTEM OPERATES.—A community rating area in which an area-specific single-payer system is operated shall meet the requirements applicable to community rating areas under section 21021.

"PART III—TREATMENT OF CERTAIN STATE LAWS

"SEC. 21041. PREEMPTION OF STATE LAW RESTRICTIONS ON NETWORK PLANS.

''(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1996—

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

''(2) a State may not prohibit or limit a network plan from requiring enrollees to obtain care from participating providers;

''(3) a State may not prohibit or limit a network plan from requiring enrollees to obtain referrals for specialty treatment;

''(4) a State may not prohibit or limit the establishment of different payment rates for network and non-network providers;

''(5) a State may not prohibit or limit a network plan from limiting the number and types of participating providers;

''(6) a State may not prohibit or limit a network plan from using single source suppliers for pharmacy services, medical equipment, and other supplies and services; and

''(7) a State may not prohibit or limit the corporate practice of medicine.

''(b) DEFINITIONS.—In this section:

''(1) NETWORK PLAN.—The term 'network plan' means a health plan—

''(A) which—

''(i) limits coverage of covered items and services to those provided by participating providers, or

''(ii) provides, with respect to such items and services provided by persons who are not participating providers, for cost-sharing which is greater than that permitted under the standard benefits package established under subtitle C for participating providers;

''(B) which has a sufficient number and distribution of participating providers to assure that the standard benefits package—

''(i) is available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and

''(ii) when medically necessary, is available and accessible twenty-four hours a day and seven days a week;

''(C) which provides benefits for covered items and services not furnished by participating providers if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

''(D) which provides out-of-area coverage.

''(2) PARTICIPATING PROVIDER.—The term 'participating provider' means an entity or individual which provides, sells, or leases health care services under a contract with a network plan, which contract does not permit—

''(A) cost-sharing in excess of the cost-sharing permitted under a standard benefits package established under subtitle C; and

''(B) any enrollee charges (for covered items or services) in excess of such cost-sharing.

"SEC. 21042. STATE LAW RESTRICTIONS ON HEALTH PROFESSIONAL LICENSURE.

''(a) IN GENERAL.—Except as otherwise provided in this section, nothing in this title shall be construed as limiting any State's authority to enact and enforce laws with respect to the licensure or certification of any class of health professional or the provision of any class of health professional services.

''(b) SCOPE OF PRACTICE.—Effective as of January 1, 1996, a State may not restrict through licensure or otherwise the practice of any class of health professionals beyond what is justified by the skills and training of such professionals.

''(c) ACADEMIC DEGREE.—Effective as of January 1, 1996, a State may not restrict the participation, reimbursement, or indemnification of a health professional solely on the basis of the academic degree of such professional if the professional is acting within the scope of the professional's license under applicable State law.

''SEC. 21043. PREEMPTION FROM STATE BENEFIT MANDATES.

''Effective as of January 1, 1996, no State shall establish or enforce any law or regulation that requires any standard health plan to cover items and services that are different from the items and services specified pursuant to subtitle C.

''SEC. 21044. PREEMPTION OF STATE LAW REGULATING UTILIZATION MANAGEMENT AND REVIEW.

''Effective as of January 1, 1996, a State may not regulate utilization management and review programs of any health plan to the extent not provided by this title.

''PART IV—FEDERAL RESPONSIBILITIES

''SEC. 21051. FEDERAL ROLE WITH RESPECT TO MULTISTATE SELF-INSURED HEALTH PLANS.

''(a) IN GENERAL.—In the case of a multistate self-insured health plan or a multistate self-insured supplemental health benefits plan, the Secretary of Labor shall carry out activities under this title in the same manner as a participating State program would carry out activities under part I with respect to a health plan subject to such part.

''(b) DETERMINATION OF MULTISTATE STATUS.—For purposes of this title, a self-insured health plan or a self-insured supplemental health benefits plan shall be considered a multistate health plan if established or main-

tained by an experience-rated employer which has a substantial number of employees enrolled in such plan in each of 2 or more States (as determined by the Secretary of Labor).

''(c) APPLICABILITY OF ERISA ENFORCEMENT MECHANISMS.—The provisions of sections 502 (relating to civil enforcement), 504 (relating to investigative authority), and 506 (relating to criminal enforcement) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of the applicable requirements for experience-rated employers described in subsection (b) in the same manner and to the same extent as such provisions apply to enforcement of title I of such Act.

"SEC. 21052. ESTABLISHMENT OF RESIDENCY RULES.

''The Secretary shall establish rules relating to identifying the State (and community rating area) in which individuals reside. Such rules shall be based on the principal residence of such an individual.

"SEC. 21053. WORKPLACE WELLNESS PROGRAM.

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

''(b) APPLICATION OF SECTION.—Any health plan may offer a uniform premium discount, not to exceed 10

percent, to employers maintaining certified workplace wellness programs.

"SEC. 21054. EMPLOYEE LEASING RULES.

''The Secretary of Labor shall promulgate such regulations as may be necessary to prevent the avoidance of any requirements of this title through the use of employee leasing businesses.

"SEC. 21055. APPROVAL OF PRIVATE ACCREDITATION PROGRAMS.

''The Secretary shall certify the private accreditation entities described under section 21011(c).

"PART V—DEFINITIONS AND RULES

"SEC. 21100. DEFINITIONS AND RULES OF GENERAL APPLICATION.

''Except as otherwise specifically provided, in this title the following definitions and rules apply:

''(1) APPROPRIATE CERTIFYING AUTHORITY.—The term 'appropriate certifying authority' means—

''(A) except as provided in subparagraph (B), in the case of a standard or nonstandard health plan, a supplemental health benefits plan, or a long-term care policy, the State commissioner or superintendent of insurance or other State authority in the participating State; or

''(B) in the case of a multistate self-insured health plan or a multistate self-insured supplemental health benefits plan, the Secretary of Labor.

''(2) COVERED ITEMS AND SERVICES.—The term 'covered items and services' means items and services included in benefit packages established under subtitle C.

''(3) DELIVERY SYSTEM.—The term 'delivery system' with respect to a health plan includes a fee-for-service, use of preferred providers, staff or group model health maintenance organizations, and such other arrangements as the Secretary may recognize.

''(4) DEPENDENT.—The term 'dependent' means, with respect to any individual, any person—

''(A) who is a child (within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986) of the individual; and

''(B) who is—

''(i) under 25 years of age and unmarried, or

''(ii) permanently and totally disabled (within the meaning of section 151(c)(5)(C) of such Code).

''(5) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND WAGES DEFINED.—

''(A) IN GENERAL.—Except as otherwise provided in this subtitle—

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

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

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

''(B) EXCEPTIONS.—For purposes of subparagraph (A)—

''(i) EMPLOYMENT.—

''(I) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19)

of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

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

''(III) EXCLUSION OF PART-TIME DOMESTIC SERVICE.—Employment shall not include domestic service in a private home of the employer (within the meaning section 3121(a)(7)(B), determined without dollar limitation) by an individual who is not a full-time employee.

''(IV) EXCLUSION OF SEASONAL OR TEMPORARY.—Employment shall not include seasonal or temporary services performed for an employer for less than 6 months in a calendar year.

''(V) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under regulation by the Secretary of Labor, an employee shall be considered to be

employed on a full-time basis by an employer (and to be a full-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of employment in the industry, represents full-time employment in that industry.

''(ii) WAGES.—

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

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

''(iii) EMPLOYEES.—

''(I) TREATMENT OF SELF-EMPLOYED.—The term 'employee' includes a self-employed individual.

''(II) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term 'employee' does not include an individual with respect to service, if the indi-

vidual is not a citizen or resident of the United States and the service is performed outside the United States.

''(C) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this title—

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

''(ii) under regulations of the Secretary of the Treasury, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under clause (ii) shall be based on principles similar to the principles which apply to taxable organizations under clause (i).

''(6) EQUIVALENT HEALTH CARE PROGRAM.—The term 'equivalent health care program' means—

''(A) part A or part B of the medicare program under title XVIII of the Social Security Act,

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

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

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

''(E) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

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

''(G) a State single-payer system approved by the Secretary under section 21031.

''(7) FAMILY.—The term 'family' includes an individual, the individual's spouse, and the individual's dependents (if any), as defined in paragraph (4).

''(8) HEALTH PLAN SPONSOR.—The term 'health plan sponsor' means, with respect to—

''(A) an insured health plan, the insurer, and

''(B) a self-insured health plan, the experience-rated employer sponsor.

''(9) HEALTH PROFESSIONAL.—The term 'health professional' means an individual who is legally authorized to provide services in the State in which such services are provided.

''(10) LEGALLY AUTHORIZED.—The term 'legally authorized' means, with respect to a provider, authorization under licensing or certification laws of a State.

''(11) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

''(12) PARTICIPATING STATE.—The term 'participating State' means a State establishing a State program under this title.

''(13) PROVIDER.—The term 'provider' includes a health professional.

''(14) PURCHASING COOPERATIVE.—The term 'purchasing cooperative' means a health insurance purchasing cooperative established under section 21411.

''(15) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services or the Secretary's delegate.

''(16) STATE.—The term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Subtitle B—Standards for Reform

"PART I—ESTABLISHMENT AND APPLICATION OF STANDARDS

"SEC. 21101. CERTIFIED STANDARD HEALTH PLANS.

''(a) IN GENERAL.—A standard health plan shall meet the applicable reform standards established under subsection (b).

''(b) REFORM STANDARDS.—

''(1) ESTABLISHMENT OF GENERAL STANDARDS.—

''(A) IN GENERAL.—Except as provided in this paragraph and paragraphs (2), (3), and (4), the Secretary, in consultation with the National Health Plan Standards and Quality Advisory Committee, shall develop and publish specific standards and evaluation criteria to implement the standards specified in part II and

guidelines for an accreditation, certification, enforcement, and information program for participating States by not later than July 1, 1995.

''(B) ADAPTATION TO DELIVERY SYSTEMS.—The Secretary shall adapt the standards specified in subpart B of part II with respect to each particular delivery system.

''(C) ESTABLISHMENT OF PROVISIONAL STANDARDS.—With respect to any health plan operating in an underserved area (as designated by the State or the Secretary under section 21601), the Secretary may adopt provisional standards for use for not more than 3 years in lieu of the standards specified in subpart B of part II.

''(2) ESTABLISHMENT OF STANDARDS FOR REINSURANCE AND RISK ADJUSTMENT PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall develop standards under subparagraphs (B), (C), and (D), for participating States to provide reinsurance pools, risk adjustment programs, and subsidy adjustment programs under section 21023 for participation by standard health plans as provided in section 21121.

''(B) MANDATORY REINSURANCE POOLS.—The standards developed by the Secretary under this subparagraph shall include a system of mandatory reinsurance which—

''(i) specifies the manner of creation, structure, and operation of the system, including—

''(I) the manner (which may be prospective or retrospective) in which community-rated and self-insured standard health plans make payments to their respective systems, and

''(II) the type and level of reinsurance coverage provided;

''(ii) provides for such health plans to make payments to the State-established reinsurance program for the purpose of eliminating incentives for plans to discriminate against individuals on the basis of their expected utilization of health services; and

''(iii) provides such health plans with incentives to manage the care and health care costs of individuals with above-aver-

age needs (or expected needs) for health care services.

''(C) RISK ADJUSTMENT PROGRAM.—

''(i) IN GENERAL.—The standards developed by the Secretary under this subparagraph shall include a risk adjustment program which—

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

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

''(ii) FACTORS TO BE CONSIDERED.—In developing the standards for a risk ad-

justment program, the Secretary may take into account the following factors with respect to enrollees:

''(I) Demographic characteristics.

''(II) Health status.

''(III) Socio-economic status.

''(IV) Subsidy status.

''(V) Other factors determined appropriate by the Secretary.

''(iii) ZERO SUM.—The standards for the risk adjustment program methodology shall assure that the total payments to all community-rated standard health plans after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.

''(D) COST-SHARING ADJUSTMENT PROGRAM.—The standards developed by the Secretary under this subparagraph shall include a cost-sharing adjustment program which redistributes losses among all standard health plans, except multistate self-insured health plans, resulting from the reduced cost-sharing obligations of individuals receiving assistance as is

provided under the program described in part B of title XIX.

''(3) ESTABLISHMENT OF CAPITAL STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop, in consultation with the NAIC, by not later than July 1, 1995, a risk-based capital standards formula for health plans under section 21122.

''(B) NO PREEMPTION.—Nothing in this title shall preclude or preempt State law on, or regulation of, health plan deposit reserve requirements.

''(4) CONSULTATION WITH SECRETARY OF LABOR.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of multistate self-insured health plans, the Secretary, in consultation with the Secretary of Labor, shall develop and publish the standards for such plans.

''(B) REINSURANCE PROGRAM.—The Secretary of Labor shall develop, by not later than July 1, 1995, standards for a reinsurance program for multistate self-insured health plans under section 21121.

''(c) NATIONAL HEALTH PLAN STANDARDS AND QUALITY ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish a National Health Plan Standards and Quality Advisory Committee (hereafter referred to in this subsection as the 'Committee') by March 1, 1995, to advise the Secretary on—

''(A) standards and evaluation criteria to be used in the certification of all plans;

''(B) the use and accountability of funds from the Health Security Trust Fund to support State establishment of accreditation, certification, enforcement, and information programs; and

''(C) national measures of quality performance, comparative value information criteria, population health status measures, and other aspects of quality and consumer information.

''(2) NUMBER AND APPOINTMENT.—The Committee shall be composed of the Administrator of the Agency for Health Care Policy and Research, the Administrator of the Health Care Financing Administration, and 11 members appointed by the Secretary. The appointed members shall be broadly rep-

resentative of the population of the United States and shall include—

''(A) a representative of State insurance commissioners or State health departments;

''(B) a representative of health plans;

''(C) a representative of employers purchasing health care;

''(D) a representative of health care providers;

''(E) a representative of consumers of health care;

''(F) a representative of associations of private accreditation entities; and

''(G) individuals distinguished in the fields of law, medicine, economics, public health, and health services research.

''(3) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the appointed members of the Committee shall serve for a term of 4 years.

''(B) STAGGERED ROTATION.—Of the members first appointed to the Committee under paragraph (2), the Secretary shall appoint 4 members to serve for a term of 4 years,

4 members to serve for a term of 3 years, 3 members to serve for a term of 2 years.

''(C) SERVICE BEYOND TERM.—An appointed member of the Committee may continue to serve after the expiration of the term of the member until a successor is appointed.

''(4) VACANCIES.—If an appointed member of the Committee does not serve the full term applicable under paragraph (3), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(5) CHAIR.—The Secretary shall designate an individual to serve as the chair of the Committee.

''(6) MEETINGS.—The Committee shall meet not less than once during each 4-month period and shall otherwise meet at the call of the Secretary or the chair.

''(7) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Committee shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable

for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(8) STAFF.—The Secretary shall provide to the Committee such staff, information, and other assistance as may be necessary to carry out the duties of the Committee.

''(9) FACA NOT APPLICABLE.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(d) TAX QUALIFICATION.—For favorable Federal income tax treatment which is available only to certified standard health plans, see sections 213(f) and 4521 of the Internal Revenue Code of 1986.

''SEC. 21102. CERTIFIED SUPPLEMENTAL HEALTH BENEFITS PLANS.

''(a) IN GENERAL.—A supplemental health benefits plan shall meet the applicable reform standards established under subsection (b).

''(b) ESTABLISHMENT OF STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall develop and publish specific standards to implement the standards specified in part III by not later than January 1, 1996.

''(2) CONSULTATION WITH SECRETARY OF LABOR.—In the case of multistate self-insured sup-

plemental health benefits plans, the Secretary, in consultation with the Secretary of Labor, shall develop and publish the standards described in paragraph (1).

''(c) TAX QUALIFICATION.—For favorable Federal income tax treatment which is available only to certified supplemental health benefits plans, see section 4521 of the Internal Revenue Code of 1986.

"SEC. 21103. CERTIFIED LONG-TERM CARE POLICIES.

''(a) IN GENERAL.—A long-term care policy shall meet the applicable reform standards established under subsection (b).

''(b) ESTABLISHMENT OF STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, in consultation with the NAIC, shall develop and publish specific standards to implement the standards specified in part IV by not later than September 1, 1996.

''(2) STATE STANDARDS.—Nothing in this title shall be construed as preventing a participating State from applying standards that provide greater protection to insured individuals under long-term care policies than the standards promulgated under this section, except that such State standards may

not be inconsistent with any of the standards specified in part IV.

''(c) TAX QUALIFICATION.—For favorable Federal income tax treatment which is available only to certified long-term care policies, see section 7702B of the Internal Revenue Code of 1986.

"SEC. 21104. GENERAL RULES.

''(a) CONSTRUCTION.—Whenever in this subtitle a requirement or standard is imposed on a health plan, supplemental health benefits plan, or long-term care policy, the requirement or standard is deemed to have been imposed on the insurer or sponsor of the plan or policy in relation to that plan or policy.

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

''(c) REFERENCE TO REFORM STANDARDS.—For purposes of this title, the term 'reform standards' means the standards developed under this subtitle and applicable under parts II, III, and IV.

“PART II—STANDARDS APPLICABLE TO STANDARD HEALTH PLANS

“Subpart A—Insurance Standards

“SEC. 21111. GUARANTEED ISSUE AND RENEWAL.

‘‘(a) ISSUE.—

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

‘‘(A) offering a community-rated health plan shall offer such plan to any community-rated individual applying for coverage; and

‘‘(B) offering an experience-rated health plan or a self-insured health plan shall offer such plan to any experience-rated individual eligible for coverage under the plan through the individual’s experience-rated employer.

‘‘(2) AVAILABILITY.—

‘‘(A) IN GENERAL.—A community-rated standard health plan shall be made available throughout the entire community rating area in which such plan is offered, including through any purchasing cooperative choosing to offer such plan.

‘‘(B) GEOGRAPHIC LIMITATIONS.—A community-rated standard health plan may deny coverage under the plan to a community-rated

individual who resides outside the community rating area in which such plan is offered, but only if such denial is applied uniformly, without regard to health status or insurability of individuals.

''(3) APPLICATION OF CAPACITY LIMITS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an insured standard health plan may apply to the appropriate certifying authority to cease enrolling individuals under the plan if—

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

''(ii) the plan can demonstrate to the applicable certifying authority that its financial or provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation with such previously covered groups or individuals) will be impaired if it is required to enroll other individuals.

''(B) FIRST-COME-FIRST-SERVED.—An insured standard health plan is only eligible to exercise the limitations provided for in subpara-

graph (A) if such plan provides for enrollment of individuals on a first-come-first-served basis (except in the case of additional individuals described in subparagraph (A)(ii)).

''(b) RENEWAL.—

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

''(2) GROUNDS FOR REFUSAL TO RENEW.—A health plan sponsor may refuse to renew, or may terminate, a standard health plan under this title only for—

''(A) nonpayment of premiums;

''(B) fraud on the part of the individual; or

''(C) misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits.

''(c) FEHBP PLANS.—Any standard health plan sponsor participating in the Federal Employees Health Benefits Program, and operating a standard health plan within a community rating area, shall offer a community-rated standard health plan in such area, except that this requirement shall not apply to nationwide plans under

paragraphs (1), (2), and (3) of section 8903 of title 5, United States Code.

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

''(e) APPLICATION OF INTERIM STANDARDS.—

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

''(2) SPECIFIED STANDARDS.—

''(A) ISSUE.—The standards specified in subsection (a) with respect to self-insured health plans.

''(B) RENEWAL.—The standards specified in subsection (b).

''(C) EXIT FROM MARKET.—

''(i) IN GENERAL.—An insurer shall renew an insured health plan through a particular type of delivery system (as de-

fined in section 21100) with respect to a community-rated individual, unless such insurer—

''(I) elects not to renew all of its insured health plans using such delivery system issued to all such individuals in a State; and

''(II) provides notice to the appropriate certifying authority and to each such individual covered under the plan of such termination at least 180 days before the date of expiration of the plan.

''(ii) PROHIBITION ON MARKET REENTRY.—In the case of such a termination, such insurer may not provide for the issuance of any insured health plan using such a delivery system to a community-rated individual in such State during the 5-year period beginning on the date of the termination of the last plan not so renewed.

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

''(A) in the case of the standard specified in paragraph (2)(A), on or after January 1, 1995, and before January 1, 1996;

''(B) in the case of the standards specified in paragraph (2)(B), on or after June 28, 1994, and before January 1, 1996; and

''(C) in the case of the standard specified in paragraph (2)(C), on or after the date of the enactment of this title, and before January 1, 1996.

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

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

''(6) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations

regarding the application of this subsection in the case of health plans (or groups of such plans) which are transferred from one health plan sponsor to another sponsor through assumption, acquisition, or otherwise.

"SEC. 21112. ENROLLMENT.

''(a) ENROLLMENT PROCESS.—

''(1) IN GENERAL.—A standard health plan shall establish an enrollment process consistent with this subsection.

''(2) INITIAL ENROLLMENT PERIOD.—Each individual shall have an initial enrollment period in which to enroll in a standard health plan—

''(A) except as provided in subparagraph (B), beginning on January 1, 1996, and ending on March 31, 1996,

''(B) with respect to premium subsidy eligible individuals described in section 1952(a)(2)(A)(i) in States which have not established a premium subsidy program in 1996, beginning on January 1, 1997, and ending on March 31, 1997.

''(3) GENERAL ENROLLMENT PERIOD.—Each standard health plan shall permit eligible individuals to enroll (or change enrollment) in the plan during

each general annual enrollment period specified by the appropriate certifying authority under section 21024.

''(4) SPECIAL ENROLLMENT PERIODS.—In the case of an individual who—

''(A) through marriage, separation, divorce, birth or adoption of a child, death, or similar circumstances, experiences a change in family composition;

''(B) experiences a change in employment status (including a significant change in the terms and conditions of employment) or in continuation coverage;

''(C) changes residence to another community rating area;

''(D) disenrolls for cause from a standard health plan; or

''(E) is subject to the decertification of a standard health plan under section 21012,

each standard health plan shall provide for a special enrollment period in which the employee or individual is permitted to change the individual or family basis of coverage or the plan in which the employee or individual is enrolled. The circumstances under which such special enrollment periods are required

and the duration of such periods shall be specified in the reform standards.

''(b) COMMENCEMENT OF COVERAGE.—

''(1) IN GENERAL.—In the case of an individual who enrolls with a standard health plan during an enrollment period, coverage under the plan shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the reform standards specify.

''(2) NEWBORNS.—In the event of the birth or adoption of a child of an enrollee, coverage of such child under such enrollee's standard health plan (regardless of the class of enrollment) shall begin on the date of such birth or adoption and shall continue, in the absence of any enrollment of such child during a special enrollment period provided under subsection (a)(4), for at least 45 days.

"SEC. 21113. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

''(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE INDIVIDUALS.—Each standard health plan which covers community-rated individuals shall establish within each community rating area in which

the plan is to be offered a standard premium for individual enrollment for—

''(1) the standard benefits package established under subtitle C, and

''(2) the alternative standard benefits package established under subtitle C.

''(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each package described in subsection (a) for all community-rated individuals within a community rating area shall be the same and shall not include the costs of premium processing, enrollment, and marketing that would vary depending on whether the method of enrollment is through a purchasing cooperative, or directly through a health plan, an employer, or a broker.

''(2) APPLICATION TO ENROLLEES.—

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

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

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

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

''(B) FAMILY ADJUSTMENT FACTOR.—

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

''(ii) CLASSES OF ENROLLMENT.—For purposes of this title, there are 6 classes of enrollment:

''(I) Coverage only of an individual (other than an individual described in subclause (II)) (referred to in this title as the 'individual' enrollment or class of enrollment).

''(II) Coverage only of an individual who has not attained age 18 (referred to in this title as the 'single

child' enrollment or class of enrollment).

''(III) Coverage only of two or more children (referred to in this title as the 'multiple children' enrollment or class of enrollment).

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

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

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

''(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this title:

''(I) FAMILY.—The terms 'family enrollment' and 'family class of enrollment' refer to enrollment in a class of enrollment described in any subclause

of clause (ii) (other than subclause (I)).

''(II) COUPLE.—The term 'couple class of enrollment' refers to enrollment in a class of enrollment described in subclause (IV) or (VI) of clause (ii).

''(iv) SPOUSE; MARRIED; COUPLE.—

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

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

''(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age

adjustment factor may not exceed twice the lowest age adjustment factor.

''(3) ADMINISTRATIVE CHARGES.—

''(A) IN GENERAL.—In accordance with the reform standards, a standard health plan which covers community-rated individuals may add a separately-stated administrative charge which is based on identifiable differences in marketing and other legitimate administrative costs which vary by size of the enrolling group and method of enrollment, including enrollment directly through a health plan, an employer, or a broker (as defined in such standards).

''(B) APPLICATION.—The administrative charge for any plan described in subparagraph (A) shall be applied uniformly with respect to group size and method of enrollment and the Secretary shall specify the permitted variation in the administrative charge of a plan.

''(C) DISALLOWANCE OF SEPARATE CHARGE ON COOPERATIVE.—No standard health plan which covers community-rated individuals may impose a separately-stated administrative charge for enrollment through any purchasing cooperative.

''(c) TREATMENT OF NEGOTIATED RATE AS COMMUNITY RATE.—Notwithstanding any other provision of this section, a standard health plan which covers community-rated individuals in a community rating area may only charge a premium for any coverage which is the same as the premium for such coverage when it is offered through a purchasing cooperative in such area.

"SEC. 21114. RATING PRACTICES AND PAYMENT OF PREMIUMS.

''(a) FULL DISCLOSURE OF RATING PRACTICES.—

''(1) IN GENERAL.—At the time a health plan sponsor offers a standard health plan, such sponsor shall fully disclose rating practices for such plan to the appropriate certifying authority.

''(2) NOTICE ON EXPIRATION.—A health plan sponsor providing a standard health plan shall provide for notice, at least 60 days before the date of expiration of the plan, of the terms for renewal of the plan.

''(3) ACTUARIAL CERTIFICATION.—Each health plan sponsor shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) certifying that, based upon an examination by the individual

which includes a review of the appropriate records and of the actuarial assumptions of such sponsor and methods used by such sponsor in establishing premium rates for insured standard health plans—

''(A) such sponsor is in compliance with the applicable provisions of this section; and

''(B) the rating methods are actuarially sound.

Each such sponsor shall retain a copy of such statement at its principal place of business for examination by any individual.

''(b) PAYMENT OF PREMIUMS.—

''(1) IN GENERAL.—With respect to a new enrollee in a standard health plan, the plan may require advanced payment of an amount equal to the monthly applicable premium for the plan at the time such individual is enrolled.

''(2) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a standard health plan fails to receive payment on a premium due with respect to an individual covered under the plan, the plan shall provide notice of such failure to the individual within the 20-day period after the date on which such premium payment was due.

"SEC. 21115. NONDISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—Except as provided under subsection (b), a standard health plan may not—

''(1) deny, limit, or condition the coverage under (or benefits of) the plan;

''(2) engage, directly or through contractual arrangements, in any activity, including the selection of a service area; and

''(3) in the case of a self-insured standard health plan, vary the premium,

based on the health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care expenses, disability, or lack of evidence of insurability, of an individual.

''(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

''(1) IN GENERAL.—Subject to paragraph (4), a standard health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual only if—

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

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

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

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

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

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

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

rolled for a continuous period of more than 3 months.

''(B) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a standard health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day before the date of enrollment (without regard to any waiting period).

''(4) SPECIAL RULE FOR 1996.—This subsection shall be applied for calendar year 1996 by substituting '6-month' for '3-month' in paragraph (1)(A).

''(5) PROHIBITION ON PREEXISTING CONDITION EXCLUSION DURING AMNESTY PERIOD.—This subsection shall not apply during an initial enrollment period described in section 21112(a)(2).

''(c) APPLICATION OF INTERIM STANDARDS.—

''(1) IN GENERAL.—During the interim standards application period, a health plan sponsor may only offer a self-insured health plan in a State if such plan meets the standards specified in paragraph (2).

''(2) SPECIFIED STANDARDS.—

''(A) ISSUE.—The standards specified in subsection (a) with respect to self-insured health plans.

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

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

''(A) in the case of the standard specified in paragraph (2)(A), on or after January 1, 1995, and before January 1, 1996; and

''(B) in the case of the standards specified in paragraph (2)(B), on or after June 28, 1994, and before January 1, 1996.

''(4) APPLICATION OF RULES.—Paragraphs (4), (5), and (6) of section 21111(e) shall apply to this subsection.

''SEC. 21116. BENEFITS OFFERED.

''A standard health plan shall offer to all enrollees in the plan the standard benefits package or the alternative standard benefits package established under subtitle C.

"Subpart B—Delivery System Standards

"SEC. 21121. REINSURANCE, RISK ADJUSTMENT, AND COST-SHARING ADJUSTMENT.

''(a) COMMUNITY-RATED PLANS.—Each community-rated standard health plan shall participate in a reinsurance pool, risk adjustment program, and cost-sharing adjustment program of the State described in section 21101(b)(2).

''(b) EXPERIENCE-RATED PLANS.—Each experience-rated health plan shall participate in a cost-sharing adjustment program described in section 21101(b)(2).

''(c) SELF-INSURED PLANS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), each self-insured standard health plan shall participate in a reinsurance pool and the cost-sharing adjustment program of the State described in section 21101(b)(2).

''(2) MULTISTATE PLANS.—Each multistate self-insured standard health plan shall participate in a reinsurance program developed under section 21101(b)(4)(B).

''(d) HOLD-HARMLESS PROTECTIONS.—Each standard health plan shall hold individual providers harmless from the effects of the cost-sharing assistance program under section 1953(b).

''SEC. 21122. CAPITAL REQUIREMENTS.

''Each standard health plan shall meet the risk-based capital standards formula applicable to such plan under the standards established under section 21101(b)(3).

''SEC. 21123. COLLECTION AND PROVISION OF STANDARDIZED INFORMATION.

''(a) HEALTH PLANS REQUIRED TO SUBMIT INFORMATION TO PROGRAM.—Each standard health plan offered or operated in a State shall submit to the consumer information program of such State established under section 21013 the program descriptive information regarding—

''(1) certification status of the plan;

''(2) benefits offered under the plan;

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

''(4) risk and referral arrangements under the plan;

''(5) health care providers used under the plan and the availability of such providers;

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

''(7) other appropriate information as determined by the Secretary.

The submission of such information shall be in the form of nonidentifiable health information (as defined in section 11702(7)).

''(b) ADDITIONAL REQUIREMENTS.—Each standard health plan shall meet the requirements specified under subtitles B and C of title XI with respect to such plans.

"SEC. 21124. QUALITY IMPROVEMENT AND ASSURANCE.

''(a) IN GENERAL.—Each standard health plan shall—

''(1) develop and implement an internal quality improvement program designed to measure, assess, and improve enrollee health status, enrollee outcomes, enrollee processes of care, and enrollee satisfaction;

''(2) develop and implement quality improvement goals based on the results of population health status measurements conducted under subtitle E; and

''(3) maintain a program to assure that the quality of health care services furnished to enrollees meets minimum standards of safety and clinical practice.

''(b) UTILIZATION MANAGEMENT.—

''(1) IN GENERAL.—Each standard health plan shall provide that all review determinations shall be

made by licensed or certified health professionals with appropriate clinical training.

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

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

''(4) CONSUMER DISCLOSURE.—Each standard health plan shall disclose, upon request, to enrollees (and prospective enrollees) and to participating providers (and prospective providers) the utilization review protocols used by the plan, while protecting proprietary business information to the extent specified by the Secretary in the reform standards.

''(c) CREDENTIALING.—Each standard health plan shall—

''(1) credential participating physicians and practitioners; and

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

''(d) CONTINUITY OF CARE.—Each standard health plan shall develop and implement mechanisms for coordinating the delivery of care across provider settings.

''(e) MEDICAL RECORDKEEPING.—Each standard health plan shall assure that pertinent information is readily available to appropriate professionals.

"SEC. 21125. PATIENT PROTECTIONS AND PROVIDER SELECTION.

''(a) PATIENT INFORMATION.—Each standard health plan shall provide to enrollees clear descriptive information about the rights and responsibilities of enrollees.

''(b) INFORMATION REGARDING A PATIENT'S RIGHT TO SELF-DETERMINATION IN HEALTH CARE SERVICES.—Each standard health plan shall—

''(1) provide written information to each individual enrolling in such plan of—

''(A) such individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to

formulate advance directives (as defined in section 1866(f)(3)), and

''(B) the written policies of the plan with respect to such right;

''(2) provide for educational activities for patients and participating providers; and

''(3) require participating primary care physicians to include in their patients' charts the wishes of the patient concerning advance directives.

''(c) CONFIDENTIALITY OF PATIENT RECORDS.—Each standard health plan shall have explicit procedures to protect the confidentiality of individual patient information consistent with the rules established under subtitle C of title XI.

''(d) MARKETING.—No insurer may engage in selective marketing that would have the effect of avoiding high-risk subscribers within a community rating area. Marketing materials may not contain false or materially misleading information.

''(e) NO PATIENT LIABILITY FOR UNPAID PLAN OBLIGATIONS.—Each standard health plan shall hold enrollees harmless with respect to any plan obligations for payment to providers.

''(f) REMEDIES AND ENFORCEMENT.—

''(1) IN GENERAL.—Each standard health plan shall comply with the remedies and enforcement requirements described in subtitle H.

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

''(g) PROVIDER SELECTION.—

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

''(2) NO DISCRIMINATION BASED ON ACADEMIC DEGREE.—No standard health plan may discriminate in participation, reimbursement, or indemnification against a health professional solely on the basis of the academic degree of such professional if the professional is acting within the scope of the professional's license under applicable State law.

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

''(A) prevent a standard health plan from matching the number and type of health care providers to the needs of the plan members;

''(B) require any such plan to contract with any type of provider legally authorized to provide services in the State in which such services are provided; or

''(C) except as specifically provided in this title, establish any other measure designed to maintain quality or to control costs.

''(h) PHYSICIAN INCENTIVE PLANS.—A standard health plan may not operate a physician incentive plan unless such incentive plan meets the requirements of section 1876(i)(8)(A).

''(i) PHYSICIAN PARTICIPATION.—

''(1) IN GENERAL.—Each standard health plan shall establish mechanisms through which physicians have input into matters affecting patient care and through which patients have the ability to choose any primary care physician from available practitioners.

''(2) CONTRACT PROCEDURES.—Each standard health plan shall provide not less than 30 days notification to physicians of decisions to cancel or deny renewal of contracts and shall establish an informal,

non-binding, and advisory review process for appeals.

''(j) ETHICAL BUSINESS CONDUCT.—Each standard health plan shall develop and implement a code of ethical business conduct for its activities, including those of its components, and assure proficient management and planning functions.

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

''SEC. 21126. ALTERNATIVE DISPUTE RESOLUTION PROCEDURES RELATING TO MALPRACTICE CLAIMS.

''Each standard health plan shall establish and maintain an alternative dispute resolution procedures program that complies with the standards developed under section 1129.

''SEC. 21127. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.

''(a) IN GENERAL.—Each standard health plan sponsor shall, with respect to at least one of each category of essential community provider (as defined in subsection (c)) located within health plan service areas designated under section 21022, offer to enter into a written provider participation agreement (described in subsection (b)) with the provider covering the 5-year period beginning on Janu-

ary 1, 1996. The Secretary may require participation agreements to be offered to more than one essential community provider in each category if the Secretary determines extra capacity is required to serve the needs of enrollees in a particular health plan service area.

''(b) PARTICIPATION AGREEMENT.—A participation agreement between a standard health plan sponsor and an essential community provider under this subsection shall provide that the plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan with respect to the scope of services and the basis for which payment is made by the plan to the provider.

''(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an 'essential community provider' means any of the following entities certified by the Secretary:

''(1) MIGRANT HEALTH CENTERS.—A recipient or subrecipient of a grant under section 329 of the Public Health Service Act.

''(2) COMMUNITY HEALTH CENTERS.—A recipient or subrecipient of a grant under section 330 of such Act.

''(3) HOMELESS PROGRAM PROVIDERS.—A recipient or subrecipient of a grant under section 340 of such Act.

''(4) PUBLIC HOUSING PROVIDERS.—A recipient or subrecipient of a grant under section 340A of such Act.

''(5) FAMILY PLANNING CLINICS.—A recipient or subrecipient of a grant under title X of such Act.

''(6) INDIAN HEALTH PROGRAMS.—A service unit of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act.

''(7) HIV PROVIDERS UNDER RYAN WHITE ACT.—A public or private nonprofit health care provider that is a recipient or subrecipient of a grant under title XXVI of the Public Health Service Act.

''(8) MATERNAL AND CHILD HEALTH PROVIDERS.—A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act.

''(9) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as de-

fined in section 1861(aa)(4)) or an entity that would be such a center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

''(10) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2)).

''(11) PROVIDER OF SCHOOL HEALTH SERVICES.—A provider of school health services.

''(12) COMMUNITY NETWORKS.—A community network receiving development funding in designated urban or rural underserved areas under subtitle F.

''(13) CERTAIN HOSPITALS.—A public hospital or non-profit hospital meeting the criteria for public hospitals which are covered entities under section 340B of the Public Health Service Act, with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi)) greater than 11.75 percent.

''(14) CHILDREN'S HOSPITALS.—A children's hospital meeting criteria comparable to paragraph (13) as determined appropriate by the Secretary.

During the 5-year period described in subsection (a), the reform standards may be modified for the designation of

additional health professionals and institutions as essential community providers to the extent the Secretary determines that standard health plans would not be able to assure adequate access to the standard benefits package established under subtitle C in a health plan service area without such designation.

''(d) SUBRECIPIENT DEFINED.—In this section, the term 'subrecipient' means, with respect to a recipient of a grant under a particular authority, an entity that—

''(1) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

''(2) meets the requirements established to be a recipient of such a grant.

''(e) STUDY.—During the 5-year period described in subsection (a), the Office of Technology Assessment shall conduct a continuing study on improving access in underserved areas.

"SEC. 21128. HEALTH PLAN SERVICE AREA CAPACITY.

''(a) AVAILABILITY OF SERVICES IN ENTIRE HEALTH PLAN SERVICE AREA.—On and after January 1, 2001, each standard health plan shall have the capacity within the plan's network, or through contracts with a sufficient number, distribution, and variety of providers, to deliver to all parts of any health plan service area (des-

ignated under section 21022) in which such plan is offered, with reasonable promptness and in a manner which assures continuity, the standard benefits package established under subtitle C and any benefits offered by such sponsor through certified supplemental health benefits plans. Such capacity shall include the provision of emergency services 24 hours a day, 7 days a week.

''(b) CAPABILITY.—Each standard health plan shall make available and accessible translation, case management, and transportation services, if necessary, to deliver the benefits and services described in subsection (a).

''(c) DIVERSITY.—Each standard health plan shall ensure that criteria for the selection of participating providers take into account the needs of diverse populations within a health plan service area served by the plan.

''(d) APPLICATION OF STANDARDS TO SELF-INSURED PLANS.—The standards specified in this section shall apply to self-insured standard health plans, but only to the extent necessary to deliver services to individuals enrolled in such plans.

"SEC. 21129. ACCESS TO SPECIALIZED SERVICES.

''(a) IN GENERAL.—Each standard health plan shall have within the plan's network, or contract with, a sufficient number, distribution, and variety of providers of specialized services to assure that such services are available

and accessible to adults, infants, children, and persons with disabilities.

''(b) CENTERS OF EXCELLENCE.—

''(1) IN GENERAL.—A standard health plan may satisfy the standard under subsection (a) by contracting with, and demonstrating sufficient referrals (as determined by standards set by the Secretary) of, adults, infants, children, and persons with disabilities requiring specialized services to centers of excellence designated by the Secretary under subsection (a). For children, such specialized treatment expertise shall be in pediatrics.

''(2) REQUIREMENTS FOR CENTERS.—The Secretary shall designate centers of excellence in the field of institutional care that meet evaluation criteria established by the Secretary for the delivery of care for complex cases requiring specialized treatment and also meet 2 or more of the following requirements:

''(A) Provide specialized education and training through approved graduate medical education programs with multi-specialty, multidisciplinary teaching and services in both inpatient and outpatient settings, with medical staff

with faculty appointments at an affiliated medical school.

''(B) Attract patients from outside the center's local geographic region.

''(C) Either sponsor or participate in, or have medical staff who participate in, peer-reviewed research.

''(c) OTHER EVALUATION CRITERIA FOR SPECIALIZED SERVICES STANDARDS.—Reform standards shall include evaluation criteria determined by the Secretary for the standard under subsection (a) for standard health plans which choose to provide specialized services within a network setting, including requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. For children, such specialized treatment expertise shall be in pediatrics.

''(d) OUTCOMES CRITERIA.—The Secretary shall develop evaluation criteria for outcomes of specialized services as research findings become available.

''SEC. 21130. PARTICIPATING PHYSICIAN PROGRAM.

''Each standard health plan shall establish a program under which participating physicians shall agree to accept the plan's payment schedule as payment in full, and agree not to charge patients more than the co-insurance re-

quired by such plan. Each such plan shall make available the list of participating physicians to enrollees. Each plan shall have an appropriate number of physicians in each specialty as participating physicians.

''SEC. 21131. OUT-OF-AREA COVERAGE.

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

''PART III—STANDARDS APPLICABLE TO SUPPLEMENTAL HEALTH BENEFITS PLANS

''SEC. 21141. IMPOSITION OF REQUIREMENTS ON SUPPLEMENTAL HEALTH BENEFITS PLANS.

''(a) IN GENERAL.—In the case of a supplemental health benefits plan—

''(1) which is a supplemental services plan (as defined in subsection (b)(2)), the requirements of section 21142 shall be met with respect to the plan; and

''(2) which is a cost-sharing plan (as defined in subsection (b)(3)), the requirements of section 21143 shall be met with respect to the plan.

''(b) PLANS DEFINED.—In this title:

''(1) SUPPLEMENTAL HEALTH BENEFITS PLAN.—The term 'supplemental health benefits plan'

means a supplemental services plan or a cost-sharing plan.

''(2) SUPPLEMENTAL SERVICES PLAN.—The term 'supplemental services plan' means a health plan which provides—

''(A) coverage for services and items not included in the standard benefits package established under subtitle C,

''(B) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits, or

''(C) both.

''(3) COST-SHARING PLAN.—The term 'cost-sharing plan' means a health plan which provides coverage for deductibles, coinsurance, and copayments imposed as part of the standard benefits package established under subtitle C.

"SEC. 21142. STANDARDS FOR SUPPLEMENTAL SERVICES PLANS.

''(a) APPLICATION OF CERTAIN HEALTH PLAN STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (3), the standards specified in paragraph (2) shall apply with respect to each supplemental serv-

ices plan in the same manner as such standards apply with respect to a certified standard health plan.

''(2) SPECIFIED STANDARDS.—The standards specified in this paragraph are as follows:

''(A) Section 21111 (relating to guaranteed issue and renewal).

''(B) Section 21112 (relating to enrollment).

''(C) Section 21113 (relating to rating limitations for community-rated market).

''(D) Section 21114 (relating to rating practices and payment of premiums).

''(E) Section 21115 (relating to nondiscrimination based on health status).

''(F) Section 21123 (relating to collection and provision of standardized information).

''(G) Section 21124 (relating to quality improvement and assurance).

''(H) Section 21125 (relating to patient protections and provider selection).

''(b) PROHIBITING DUPLICATION OF COVERAGE.—No health plan sponsor or any other person may offer to any medicare-eligible individual a supplemental services

plan that duplicates any coverage provided under the medicare program under title XVIII.

''(c) RESTRICTIONS ON MARKETING ABUSES.—Not later than January 1, 1996, the Secretary shall develop (in consultation with the States) minimum standards that prohibit marketing practices by entities offering supplemental services plans that involve—

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

''(2) using or disclosing to any party information about the health status or claims experience of participants in a certified standard health plan for the purpose of marketing a supplemental services plan; and

''(3) providing a supplemental services plan by a managed care plan to an individual not enrolled in such managed care plan.

"SEC. 21143. STANDARDS FOR COST-SHARING PLANS.

''(a) RULES FOR OFFERING OF PLANS.—A cost-sharing plan may be offered to an individual only if—

''(1) the plan is offered by a certified standard health plan with a standard benefits package in which the individual is enrolled;

''(2) the certified standard health plan offers the cost-sharing plan to all individuals enrolled in the certified standard health plan and only such individuals; and

''(3) the cost-sharing plan is offered only during an enrollment period for the applicable certified standard health plan.

Nothing in this subsection shall be construed to require an individual to obtain a cost-sharing plan or a certified standard health plan to provide a cost-sharing plan.

''(b) EQUIVALENT COVERAGE FOR ALL SERVICES.—Each cost-sharing plan shall provide coverage for items and services in the standard benefits package established under subtitle C to the same extent as the applicable certified standard health plan provides coverage for all items and services in such package.

''(c) REQUIREMENTS FOR PRICING.—The price of any cost-sharing plan shall—

''(1) be the same for each individual to whom the plan is offered; and

''(2) take into account any expected increase in utilization resulting from the purchase of the plan by individuals enrolled in the applicable certified standard health plan.

"SEC. 21144. PROHIBITION ON OFFERING OF MULTIPLE PACKAGES TO INDIVIDUAL.

''A supplemental health benefits plan may not be offered to an individual who is covered under another such plan, unless the individual's coverage under the new plan begins only after the individual's coverage under the original plan is terminated.

"PART IV—STANDARDS APPLICABLE TO LONG-TERM CARE POLICIES

"SEC. 21151. REGULATION OF SALES PRACTICES.

''(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

''(1) IN GENERAL.—Each carrier that is selling or offering for sale a long-term care policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

''(2) POLICY REPLACEMENT FORM.—With respect to any individual who elects to replace or effect a change in a long-term care policy, the carrier that is selling such policy shall ensure that such individual completes a policy replacement form developed as part of the reform standards. A copy of such form shall be provided to such individual and additional copies shall be delivered by the carrier to the old policy carrier and kept on file by the new carrier for inspection by the appropriate certifying authority.

''(3) PROHIBITED PRACTICES.—A carrier is considered to have violated paragraph (1) if the carrier engages in any of the following practices:

''(A) MISLEADING REPRESENTATION.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care policy.

''(B) UNDUE PRESSURE.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care policy through force, fright, threat or undue pressure, whether explicit or implicit.

''(C) MISLEADING MARKETING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

''(D) OTHERS.—Engaging in such other practices determined inappropriate under the reform standards.

''(b) FINANCIAL NEEDS STANDARDS.—The reform standards shall include minimum financial needs standards (including both income and asset criteria) for the purpose of advising individuals as to the costs and amounts of insurance needed when considering the purchase of a long-term care policy.

''(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—A carrier may not knowingly sell or issue a long-term care policy to an individual who is eligible for medical assistance under title XIX.

''(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE-BENEFIT POLICIES.—A carrier may not sell or issue a service-benefit long-term care policy to an individual—

''(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care policy held by such individual (unless the policy is intended to replace such other policy); or

''(2) for the benefit of an individual unless the individual (or a representative of the individual) pro-

vides a written statement to the effect that the coverage—

''(A) does not duplicate other coverage in effect under a service-benefit long-term care policy; or

''(B) will replace another service-benefit long-term care policy.

In this subsection, the term 'service-benefit long-term care policy' means a long-term care policy which provides for benefits based on the type and amount of services furnished.

''(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care policy that reduces, limits, or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care coverage or benefits.

''(f) PROVISION OF OUTLINE OF COVERAGE.—No carrier may sell or offer for sale a long-term care policy without providing to every individual purchaser or potential purchaser (or representative) an outline of coverage that complies with the reform standards.

''(g) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The reform standards shall include re-

quirements for long-term care insurance agent training and certification that—

''(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care policies; and

''(2) specify procedures for certifying and recertifying agents who have completed such training and who are qualified to sell or offer for sale long-term care policies.

''SEC. 21152. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

''(a) REFUND OF PREMIUMS.—If an application for a long-term care policy (or for a certificate under a group long-term care policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 21156, the carrier shall, not later than 30 days after the date of the denial or return, refund directly to the applicant, or in the case of an employer to whomever remits the premium, any premiums paid with respect to such a policy (or certificate). Any such refund shall not be made by delivery by the carrier.

''(b) MAILING OF POLICY.—If an application for a long-term care policy (or for a certificate under a group long-term care policy) is approved, the carrier shall pro-

vide each individual applicant the policy (or certificate) of insurance and outline of coverage not later than 30 days after the date of the approval.

''(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care policy is denied, the carrier shall, within 15 days of the date of a written request by the policyholder or certificate holder (or representative)—

''(1) provide a written explanation of the reasons for the denial;

''(2) make available all medical and patient records directly relating to such denial; and

''(3) provide a written explanation of the manner in which to appeal the denial.

Except as provided in subsection (e) of section 21154, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

''(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care policies shall periodically (not less often than annually) report, in a form and in a manner specified by the reform standards, to the appropriate certifying authority for the State in which the policy is delivered, and shall make available to the Sec-

retary, upon request, information in a form and manner so specified concerning—

''(1) the long-term care policies of the carrier that are in force;

''(2) the most recent premiums for such policies and the premiums imposed for such policies since the initial issuance of such policies;

''(3) the lapse rate, replacement rate, and rescission rates by policy; and

''(4) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

''(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

''(1) IN GENERAL.—Until the Secretary, in consultation with the NAIC, promulgates mandatory standards concerning compensation for the sale of long-term care policies, a carrier that issues one or more long-term care policies may provide a commission or other compensation to an agent or other rep-

resentative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed the greater of—

''(A) 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or

''(B) 50 percent of the premium paid on the first year policy.

''(2) SUBSEQUENT YEARS.—The commission or other compensation provided for the sale of long-term care policies to an individual during each of the years during the 5-year period subsequent to the first year of the policy shall be the same as that provided in the second subsequent year.

''(3) LIMITATION.—No carrier shall provide compensation to its agents for the sale of a long-term care policy which replaces an existing policy, and no agent shall receive compensation for such sale greater than the renewal compensation payable by the replacing carrier on renewal policies.

''(4) COMPENSATION DEFINED.—As used in this subsection, the term 'compensation' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, includ-

ing, but not limited to, deferred compensation, bonuses, gifts, prizes, awards, and finders' fees.

"SEC. 21153. RENEWAL STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

''(a) IN GENERAL.—No long-term care policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation, or fraud.

''(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

''(1) IN GENERAL.—Each group long-term care policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

''(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premiums when due. A group policy which restricts provision of benefits and services to, or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

''(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

''(A) whose coverage under the group policy would otherwise be terminated for any reason; and

''(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits not less than, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

''(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

''(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care policy is replaced by another long-term care policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its

date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

''(c) STANDARDS FOR ISSUANCE.—

''(1) IN GENERAL.—

''(A) GUARANTEE.—A carrier that sells or issues long-term care policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

''(B) PREMIUM FOR CONVERTED POLICY.—If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy.

''(2) UPGRADE FOR CURRENT POLICIES.—The reform standards shall specify standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

''(3) RATE STABILIZATION.—The reform standards shall specify standards for premium rate stabilization.

''(d) EFFECT OF INCAPACITATION.—

''(1) IN GENERAL.—

''(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care policy in effect as of the effective date of the reform standards may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider (independent of the issuer of the policy), to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

''(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the carrier is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

''(2) PERMITTED CANCELLATION.—A long-term care policy may be canceled under paragraph (1) for nonpayment if—

''(A) the period of such nonpayment is in excess of 30 days; and

''(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"SEC. 21154. BENEFIT STANDARDS.

''(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Pursuant to the reform standards, each long-term care policy shall, with respect to services, providers or facilities—

''(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers; and

''(2) use a uniform format for presenting the outline of coverage under such a policy.

''(b) DISCLOSURE.—

''(1) OUTLINE OF COVERAGE.—

''(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care policy shall provide in a uniform format an outline of coverage to each individual policyholder under such policy that meets the reform standards and complies with the requirements of subparagraph (B).

''(B) CONTENTS.—The outline of coverage for each long-term care policy shall substantially and accurately reflect the contents of the policy or the master policy and shall include at least the following:

''(i) A description of the benefits and coverage under the policy.

''(ii) A statement of the exclusions, reductions, and limitations contained in the policy.

''(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and

any reservation in the policy of a right to change premiums.

''(iv) Consumer protection information, including the manner in which to file a claim and to register complaints.

''(v) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only and not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern.

''(vi) A description of the terms, specified in section 21156, under which a policy or certificate may be returned and premium refunded.

''(vii) Information on—

''(I) national average costs for nursing facility and home health care and information (in graph form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs; and

''(II) other public and private long-term care products and long-term care programs made available by the Federal Government or by a State government.

''(viii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

''(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care policy shall include—

''(A) a description of the principal benefits and coverage provided in the policy;

''(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

''(C) a statement that the group master policy determines governing contractual provisions.

''(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

''(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

''(B) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits (if any) for each covered person; and

''(C) any exclusions, reductions, and limitations on benefits of long-term care.

''(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

''(1) IN GENERAL.—A long-term care policy may not condition or limit eligibility—

''(A) for benefits for a type of services to the need for or receipt of any other services;

''(B) for any benefit on the medical necessity for such benefit;

''(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, or if no State licensure or certification laws exists, to those developed by the Secretary, in consultation with the NAIC; or

''(D) for residential care (if covered under the policy) only—

''(i) to care provided in facilities which provide a higher level of care; or

''(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

''(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care policy provides benefits for the payment of specified home health care or community-based services, the policy—

''(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

''(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or a home care worker who is licensed or certified;

''(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

''(D) shall provide, at a minimum, benefits for personal care services (including home health aide) and adult day care.

''(3) NURSING FACILITY SERVICES.—If a long-term care policy provides benefits for the payment of specified nursing facility services, the policy shall provide such benefits with respect to all nursing facilities in the State. Except as provided in the reform standards establishing uniform language and definitions under section 21154(a)(1)), the term 'nursing facilities' has the meaning given such term by section 1919(a).

''(4) PER DIEM POLICIES.—

''(A) DEFINITION.—For purposes of this part, the term 'per diem long-term care policy' means a long-term care policy (or certificate under a group long-term care policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(B) LIMITATION.—No per diem long-term care policy (or certificate) may condition, limit or otherwise exclude benefit payments based on

the receipt of any type services from any type providers of long-term care service providers.

''(d) PROHIBITION OF DISCRIMINATION.—A long-term care policy may not, with respect to benefits under the policy, treat an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment, differently from an individual having a functional impairment for which such benefits may be made available.

''(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

''(1) INITIAL ISSUANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a long-term care policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

''(B) 6-MONTH LIMIT.—A long-term care policy or certificate issued under this part may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective

date of the policy or certificate with respect to an individual if—

''(i) a condition that was diagnosed or treated during the 6-month period ending on the day before the first date of coverage under the policy or certificate; and

''(ii) the limitation or exclusion extends for a period not more than 6 months after the date of coverage under the policy or certificate.

''(2) REPLACEMENT POLICIES.—If a long-term care policy replaces another long-term care policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

''(f) ELIGIBILITY FOR BENEFITS.—

''(1) LONG-TERM CARE POLICIES.—Each long-term care policy shall—

''(A) describe the level of benefits available under the policy; and

''(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive,

or mental impairment required in order to receive benefits under the policy.

''(2) FUNCTIONAL ASSESSMENT.—In order to be determined eligible for benefits under any long-term care policy, each claimant shall have a professional functional assessment of the claimant's functional or cognitive abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the Secretary. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy.

''(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care policy.

''(4) APPEALS PROCESS.—

''(A) IN GENERAL.—Each long-term care policy shall provide for a timely and independent appeals process, meeting the requirements of sections 21802 through 21815, for individuals who dispute the results of the claims review conducted under paragraph (3) or the policyholder's functional assessment conducted under paragraph (2).

''(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's functional or cognitive abilities.

''(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the Secretary to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

''(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

''(ii) by an entity that provides services to the policyholder or certificate holder for which benefits are available under the long-term care policy; or

''(iii) by an individual or entity controlled by the issuer of the policy.

''(5) CONTROL DEFINED.—For purposes of paragraphs (2) and (4), the term 'control' means the

direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing at least 10 percent of the voting securities of another person.

''(g) INFLATION PROTECTION.—

''(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a long-term care policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

''(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

''(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

''(i) the existing policy benefit; and

''(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

''(C) With respect to service-benefit long-term care policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

''(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

''(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this part:

''(A) A comparison (shown as a graph) of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

''(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

''(4) CONTINUATION OF PROTECTION.—Benefit increases under a policy described in paragraph (1) shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

''(5) CONSTANT PREMIUM.—A policy described in paragraph (1) that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer

shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

''(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 21155. NONFORFEITURE.

''(a) IN GENERAL.—Each long-term care policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period as specified under the reform standards, the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by such standards.

''(b) ESTABLISHMENT OF STANDARDS.—The reform standards shall provide that the percentage or amount of benefits under subsection (a) shall increase based upon the policyholder's equity in the policy.

"SEC. 21156. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

''(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care policy or deny a claim under the policy based on fraud or intentional misrepresentation relating to the issuance of the policy unless notice of such

fraud or misrepresentation is provided within a time period to be determined by the reform standards.

''(b) RIGHT TO RETURN.—Each applicant for a long-term care policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 21157. CIVIL MONEY PENALTY AND PRIVATE ACTIONS.

''(a) CARRIER.—Any carrier that sells, or offers for sale, or issues a long-term care policy and that—

''(1) violates any sales practice under section 21151;

''(2) fails to make a refund in accordance with section 21152(a);

''(3) fails to transmit a policy in accordance with section 21152(b);

''(4) provides a commission or compensation in violation of section 21152(e);

''(5) fails to provide an outline of coverage in violation of section 21154(b)(1); or

''(6) issues a policy without obtaining certain information in violation of section 21154(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

''(b) AGENTS.—Any agent that sells or offers for sale a long-term care policy and that—

''(1) violates any sales practice under section 21151;

''(2) fails to make a refund in accordance with section 21152(a);

''(3) fails to transmit a policy in accordance with section 21152(b);

''(4) fails to provide an outline of coverage in violation of section 21154(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 21154(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

''(c) EFFECT ON STATE LAW.—Nothing in this section shall be construed as preempting or otherwise limiting stricter penalties that may be imposed by a State for the types of conduct described in this section.

''(d) PRIVATE ACTIONS.—An individual may commence a civil action in an appropriate State or United States district court to enforce the provisions of this title with respect to long-term care policies and may be awarded appropriate relief and reasonable attorney's fees.

"SEC. 21158. LONG-TERM CARE POLICY DEFINED.

''(a) IN GENERAL.—As used in this part, the term 'long-term care policy' means any insurance policy, rider, or certificate advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

''(1) group and individual annuities and life insurance policies, riders, or certificates that provide directly, or that supplement, long-term care insurance; and

''(2) a policy, rider, or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(b) ISSUANCE.—

''(1) IN GENERAL.—Long-term care policies may be issued by any carrier.

''(2) CARRIER.—As used in this part, the term 'carrier' means—

''(A) an insurer;

''(B) a fraternal benefit society;

''(C) a nonprofit health, hospital, or medical service corporation;

''(D) a prepaid health plan;

''(E) a health maintenance organization; or

''(F) any similar organization to the extent such organization is otherwise authorized to issue life or health insurance.

''(c) POLICIES EXCLUDED.—The term 'long-term care policy' shall not include any insurance policy, rider, or certificate that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders, or certificates—

''(1) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement,

''(2) that provide the option of a lump-sum payment for those benefits, or

''(3) with respect to which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(d) APPLICATIONS.—Notwithstanding any other provision of this part, this part shall apply to any product advertised, marketed, or offered as a long-term insurance policy, rider or certificate.

"Subtitle C—Benefits and Cost-Sharing

"PART I—STANDARD BENEFITS PACKAGES

"SEC. 21201. GENERAL DESCRIPTION OF STANDARD BENEFITS PACKAGES.

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

''(1)(A) provides all of the items and services under the categories of health care items and services described in section 21202 as determined by the Board under section 21213(b)(4); and

''(B) provides for a cost-sharing schedule described in section 21203(a)(1); and

''(2) has an actuarial value that is equivalent to the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Pro-

gram, adjusted for an average population and adjusted for the particular cost-sharing schedule provided for in the package (as determined by the National Health Benefits Board established under section 21211 (referred to in this part as the 'Board')).

''(b) ALTERNATIVE STANDARD BENEFITS PACKAGE.—For purposes of this title, an alternative standard benefits package is a benefits package that—

''(1)(A) provides such items and services under the categories of health care items and services described in section 21202 as determined by the Board under section 21213(b)(5); and

''(B) the cost-sharing schedule described in section 21203(a)(2); and

''(2) has an actuarial value that is less than the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Program, adjusted for an average population (as determined by the Board).

"SEC. 21202. DESCRIPTION OF CATEGORIES OF ITEMS AND SERVICES.

''(a) IN GENERAL.—The categories of health care items and services described in this section are the following:

''(1) Inpatient and outpatient care, including hospital and health professional services (as defined in subsection (c)).

''(2) Emergency services, including appropriate transport services.

''(3) Clinical preventive services, including services for high risk populations, immunizations, tests, and clinician visits.

''(4) Mental illness and substance abuse services.

''(5) Family planning services and services for pregnant women.

''(6) Prescription drugs and biologicals.

''(7) Hospice care services.

''(8) Home health care services.

''(9) Outpatient laboratory, radiology, and diagnostic services and medical equipment.

''(10) Outpatient rehabilitation services.

''(11) Vision care, dental care, and hearing aids for individuals under 22 years of age.

''(12) Patient care costs associated with investigational treatments (excluding the direct costs of an investigational treatment) that are part of a peer-reviewed and approved research program (as defined by the Secretary) or research trials approved by the

Secretary, the Directors of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for cancer center support grants designated by the National Cancer Institute.

''(b) LIMITATION.—

''(1) IN GENERAL.—Items and services under the categories described in subsection (a) shall be furnished to health plan enrollees only when medically necessary or appropriate.

''(2) CLINICAL PREVENTIVE SERVICES.—For purposes of paragraph (1), any clinical preventive service furnished in accordance with a periodicity schedule established by the Board under section 21213(b)(2)(B) shall be medically necessary or appropriate.

''(3) EMERGENCY SERVICES.—For purposes of paragraph (1), any emergency service furnished to an individual with an emergency medical condition (as defined in section 1867(e)(1)) shall be medically necessary or appropriate.

''(c) DEFINITION OF HEALTH PROFESSIONAL SERVICES.—For purposes of this subtitle, the term 'health professional services' means professional services that are lawfully provided by a physician or another health professional who is legally authorized to provide such services in the State in which the services are provided.

''(d) DEFINITION OF MEDICALLY NECESSARY OR APPROPRIATE.—For purposes of this subtitle, an item or service is medically necessary or appropriate—

''(1) with respect to an enrollee who is 22 years of age or older, if the item or service is—

''(A) for the treatment or diagnosis of a health condition;

''(B) generally regarded as being safe and effective;

''(C) indicated for the enrollee; and

''(D) intended to maintain or improve the biological, psychological, or functional condition of the enrollee or to prevent or mitigate an adverse health outcome or limitation in functional capacity for the enrollee; and

''(2) with respect to an enrollee under 22 years of age, if the item or service—

''(A) is appropriate for the age and health status of the enrollee;

''(B) will prevent or ameliorate the effects of a condition, illness, injury, or disorder;

''(C) will aid the overall physical and mental growth and development of the enrollee; or

''(D) will assist in achieving or maintaining maximum functional capacity in performing daily activities.

"SEC. 21203. COST-SHARING.

''(a) IN GENERAL.—

''(1) STANDARD BENEFITS PACKAGE.—Except as provided in paragraph (3), each standard benefits package shall include a cost-sharing schedule developed by the Board for such package under section 21213(c).

''(2) ALTERNATIVE STANDARD BENEFITS PACKAGE.—Except as provided in paragraph (3), each alternative standard benefits package shall include the cost-sharing schedule developed by the Board for such package under section 21213(c).

''(3) INCREASES IN OUT-OF-POCKET LIMITS BASED ON HEALTH SPENDING.—In the case of any calendar year for which an increase in the out-of-pocket limits under any cost-sharing schedule developed by the Board for a benefits package is required under section 801 of the Health Security Act, the

out-of-pocket limits under such schedule shall be as specified in the Executive Order issued pursuant to section 801(d) of such Act.

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

''(1) APPLICATION ON AN ANNUAL BASIS.—The deductibles and out-of-pocket limits on cost-sharing for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and services furnished in the year.

''(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

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

''(B) FAMILY.—In the case of an individual enrolled under a health plan under a family

class of enrollment (as defined in section 21113(b)(2)(B)(iii)(I)), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by the individual or any member of the individual's family in a year at such time as the family has incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

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

''(3) COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered by the standard benefit package has been satisfied for a year, subject to para-

graph (4), coinsurance and copayments are amounts (expressed as a percentage of an amount otherwise payable or as a dollar amount, respectively) that an individual may be required to pay with respect to the item or service.

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

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

''(B) FAMILY.—In the case of an individual enrolled under a health plan under a family class of enrollment (as defined in section 21113(b)(2)(B)(iii)(I)), the family out-of-pocket

limit on cost-sharing in the cost-sharing schedule offered by the plan represents the amount of expenses that members of the individual's family, in the aggregate, may be required to incur under the plan in a year because of a general deductible, separate deductibles, copayments, and coinsurance before the plan may no longer impose any cost-sharing with respect to items or services covered by the standard benefit package that are provided to any member of the individual's family.

"PART II—NATIONAL HEALTH BENEFITS BOARD

"SEC. 21211. CREATION OF NATIONAL HEALTH BENEFITS BOARD; MEMBERSHIP.

''(a) IN GENERAL.—There is hereby established in the Department of Health and Human Services a National Health Benefits Board.

''(b) COMPOSITION.—The Board is composed of 7 members appointed by the President, by and with the advice and consent of the Senate. No more than 4 members of the Board may be affiliated with the same political party. Members shall be appointed not later than 90 days after the date of the enactment of this title.

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

''(d) TERMS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the term of each member of the Board is 6 years and begins when the term of the predecessor of that member ends.

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

''(3) CONTINUATION IN OFFICE.—Upon the expiration of a term of office, a member shall continue to serve until a successor is appointed and qualified.

''(e) VACANCIES.—

''(1) IN GENERAL.—If a vacancy occurs, other than by expiration of term, a successor shall be appointed by the President, by and with the consent of the Senate, to fill such vacancy. The appointment shall be for the remainder of the term of the predecessor.

''(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Board does not impair the authority of the remaining members to exercise all of the powers of the Board.

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

''(f) MEETINGS; QUORUM.—

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

''(2) QUORUM.—Four members of the Board shall constitute a quorum thereof.

"SEC. 21212. QUALIFICATIONS OF BOARD MEMBERS.

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

''(b) BASIS OF SELECTION.—Board members shall be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, nursing, or other clinical practices, health care financing and delivery, State health systems, consumer protection, business, law, and delivery of care to vulnerable populations.

''(c) EXCLUSIVE EMPLOYMENT.—During the term of appointment, Board members shall serve as employees of the Federal Government and shall hold no other employment.

''(d) PROHIBITION OF CONFLICT OF INTEREST.—During the period in which an individual is a member of the Board, such individual may not have a pecuniary interest in or hold an official relation to any health plan, health care provider, insurance company, pharmaceutical company, medical equipment company, or other affected industry. Before entering upon the duties as a member of the Board, the member shall certify under oath compliance with this requirement.

''(e) COMPENSATION OF BOARD MEMBERS.—Each member of the Board (other than the chair) shall receive an annual salary at the annual rate payable from time to time for level IV of the Executive Schedule. The chair of the Board, during the period of service as chair, shall receive an annual salary at the annual rate payable from time to time for level III of the Executive Schedule.

''SEC. 21213. GENERAL DUTIES AND RESPONSIBILITIES.

''(a) CRITERIA FOR DETERMINING MEDICAL NECESSITY OR APPROPRIATENESS.—The Board shall define the standards to be used by a health plan in determining whether an item or service under the categories of health care items and services described in section 21202 is medically necessary or appropriate for an enrollee in the plan.

''(b) CLARIFICATION AND REFINEMENT OF ITEMS AND SERVICES.—

''(1) IN GENERAL.—The Board shall promulgate such regulations or establish such guidelines as may be necessary to clarify and refine the items and services under the categories of health care items and services described in section 21202 in accordance with standards of medical necessity or appropriateness. In performing its duties under the preceding sentence, the Board shall—

''(A) develop interim coverage decisions in limited circumstances;

''(B) clarify and refine the items and services in the categories of health care items and services in a manner that prevents adverse risk selection;

''(C) not specify types of providers;

''(D) not specify particular procedures or treatments or classes of procedures or treatments; and

''(E) give priority to—

''(i)(I) parity for mental illness and substance abuse services with other medical services using the standards of medical necessity or appropriateness for the enrollee receiving the services in order to ensure that arbitrary day or visit limits or

cost-sharing requirements applied to mental illness and substance abuse services that are not different from those applied to medical health services, and

''(II) encouraging the use of outpatient treatments in delivering mental illness and substance abuse services to the greatest extent possible;

''(ii) the needs of children and vulnerable populations (including rural and underserved individuals); and

''(iii) improving the health of individuals through prevention.

''(2) SCHEDULES FOR ITEMS AND SERVICES.—

''(A) IN GENERAL.—The Board shall establish and update periodicity schedules for the items and services in the categories of health care items and services described in section 21202.

''(B) SPECIAL RULE WITH RESPECT TO CLINICAL PREVENTIVE SERVICES.—With respect to clinical preventive services, the Board—

''(i) shall specify and define specific items and services as clinical preventive

services for high risk populations and shall establish and update a periodicity schedule for such items and services;

''(ii) shall establish and update the periodicity schedules for the age-appropriate immunizations, tests, and clinician visits;

''(iii) shall establish rules with respect to coverage for an immunization, test, or clinician visit that is not provided to an individual during the age range for such immunization, test, or clinician visit that is specified under clause (ii); and

''(iv) may otherwise modify clinical preventive services taking into account age and other risk factors.

''(3) INVESTIGATIONAL TREATMENTS.—The Board shall refine policies regarding coverage of patient care costs associated with investigational treatments that are part of approved research trials.

''(4) ITEMS AND SERVICES PROVIDED BY STANDARD BENEFITS PACKAGE.—The regulations promulgated by the Board under this subsection shall provide that each standard benefits package shall provide for the same items and services in the

categories of health care items and services described in section 21202, as clarified and refined under this subsection, and provide for such items and services in the same amount, duration, or scope.

''(5) ITEMS AND SERVICES PROVIDED BY ALTERNATIVE STANDARD BENEFITS PACKAGE.—The regulations promulgated by the Board under this subsection shall specify the items and services in the categories of health care items and services described in section 21202 that an alternative standard benefits package must provide.

''(c) COST-SHARING.—The Board shall establish cost-sharing schedules to be provided by a standard benefits package or an alternative standard benefits package. In establishing such cost-sharing schedules, the Board shall meet the following requirements:

''(1) ANNUAL BASIS.—The Board shall establish cost sharing schedules on an annual basis.

''(2) OUT-OF-POCKET LIMITS.—Each cost sharing schedule developed by the Board shall include out-of-pocket limits.

''(3) LIFETIME LIMITS.—No cost-sharing schedule established by the Board may include lifetime limits.

''(4) STANDARD BENEFITS PACKAGE.—In establishing cost sharing schedules for standard benefits packages, the Board shall ensure that the schedules permit a variety of delivery systems. A standard benefit package that provides for the cost sharing schedule established by the Board under this paragraph that has the lowest actuarial value relative to the actuarial values of all other cost sharing schedules established by the Board under this paragraph, shall have an actuarial value that is equivalent to the actuarial value of the benefits package provided by the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits Program, adjusted for an average population (as determined by the Board).

''(5) ALTERNATIVE STANDARD BENEFITS PACKAGE.—The Board shall establish only one cost sharing schedule for the alternative standard benefits package. Such cost sharing schedule shall provide for a higher deductible than any deductible under a schedule established by the Board for a standard benefits package.

''(6) CLINICAL PREVENTIVE SERVICES.—No cost sharing schedule established by the Board may include cost sharing for clinical preventive services.

''(7) COST SHARING RULES.—The cost sharing schedules developed under this subsection shall be consistent with the provisions of section 21203(b).

''(d) COST-SHARING ASSISTANCE.—

''(1) IN GENERAL.—For purposes of providing cost-sharing assistance under section 1953, the Board shall determine an appropriate reduction in the cost-sharing applicable to cost-sharing subsidy eligible individuals (as defined in section 1953(a)(2)) under certified standard health plans.

''(2) CONSIDERATIONS.—The Board shall assure that reductions in cost-sharing are determined under paragraph (1) in a manner that reflects—

''(A) the extent to which an individual's family income is below the poverty line (as defined in section 1958(5)); and

''(B) whether an individual may enroll in a low-cost-sharing plan.

''(e) LEGISLATIVE RECOMMENDATIONS.—

''(1) IN GENERAL.—The Board may submit recommendations to Congress for such modifications to the provisions of this subtitle as the Board determines appropriate in accordance with section 21217(a)(1).

''(2) CONSULTATIONS.—In performing its duties under this subsection, the Board shall consult with the President and Congress.

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

''SEC. 21214. POWERS.

''(a) STAFF; CONTRACT AUTHORITY.—The Board shall have authority, subject to the provisions of the civil-service laws and chapter 51 and subchapter III of chapter 53 of title 5, United States Code, to appoint such officers and employees as are necessary to carry out its functions. The Board may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Board to assist the Board in carrying out its duties.

''(b) CONSULTATIONS WITH EXPERTS.—The Board may consult with any outside expert individuals or groups that the Board determines appropriate in performing its duties under section 21213. The Board may establish advisory committees.

''(c) ACCESS TO INFORMATION.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out its

functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Board.

''(d) DELEGATION OF AUTHORITY.—Except as otherwise provided, the Board may delegate any function to such officers and employees as the Board may designate and may authorize such successive redelegations of such functions with the Board as the Board deems to be necessary or appropriate. No delegation of functions by the Board shall relieve the Board of responsibility for the administration of such functions.

''(e) RULEMAKING.—The National Health Board is authorized to establish such rules as may be necessary to carry out this subtitle.

"**SEC. 21215. FUNDING.**

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Board such sums as may be necessary to carry out the purposes of this part.

''(b) SUBMISSION OF BUDGET.—Under the procedures of chapter 11 of title 31, United States Code, the budget for the Board for a fiscal year shall be reviewed by the Director of the Office of Management and Budget and submitted to the Congress as part of the President's

submission of the Budget of the United States for the fiscal year.

''SEC. 21216. APPLICABILITY OF FEDERAL ADVISORY COMMITTEE ACT.

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

''SEC. 21217. CONGRESSIONAL CONSIDERATION OF BOARD RECOMMENDATIONS.

''(a) IN GENERAL.—

''(1) TIMING FOR SUBMISSION.—The Board shall submit any recommendations to Congress under section 21213(e) by not later than March 1 of any year.

''(2) EFFECTIVENESS.—Except as provided in subsection (c), the recommendations submitted under paragraph (1) shall take effect unless by September 15 of the year in which such recommendations are submitted Congress enacts a joint resolution disapproving such recommendations in accordance with subsection (b).

''(b) CONGRESSIONAL DISAPPROVAL PROCEDURES.—

''(1) CONTENTS OF RESOLUTION.—For purposes of subsection (a), 'joint resolution' means only a joint resolution introduced after the date on which

the recommendations of the Board are received by Congress the matter after the resolving clause of which is as follows: 'That Congress disapproves the recommendations of the National Health Benefits Board submitted to the Congress on _____.' (the blank space being appropriately filled in).

''(2) REFERRAL TO COMMITTEE.—A resolution described in paragraph (1) introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A resolution described in paragraph (1) introduced in the Senate shall be referred to the Committee on Finance of the Senate.

''(3) DISCHARGE OF COMMITTEE.—If the committee to which is referred a resolution described in paragraph (1) has not reported such resolution (or an identical resolution) by July 1, such committee shall be deemed to be discharged from further consideration of such resolution and such resolution shall be placed on the appropriate calendar of the House involved.

''(4) FLOOR CONSIDERATION.—

''(A) IN GENERAL.—When the committee to which a resolution is referred has reported, or has been deemed to be discharged (under

paragraph (3)) from further consideration of, a resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the resolution, and all points of order against the resolution (and against consideration of the resolution) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the respective House shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the respective House until disposed of.

''(B) DEBATE.—Debate on the resolution, and on all debatable motions and appeals in

connection therewith, shall be limited to not more than 2 hours, which shall be divided equally between those favoring and those opposing the resolution. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the resolution is not in order. A motion to reconsider the vote by which the resolution is agreed to or disagreed to is not in order.

''(C) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on a resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the resolution shall occur.

''(D) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a resolution described in paragraph (1) shall be decided without debate.

''(5) COORDINATION WITH ACTION BY OTHER HOUSE.—

''(A) IN GENERAL.—If, before the passage by one House of a resolution of that House described in paragraph (1), that House receives from the other House a resolution described in paragraph (1), then the following procedures shall apply:

''(i) The resolution of the other House shall not be referred to a committee except in the case of final passage as provided in clause (ii)(II).

''(ii) With respect to a resolution described in paragraph (1) of the House receiving the resolution—

''(I) the procedure in that House shall be the same as if no resolution had been received from the other House; but

''(II) the vote on final passage shall be on the resolution of the other House.

''(B) DISPOSITION.—Upon disposition of the resolution received from the other House, it

shall no longer be in order to consider the resolution that originated in the receiving House.

''(6) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by Congress—

''(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution described in paragraph (1), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(c) RECOMMENDATIONS IN 2002.—Subsection (a)(2) shall not apply to any recommendations submitted to Congress by the Board during 2002.

''PART III—PROVISIONS RELATING TO ABORTION AND RELIGIOUS BELIEFS

''SEC. 21221. REGULATION OF ABORTION BY THE STATES.

''Nothing in this title shall be construed to conflict with any constitutionally permissible regulation of abortion by a State.

''SEC. 21222. NO REQUIREMENT TO CREATE OR MAINTAIN ABORTION CLINICS AND PROVIDERS.

''Nothing in this title shall be construed to—

''(1) require the creation or maintenance of abortion clinics or other abortion providers within a State or any region of a State; or

''(2) authorize any Federal agency or State to—

''(A) require the creation or maintenance of abortion clinics or other abortion providers; or

''(B) deny certification, or any other benefit granted by this title, to a health plan based on the number of, or the presence or absence of, abortion clinics or other abortion providers in or affiliated with the plan.

''SEC. 21223. PROVISIONS RELATING TO RELIGIOUS BELIEF OR MORAL CONVICTION.

''Nothing in this title shall be construed to—

''(1) prevent any individual from purchasing a standard benefits package which excludes coverage of abortion services, if the individual objects to abortion on the basis of a religious belief or moral conviction;

''(2) prevent any employer from contributing to the purchase of a standard benefits package which excludes coverage of abortion or other services, if the employer objects to such services on the basis of a religious belief or moral conviction;

''(3) require any health professional or health facility to perform or assist in the performance of any health care service, if the health professional or facility objects to performing or assisting in the performance of such a service on the basis of a religious belief or moral conviction; and

''(4) require any commercial insurance company, Blue Cross plan, integrated health plan, or any other organization that assumes health insurance risk to offer a package including abortion or other services, if the health plan sponsor objects to covering such services on the basis of a religious belief or moral conviction.

"Subtitle D—Expanded Access to Health Plans

"PART I—ACCESS THROUGH EMPLOYERS

"SEC. 21401. GENERAL EMPLOYER RESPONSIBILITIES.

''(a) AVAILABILITY OF COVERAGE.—

''(1) IN GENERAL.—Each employer shall meet the requirement under section 21002(c)(1)(A)(i) to make available to each employee of the employer the opportunity to enroll through the employer in any of the certified standard health plans described in such section.

''(2) WAIVER OF ACCESS REQUIREMENT.—If the Governor of a participating State waives the requirement under section 21413(a)(2) that a purchasing cooperative offer at least 3 certified plans in certain rural areas of the State, any employer located in such rural area shall not be required to offer 3 certified standard health plans in such area.

''(b) FORWARDING OF INFORMATION.—

''(1) INFORMATION REGARDING PLANS.—An employer must provide each employee of such employer—

''(A) with information provided by the State under section 21013 regarding all certified standard health plans offered in the com-

munity rating area in which the employer is located, and

''(B) if the employer knows that an employee resides in another community rating area, information regarding how to obtain information on certified standard health plans offered to residents of such other community rating area.

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

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

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

''(c) PAYROLL DEDUCTION.—

''(1) IN GENERAL.—If—

''(A) a certified standard plan, or purchasing cooperative on behalf of such a plan, requests an employer under this section to withhold premiums with respect to any employee enrolled in the plan, or

''(B) an employee requests an employer to withhold premiums to a certified standard health plan in which the employee is enrolled or enrolling,

the employer shall deduct and withhold such premiums (less any employer contribution) through payroll deduction and pay the amounts deducted and withheld to the plan or to the purchasing cooperative.

''(2) PAYROLL DEDUCTIONS.—

''(A) FREQUENCY.—In the case of an employee who is paid wages or other compensation—

''(i) on a monthly or more frequent basis, the employer shall deduct and withhold, and pay, such premiums at the same time as the payment of such wages or other compensation, or

''(ii) less frequently than monthly, the employer shall pay such premiums on a monthly basis.

''(B) EMPLOYEE PROTECTIONS.—

''(i) WITHHOLDING CONSTITUTES SATISFACTION OF OBLIGATION.—If an employee notifies the health plan sponsor that

the employee has requested the employer withholding of a certain amount, the withholding of such an amount by the employer under subparagraph (A) shall constitute satisfaction of the employee's obligation to pay the standard health plan with respect to such amount.

''(ii) DIRECT PAYMENT ALLOWED IN CASE OF NONPAYMENT.—In the case of the nonpayment to a standard health plan of any amount withheld by an employer, the plan shall notify such employee of such nonpayment and shall allow the employee to make direct payments to the plan effective with the next succeeding payment period.

''(3) AUTHORITY TO CHARGE ADMINISTRATIVE FEE.—Any employer providing a payroll deduction for a premium with respect to a health plan may charge a nominal administrative fee to cover the marginal costs of processing such deduction, except that this paragraph shall not apply to any plan offered through the employer (including any plan offered through a purchasing cooperative on behalf of the employer).

''(d) TIME PERIOD FOR EMPLOYERS.—An employer shall meet the requirements of this section with respect to any new employee within the 30-day period beginning on the date of hire.

"SEC. 21402. MAINTENANCE OF EFFORT FOR COVERAGE OF CHILDREN.

''Each employer making an employer contribution toward the coverage of the children of the employees of such employer as of July 1, 1994, shall continue such contribution to the certified standard health plan offering the standard benefits package chosen by the employee.

"SEC. 21403. DEVELOPMENT OF LARGE EMPLOYER PURCHASING GROUPS.

''(a) IN GENERAL.—Nothing in this title shall be construed as prohibiting 2 or more experience-rated employers from joining together to purchase insurance for their employees, except that each such employer shall be responsible for meeting the employer's requirements under this title with respect to its employees.

''(b) NO USE OF PURCHASING COOPERATIVES.—An experience-rated employer shall be ineligible to purchase health insurance through a purchasing cooperative.

"SEC. 21404. ENFORCEMENT.

''A State program shall provide for the monitoring and enforcement of the requirements of this part. In the

case of any employer which fails to meet any requirement under this part with respect to any employee, the State program shall impose a civil money penalty on such employer in an amount not more than 25 percent of the wages of such employee during the period of such failure. The State program shall provide that provisions similar to the provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties imposed under this section in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"PART II—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

"Subpart A—Functions of Purchasing Cooperatives

"SEC. 21411. ENROLLMENT OF COMMUNITY-RATED INDIVIDUALS IN CERTIFIED STANDARD HEALTH PLANS.

''(a) IN GENERAL.—A purchasing cooperative shall offer, on behalf of all certified standard health plans with which an agreement was entered into under section 21413 and in accordance with the enrollment procedures of such plans, enrollment in the plans only to community-rated individuals residing or employed in the community rating area served by the purchasing cooperative.

''(b) OUTREACH.—In carrying out its responsibilities under subsection (a), a purchasing cooperative shall per-

form such activities, including outreach, as may be necessary to actively seek the enrollment of community-rated individuals, including children and pregnant women who are eligible for subsidies under part B of title XIX or individuals who reside in medically underserved areas.

"SEC. 21412. DUTIES OF PURCHASING COOPERATIVES.

''(a) IN GENERAL.—Subject to subsection (b), each purchasing cooperative shall—

''(1) enroll community-rated individuals in certified standard health plans in accordance with section 21411;

''(2) collect premiums from individuals enrolled in certified standard health plans through the purchasing cooperative and forward such premiums to the plans;

''(3) enter into agreements only with certified standard health plans under section 21413;

''(4) ensure that the services of the purchasing cooperative are accessible throughout the community rating area;

''(5) ensure such accessibility by providing information in accordance with section 21414;

''(6) establish a process for the receipt and disposition of complaints regarding the performance of its duties;

''(7) coordinate activities with other purchasing cooperatives under section 21420;

''(8) report to the participating State such information regarding marketing, enrollment, and administrative expenses as the Secretary requires;

''(9) comply with such fiduciary responsibilities as the Secretary requires; and

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

''(b) LIMITATION ON ACTIVITIES.—A purchasing cooperative shall not—

''(1) approve and enforce payment rates for providers;

''(2) regulate premium rates for health plans;

''(3) certify or enforce compliance of certified standard health plans with the requirements of subtitle B;

''(4) assume financial risk in relation to any such plan; or

''(5) perform other activities identified by the participating State as being inconsistent with the performance of its duties under subsection (a).

''(c) PERFORMANCE OF DUTIES.—

''(1) IN GENERAL.—If the participating State finds that a purchasing cooperative is not carrying

out its duties as required under subsections (a) and (b), the State shall notify the Board of Directors of such finding and permit such Board an opportunity to take such action as may be necessary for the purchasing cooperative to carry out such duties.

''(2) CORRECTIVE ACTION.—If, after such an opportunity, the deficiency has not been corrected, the participating State may—

''(A) order the purchasing cooperative to hold a new election for members of the Board,

''(B) take such other action as may be appropriate in order to assure the performance of such duties, or

''(C) take actions described in both subparagraphs (A) and (B).

''(3) PERFORMANCE CRITERIA.—The participating State shall develop criteria relating to the performance of duties by purchasing cooperatives.

"SEC. 21413. AGREEMENTS WITH CERTIFIED STANDARD HEALTH PLANS.

''(a) AGREEMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), each purchasing cooperative for a community rating area may enter into an agreement under this section with any certified standard health plan

the purchasing cooperative desires to be made available through such purchasing cooperative.

''(2) MINIMUM REQUIREMENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each purchasing cooperative—

''(i) shall enter into an agreement under paragraph (1) with at least 3 community-rated certified standard health plans which provide the standard benefit package under subtitle C, including, if available, a fee-for-service plan and a health plan with a point-of-service option, and

''(ii) may enter into an agreement with community-rated certified standard health plans which provide the alternative standard benefit package under subtitle C or with community-rated certified supplemental health benefit plans.

''(B) WAIVER OF REQUIREMENT.—The Governor of a participating State may waive the requirement under subparagraph (A) for any purchasing cooperative in a rural area of such State which demonstrates an insufficient popu-

lation density to support 3 community-rated certified standard health plans.

''(3) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing cooperative may terminate an agreement under paragraph (1) if the certified standard health plan's certification under section 21101 is terminated or for other good cause shown.

''(4) NO PROHIBITION ON OFFERING OF PLANS.—Nothing in this subsection shall be construed as prohibiting a certified standard health plan with which a purchasing cooperative has declined to enter into an agreement under paragraph (1) from being offered to community-rated individuals within a community rating area.

''(b) RECEIPT OF PREMIUMS ON BEHALF OF PLANS.—

''(1) IN GENERAL.—An agreement under this section shall provide that—

''(A) payment of premiums to which subparagraph (B) does not apply shall be made by individuals directly to the purchasing cooperative for the benefit of the plan, and

''(B) payments of premiums which an employer is required to make under section 21401(c) shall be made by the employer directly to the purchasing cooperative for the benefit of the plan.

''(2) PAYMENT OF PREMIUMS.—The purchasing cooperative may provide for reasonable penalties and grace periods for late payment.

''(3) CERTIFIED STANDARD HEALTH PLANS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing cooperative any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing cooperative administrative fee under section 21415).

''(c) FORWARDING OF PREMIUMS.—

''(1) IN GENERAL.—The purchasing cooperative shall forward to a certified standard health plan the amount of any premiums collected by such cooperative on behalf of such plan.

''(2) PAYMENTS.—Payments shall be made by the purchasing cooperative under this subsection within a period of days (specified by the Secretary

and not to exceed 7 days) after receipt of the premium.

"SEC. 21414. PROVISION OF INFORMATION.

''Each purchasing cooperative for a community rating area shall make available to each employer (other than an experience-rated employer) located in the community rating area and each community-rated individual residing in such area—

''(1) enrollment information, including information provided to the purchasing cooperative under section 21013 by the participating State in which such cooperative is located, and

''(2) the opportunity to enter into an agreement with the cooperative for the purchase of a certified standard health plan.

The provision of information described in paragraph (1) may also be made at designated public access sites, including public libraries and local government offices.

"SEC. 21415. ADMINISTRATIVE FEES.

''(a) IN GENERAL.—A purchasing cooperative may impose an administrative fee with respect to a community-rated individual enrolled under a certified standard health plan offered through the purchasing cooperative.

''(b) FEE.—The Secretary shall establish criteria for determining the administrative fees charged by cooperatives under subsection (a).

"Subpart B—Organization and Operation of Purchasing Cooperatives

"SEC. 21417. ESTABLISHMENT.

''(a) ESTABLISHMENT OF COOPERATIVES.—

''(1) IN GENERAL.—Any person meeting the requirements of this part may establish a purchasing cooperative.

''(2) STATE SPONSORSHIP.—If a not-for-profit purchasing cooperative has not been organized in a community rating area in a participating State, the State shall, on or before January 1, 1996, establish or sponsor, by legislation or otherwise, at least one not-for-profit purchasing cooperative to serve in such community rating area.

''(b) RULES OF CONSTRUCTION.—

''(1) NONEXCLUSIVE.—Nothing in this section shall be construed as requiring that there be only one purchasing cooperative serving a community rating area.

''(2) SINGLE ORGANIZATION SERVING MULTIPLE COMMUNITY RATING AREAS.—

''(A) IN GENERAL.—Nothing in this section shall be construed as preventing a single not-for-profit corporation from being a purchasing cooperative for more than one community rating area.

''(B) REPORTING.—If a purchasing cooperative serves more than one community rating area and such community rating areas are located in more than one State, the purchasing cooperative shall separately report to each State with respect to the residents of such State.

''(3) ROLE OF INSURERS.—An insurer may not form or underwrite a purchasing cooperative, but may administer such a cooperative.

''(4) ROLE OF GOVERNMENTAL UNITS.—Units of State or local governments may form purchasing cooperatives.

"SEC. 21418. BOARD OF DIRECTORS.

''(a) IN GENERAL.—A purchasing cooperative shall be governed by a Board of Directors (in this part, referred to as the 'Board'), appointed consistent with the provisions of this section. All powers vested in a purchasing cooperative under this title shall be vested in the Board.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Board shall consist of—

''(A) members who represent individuals who purchase coverage through the cooperative, including employees who purchase such coverage; and

''(B) members who represent employers who purchase coverage through a cooperative.

''(2) EQUAL REPRESENTATION OF EMPLOYERS AND CONSUMERS.—The number of members of the Board described under subparagraph (A) of paragraph (1) shall be the same as the number of members described in subparagraph (B) of such paragraph.

''(c) NO CONFLICT OF INTEREST PERMITTED.—An individual may not serve as a member of the Board if the individual is one of the following (or an immediate family member of one of the following):

''(1) A health care provider.

''(2) An individual who is an employee or member of the board of directors of, has a substantial ownership interest in, or derives substantial income from, a health care provider, health plan, pharmaceutical company, or a supplier of medical equipment, devices, or services.

''(3) A person who derives substantial income from the provision of health care.

''(4) A member or employee of an association, law firm, or other institution or organization that represents the interests of one or more health care providers, health plans, or others involved in the health care field, or an individual who practices as a professional in an area involving health care.

''(d) LIMITATION ON COMPENSATION.—A purchasing cooperative shall not provide compensation to members of the Board other than reimbursement for reasonable and necessary expenses incurred in the performance of their duties as members of the Board.

''(e) PROVIDER ADVISORY BOARD.—The Board shall establish a provider advisory board consisting of representatives of health care providers and professionals who provide covered items and services through certified standard health plans offered by the purchasing cooperative.

"SEC. 21419. PROHIBITION AGAINST SELF-DEALING AND CONFLICTS OF INTEREST.

''(a) PROMULGATION OF STANDARDS.—Each participating State shall promulgate standards of conduct in accordance with subsection (b) for any administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any purchasing cooperative.

''(b) REQUIREMENTS FOR STANDARDS.—The standards of conduct referred to in subsection (a) shall set forth—

''(1) the types of investment interests, ownership interests, affiliations, or other employment that would be improper for an individual described in subsection (a) to hold during the time of the individual's service or employment with the purchasing cooperative; and

''(2) the circumstances that will constitute impermissible conflicts of interest or self-dealing by such employees in performing their official duties and functions for a purchasing cooperative.

''(c) SPECIFIC PROHIBITIONS.—No individual described in subsection (a) shall, directly or indirectly—

''(1) operate, represent, be employed by, or be affiliated with a health plan participating in the same community rating area; and

''(2) use any of the information acquired through the relationship of such person or entity with the purchasing cooperative for purposes unrelated to such person's or entity's duties with such cooperative.

"SEC. 21420. COORDINATION AMONG PURCHASING COOPERATIVES.

''The State shall establish rules for coordination among purchasing cooperatives in cases in which employers are located in one community rating area and their employees who are community-rated individuals reside in a different community rating area.

"PART III—ACCESS THROUGH ASSOCIATION PLANS

"Subpart A—Qualified Association Plans

"SEC. 21431. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

''(a) GENERAL RULE.—For purposes of this title, in the case of a qualified association plan—

''(1) except as otherwise provided in this subpart, the plan shall be required to meet all applicable requirements of this title for certified standard health plans providing the standard benefit package under subtitle C which are offered by experience-rated employers,

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

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

''(b) ELECTION TO BE TREATED AS PURCHASING COOPERATIVE.—Subsection (a) shall not apply to a qualified association plan if—

''(1) the health plan sponsor makes an irrevocable election to be treated as a purchasing cooperative for purposes of this title, and

''(2) such sponsor meets all requirements of this title applicable to a purchasing cooperative.

"SEC. 21432. MODIFICATIONS OF STANDARDS APPLICABLE TO QUALIFIED ASSOCIATION PLANS.

''(a) CERTIFYING AUTHORITY.—For purposes of this title, the Secretary of Labor shall be the appropriate certifying authority with respect to a qualified association plan.

''(b) CAPITAL REQUIREMENTS.—

''(1) IN GENERAL.—The solvency requirements established under the regulations under paragraph (2) shall, on and after the effective date of such regulations, apply in lieu of the requirements under section 21122.

''(2) SOLVENCY REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary of Labor shall prescribe by regulation—

''(i) solvency standards for qualified association plans which will ensure that benefits under such plans will be provided in full when due, and

''(ii) rules for monitoring and enforcing compliance with such standards.

Such regulations may provide procedures under which the Secretary may enter into an agreement with a State to have the State enforce the Federal standards or State standards not inconsistent with the Federal standards.

''(B) ASSETS HELD IN TRUST.—For purposes of complying with regulations prescribing solvency standards pursuant to subparagraph (A), the plan sponsor of each qualified association plan shall, in accordance with such regulations, take such steps as are necessary to ensure that plan assets held for the purpose of complying with such solvency standards are held in trust under the plan and are available solely for such purpose.

''(c) AVAILABILITY.—Except in the case of a qualified association plan with respect to which an election is

in effect under section 21431(b), a qualified association plan may only include in coverage any individual who is a member of the association establishing or maintaining the plan, an employee of such member, or a spouse or dependent of either.

''(d) LIMITATION ON GROWTH.—The number of participants enrolled in a qualified association plan for any year shall not exceed 110 percent of the number of participants enrolled in the plan during the preceding year.

"SEC. 21433. QUALIFIED ASSOCIATION PLAN DEFINED.

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

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

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

''(b) EXISTING PLAN.—For purposes of this section, a health plan is an existing plan if such plan—

''(1) was in existence and operating at all times as a multiple employer welfare arrangement (or rural electric cooperative or rural telephone cooperative association plan) during the 3-year period ending on the date of the enactment of the Health Security Act, and

''(2) covered at least 500 participants in the United States on June 1, 1994.

''(c) QUALIFIED ASSOCIATION.—For purposes of this section, the term 'qualified association' means any organization which—

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

''(2) is organized and maintained for substantial purposes other than to provide a health plan,

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

''(4) receives the active support of its members, and

''(5) has been in operation continuously during the 3-year period ending on the date of the enactment of the Health Security Act.

''(d) SPECIAL RULE FOR CERTAIN ARRANGEMENTS.—

''(1) IN GENERAL.—If, as of June 1, 1994, a multiple employer welfare arrangement had been in existence at least 18 months and an application with the State insurance commissioner for a certificate of operation as a health plan had been approved or was

pending, the requirements of subsections (a)(2) and (b)(1) shall not apply to such arrangement.

''(2) DISQUALIFICATION OF CERTAIN ARRANGEMENTS.—A multiple employer welfare arrangement shall not be treated as meeting the requirements of paragraph (1) if a State demonstrates that—

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

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

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

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

''(f) DEFINITIONS.—For purposes of this subchapter, the terms 'multiple employer welfare arrangement', 'rural electric cooperative', and 'rural telephone cooperative association' have the meanings given such terms by section 3(40) of the Employee Retirement Income Security Act

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

"Subpart B—Special Rule for Church and Multiemployer Plans

"SEC. 21435. SPECIAL RULE FOR CHURCH AND MULTIEMPLOYER PLANS.

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

''(1) except as otherwise provided in this part, the plan shall be required to meet all applicable requirements of this title for certified standard health plans providing the standard benefit package under subtitle C which are offered by experience-rated employers,

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

''(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated as an experience-rated individual solely by reason of being eligible to enroll in the plan.

''(b) MODIFIED STANDARDS.—

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

''(2) SOLVENCY AND AVAILABILITY.—Rules similar to the rules of subsections (b) and (c) of section 21432 shall apply to a plan to which this section applies.

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

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

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

''(2) is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974) which is maintained by a health plan sponsor described in section 3(16)(B)(iii) of such Act but only if such plan (or a predecessor plan)—

''(A) offered health benefits as of June 1, 1994, and

''(B) as of June 1, 1994—

''(i) covered at least 500 participants in the United States, or

''(ii) was maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering at least 500 employees in the United States.

"Subtitle E—Implementation of Consumer Information Programs and Quality Research

"SEC. 21501. CONSUMER INFORMATION PROGRAMS.

''(a) IN GENERAL.—To support the consumer information program established by each participating State under section 21013, the Secretary, in consultation with the National Health Plan Standards and Quality Advisory Committee (established under section 21101(c)), shall—

''(1) develop a set of national measures of quality performance under subsection (b);

''(2) determine a national standard survey design and sampling strategy;

''(3) determine a standard format for comparative value information;

''(4) determine appropriate case-mix adjustments for data comparisons;

''(5) approve interstate geographic areas with respect to which comparative value information may be prepared;

''(6) establish standards for the distribution of such information; and

''(7) provide technical assistance and training.

''(b) NATIONAL MEASURES OF QUALITY PERFORMANCE.—

''(1) IN GENERAL.—The Secretary shall develop a set of national measures of quality performance in accordance with paragraph (2), which shall be used—

''(A) to provide comparative value information for consumers under section 21013, and

''(B) to assess the provision of health care services and access to such services.

''(2) SUBJECT OF MEASURES.—National measures of quality performance shall be developed in accordance with criteria to be determined by the Secretary and shall measure information on the following subjects:

''(A) Access to health care services by consumers.

''(B) Appropriateness of health care services provided to consumers.

''(C) Outcomes of health care services and procedures.

''(D) Health promotion.

''(E) Prevention of diseases, disorders, and other health conditions.

''(F) Consumer satisfaction with care.

''(G) Risk assessment factors.

''(H) Population health status.

''(3) MODIFICATIONS TO PERFORMANCE MEASURES.—The Secretary shall update the set of national measures of quality performance developed under paragraph (1) as the Secretary determines appropriate.

''(c) POPULATION HEALTH STATUS.—The Secretary, in consultation with public health experts and the National Health Plan Standards and Quality Advisory Committee (established under section 21101(c)), shall develop and define methods to measure population health status, including risk factor assessment. The Secretary shall use the methods developed for measuring population health status as the basis for developing consumer-focused quality im-

provement goals and the health plan standards in section 21124.

"SEC. 21502. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH.

''(a) HEALTH SERVICES RESEARCH.—

''(1) IN GENERAL.—The Secretary shall direct the Agency for Health Care Policy and Research and the Health Care Financing Administration to support and conduct research on the effects of health care reform on health care delivery systems and methods for risk adjustment.

''(2) QUALITY RESEARCH.—The Agency for Health Care Policy and Research shall conduct and support research on medical effectiveness including—

''(A) outcomes research;

''(B) clinical practice guidelines;

''(C) technology assessment; and

''(D) dissemination and implementation techniques.

''(b) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other amounts appropriated to carry out the provisions of this section from the Biomedical and Behavioral Research Trust Fund under section 9553 of the Internal Revenue Code of 1986, there are authorized to be

appropriated $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for the fiscal years 1998 through 2004.

"SEC. 21503. IMPLEMENTING QUALITY IMPROVEMENT RESEARCH.

''(a) IN GENERAL.—The Secretary shall award grants to States or community-based, independent, not-for-profit organizations that have submitted applications in accordance with subsection (b) to establish demonstration projects that provide certified standard health plans with the technical assistance to implement the results of quality improvement research into medical practice.

''(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if the applicant submits the application to the Secretary at such time, in such manner, and containing such information and assurances as the Secretary may reasonably require.

''(c) AVAILABILITY OF TRUST FUND AMOUNTS.—There shall be available $50,000,000 in each of the fiscal years 1996 through 2004 from the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986 to make grants under subsection (a).

''SEC. 21504. ANNUAL REPORTS.

''The Secretary shall provide an annual report to Congress which—

''(1) reviews the results of the quality improvement research grants under section 21503;

''(2) evaluates consumer information programs established by participating States;

''(3) tracks the evolution of national performance measures and other research; and

''(4) evaluates State, regional, and national trends on quality of health care.

''Subtitle F—Programs to Improve Access To Underserved Areas

''PART I—GRANTS FOR THE DEVELOPMENT AND OPERATION OF COMMUNITY HEALTH GROUPS AND FOR CAPITAL ASSISTANCE

''SEC. 21601. DESIGNATION OF RURAL AND URBAN UNDERSERVED AREAS.

''(a) STATE DESIGNATION.—

''(1) IN GENERAL.—Subject to paragraph (2), a participating State may designate areas within the State as rural or urban underserved areas in accordance with the criteria developed by the Secretary under subsection (c).

''(2) SECRETARIAL APPROVAL OF STATE DESIGNATION.—A State designation of an area within

the State as a rural or urban underserved area is subject to approval by the Secretary.

''(b) DESIGNATION BY THE SECRETARY.—In addition to rural and urban underserved areas designated by a participating State under subsection (a)(1) and approved by the Secretary under subsection (a)(2), the Secretary may designate additional areas within participating States as rural or urban underserved areas in accordance with the criteria developed by the Secretary under subsection (c).

''(c) CRITERIA.—The Secretary shall develop criteria for designating an area as a rural or underserved area. Such criteria shall take into account—

''(1) whether the area is—

''(A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage,

''(B) a population group which the Secretary determines has such a shortage, or

''(C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage,

except that the Secretary shall not remove an area from an area determined to be an area described in subparagraph (A) until the Secretary has afforded interested persons and groups in such area an opportunity to provide data and information in support of the designation as such an area or a population group described in subparagraph (B) or a facility described in subparagraph (C), and has made a determination on the basis of the data and information submitted by such persons and groups and other data and information available to the Secretary;

''(2) whether a significant number of individuals who are furnished health care services in the area are members of a population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or are a population group designated by the Secretary as having a shortage of such services;

''(3) the financial and geographic access to certified standard health plans;

''(4) the availability, adequacy, and quality of health care providers and health care facilities; and

''(5) the health status of residents of the area.

''SEC. 21602. COMMUNITY HEALTH GROUP; CERTIFIED COMMUNITY HEALTH PLAN; COMMUNITY HEALTH NETWORK; ELIGIBLE ENTITIES; ISOLATED RURAL FACILITIES.

''(a) COMMUNITY HEALTH GROUP.—For purposes of this part, the term 'community health group' means a certified community health plan or a community health network.

''(b) COMMUNITY HEALTH NETWORK.—For purposes of this part, the term 'community health network' means a consortium of health care providers that—

''(1) is a public or non-profit private entity;

''(2) furnishes at least a portion of the services included in the standard benefit package either directly or indirectly through affiliations with other entities;

''(3) has an agreement with one or more certified standard health plans;

''(4) has a written agreement with each of the health care providers in the consortium governing the participation of the providers;

''(5) has as participating members of the consortium two or more of the categories of eligible entities described in subsection (d);

''(6) ensures that the health care services furnished by the consortium are available and accessible to each client with reasonable promptness; and

''(7) furnishes a significant volume of health care services in a rural or urban underserved area designated by the State and approved by the Secretary under section 21601(a), or designated by the Secretary under subsection (b) of such section.

''(c) CERTIFIED COMMUNITY HEALTH PLAN.—For purposes of this part, the term 'certified community health plan' means a health plan that—

''(1) is a public or nonprofit private entity;

''(2) furnishes a significant volume of health care services in a rural or urban underserved area designated by the State and approved by the Secretary under section 21601(a), or designated by the Secretary under subsection (b) of such section;

''(3) has two or more of the categories of eligible entities described in subsection (d) furnishing health services through the health plan;

''(4) ensures that each individual enrolled with the plan has a primary care provider; and

''(5) meets all other criteria required of a certified standard health plan, including the offering of a standard benefits package under subtitle C.

''(d) ELIGIBLE ENTITIES.—For purposes of this part, the term 'eligible entities' means the following categories of entities:

''(1) Physicians, other health professionals, or health care institutions, including public hospitals, that provide a significant amount of health care services in a rural or urban underserved area designated by the State and approved by the Secretary under section 21601(a) or designated by the Secretary under subsection (b) of such section.

''(2) Entities providing health services under grants under sections 329 and 330 of the Public Health Service Act.

''(3) Entities providing health services under grants under sections 340 and 340A of such Act.

''(4) Entities providing health services under grants under section 1001 or title XXVI of such Act.

''(5) Entities providing health services under title V of the Social Security Act.

''(6) Entities providing health services through rural health clinics (as defined in section 1861(aa)(2)) and other federally qualified health centers (as defined in 1861(aa)(4)).

''(7) Entities providing health services in urban areas through programs under title V of the Indian Health Care Improvement Act, and entities providing outpatient health services through programs under the Indian Self-Determination Act.

''(8) Programs providing personal health services and operating through State or local public health agencies.

''(9) Isolated rural facilities (as defined in subsection (e)).

''(e) ISOLATED RURAL FACILITIES.—The term 'isolated rural facility' means a facility providing health services that is located in a county (or equivalent unit of local government) with fewer than 6 residents per square mile.

"Subpart A—Grants for the Development and Operation of Community Health Groups

"SEC. 21611. GRANTS AND CONTRACTS FOR DEVELOPMENT OF PLANS AND NETWORKS.

''(a) IN GENERAL.—In the case of a public or private non-profit consortium of eligible entities that submits an application in accordance with subsection (b), the Secretary may make grants to and enter into contracts with such consortium for the development of community health groups.

''(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if—

''(1) the applicant submits an application to the Secretary at such time and in such manner as the Secretary may reasonably require;

''(2) the application is accompanied by an assessment of need of the population or populations proposed to be served by the applicant;

''(3) the application is accompanied by the following information:

''(A) A description of how the applicant will design the proposed community health group (including the service sites involved) for such populations based on the assessment of need.

''(B) A description of efforts to secure, within the proposed service area of such community health group (including the service sites involved), financial and professional assistance and support for the project.

''(C) Evidence of significant community involvement in the initiation, development and ongoing operation of the project;

''(4) the application is accompanied by the assurances described in subsection (c); and

''(5) the application is accompanied by such additional assurances, agreements and other information as the Secretary may reasonably require.

''(c) ASSURANCES DESCRIBED.—The assurances described in this subsection are the following:

''(1) GUARANTEED ACCESS AND CONTINUED DELIVERY OF HEALTH CARE SERVICES IN A DESIGNATED AREA.—An assurance that the applicant involved will furnish—

''(A) a significant volume of health care services within a rural or urban underserved area designated by the State and approved by the Secretary under section 21601(a) or designated by the Secretary under subsection (b) of such section, and

''(B) health care services without regard to the financial or insurance status of an individual.

''(2) ACCESSIBILITY OF SERVICES.—

''(A) SERVICES FOR CERTAIN INDIVIDUALS.—An assurance that the applicant will ensure that the services of the applicant will be accessible directly or through formal contractual arrangements with its participating providers regardless of whether individuals who seek

care from the applicant are eligible individuals (as such term is defined in section 1958(3)).

''(B) USE OF THIRD-PARTY PAYORS.—An assurance that the applicant will ensure that the health care providers of the group are all approved by the Secretary as providers under title XVIII and by the appropriate State agency as providers under title XIX, and the applicant has made or will make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to individuals who are enrolled in a private health insurance program or certified standard health plan, or who are entitled to insurance benefits under title XVIII, medical assistance under a State plan approved under title XIX, or to assistance for medical expenses under any other public assistance program.

''(C) SCHEDULE OF FEES.—An assurance that the applicant will—

''(i) prepare a schedule of fees or payments for the provision of all health care services furnished by the applicant that is consistent with locally prevailing rates or charges and designed to cover its reason-

able costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments (or payments of cost sharing amounts owed in the case of covered benefits), which discounts are applied on the basis of the patient's ability to pay; and

''(ii) make every reasonable effort to secure from patients payment in accordance with such schedules, and to collect reimbursement for services to persons entitled to public or private insurance benefits or other medical assistance on the basis of full fees without application of discounts, except that the applicant will ensure that no person is denied service based on the person's inability to pay therefor.

''(D) BARRIERS WITHIN SERVICE AREA.—An assurance that the applicant will ensure that the following conditions are met:

''(i) In the service area of the group, the applicant will ensure that—

''(I) the services of the applicant are accessible to all residents; and

''(II) to the maximum extent possible, barriers to access to the services of the applicant are eliminated, including barriers resulting from the area's physical characteristics, its residential patterns, its economic, social and cultural groupings, its available transportation, and the ability of the area's residents to speak the English language.

''(ii) The applicant will periodically conduct reviews within the service area of the group to determine whether the conditions described in clause (i) are being met.

''(3) QUALITY CONTROL SYSTEM.—An assurance that the applicant will maintain a community-oriented, patient responsive, quality control system under which the group, in accordance with regulations prescribed by the Secretary—

''(A) conducts an ongoing quality assurance program for the health services delivered by participating provider entities;

''(B) maintains a continuous community health status improvement process; and

''(C) maintains a system for development, compilation, evaluation, and reporting of information to the public regarding the costs of operation, service utilization patterns, availability, accessibility and acceptability of services, developments in the health status of the populations served, uniform health and clinical performance measures and financial performance of the applicant.

''(4) USE OF EXISTING RESOURCES.—An assurance that the applicant will, in developing the community health group involved, utilize existing resources to the maximum extent practicable.

''(d) DEVELOPMENT GRANTS.—

''(1) PREFERENCE.—In making a grant or entering into a contract under subsection (a), the Secretary shall give a greater degree of preference to applicants—

''(A) according to the extent to which a greater number of categories of eligible entities described in section 21602(d) are members of the consortium, except in areas such as rural areas, where providers are severely limited in number, and

''(B) in which the population to be served by the consortium has a higher degree of unmet need.

''(2) USE OF FINANCIAL ASSISTANCE.—A consortium of eligible entities receiving financial assistance under a grant or contract pursuant to subsection (a) may use such assistance for activities relating to the development of a community health group, including—

''(A) planning such group, including entering into contracts between the recipient of the award and health care providers who are to participate in the group;

''(B) recruitment, compensation, training, and retention of health care professionals and administrative staff;

''(C) acquisition and development of information, billing, and reporting systems;

''(D) providing linkages between providers, including through the use of information systems;

''(E) in the case of a consortium receiving a grant or contract pursuant to subsection (a) for the development of a certified community health plan, the establishment of reserves re-

quired for furnishing services on a prepaid or capitated basis; and

''(F) such other expenditures as the Secretary determines to be appropriate to support other activities related to the development of community groups.

''(e) REPORTS AND AUDITS.—A public or private non-profit consortium of eligible entities that receives a grant or contract under subsection (a) shall—

''(1) provide such reports and information on activities carried out under this section in a manner and form required by the Secretary; and

''(2) provide an annual organizationwide audit that meets applicable standards of the Secretary.

''(f) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in part III, the following amounts shall be available for a calendar year for making payments under subsection (a) from the Infrastructure Development Account in the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986:

''(1) In the case of calendar year 1995, $250,000,000.

''(2) In the case of calendar year 1996, $300,000,000.

''(3) In the case of calendar year 1997, $300,000,000.

''(4) In the case of calendar year 1998, $300,000,000.

''(5) In the case of calendar year 1999, $200,000,000.

''(6) In the case of subsequent calendar years, the amount made available under this subsection for the previous calendar year (without regard to any reduction in such amount under part III), updated through the midpoint of the year by the estimated percentage change in the Consumer Price Index for All Urban Consumers (United States city average) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this paragraph in the projected percentage change in such Consumer Price Index.

''SEC. 21612. GRANTS AND CONTRACTS FOR OPERATION OF PLANS AND NETWORKS.

''(a) IN GENERAL.—In the case of a community health group that submits an application in accordance with subsection (b), the Secretary may make grants to and enter into contracts with such groups for the operation of such groups.

''(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if—

''(1) the applicant submits an application to the Secretary at such time and in such manner as the Secretary may reasonably require;

''(2) the application is accompanied by an assessment of need of the population or populations served by the applicant;

''(3) the application provides evidence of significant community involvement in the ongoing operation of the community health group;

''(4) the application is accompanied by the assurances described in section 21611(c); and

''(5) the application is accompanied by such additional assurances, agreements, and other information as the Secretary may reasonably require.

''(c) OPERATION GRANTS.—

''(1) PREFERENCE.—In making a grant or entering into a contract under subsection (a), the Secretary shall give a greater degree of preference to applicants in accordance with subparagraphs (A) and (B) of section 21611(d)(1).

''(2) USE OF FINANCIAL ASSISTANCE.—A community health group receiving financial assistance for the operation of the group under a grant or con-

tract pursuant to subsection (a) may use such assistance to address geographic, financial, and other barriers to access health care services including—

''(A) transportation, including rural and frontier emergency transportation systems;

''(B) patient outreach;

''(C) patient education;

''(D) translation services;

''(E) consumer information that would improve access to care; and

''(F) other services related to the provision of health care services.

''(d) REPORTS AND AUDITS.—A community health group that receives a grant or contract under subsection (a) shall—

''(1) provide such reports and information on activities carried out under this section in a manner and form required by the Secretary; and

''(2) provide an annual organization-wide audit that meets applicable standards of the Secretary.

''(e) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in part III, the following amounts shall be available for a calendar year for making payments under subsection (a) from the Infrastructure Development Account in the Health Security Trust Fund

established under section 9551 of the Internal Revenue Code of 1986:

''(1) In the case of calendar year 1995, $230,000,000.

''(2) In the case of calendar year 1996, $380,000,000.

''(3) In the case of calendar year 1997, $380,000,000.

''(4) In the case of calendar year 1998, $400,000,000.

''(5) In the case of calendar year 1999, $400,000,000.

''(6) In the case of subsequent calendar years, the amount made available under this subsection for the previous calendar year (without regard to any reduction in such amount under part III), updated through the midpoint of the year by the estimated percentage change in the Consumer Price Index for All Urban Consumers (United States city average) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this paragraph in the projected percentage change in such Consumer Price Index.

''Subpart B—Capital Assistance

''SEC. 21613. LOANS, LOAN GUARANTEES, AND GRANTS FOR CAPITAL INVESTMENT.

''(a) IN GENERAL.—In the case of a community health group or isolated rural facility that submits an application in accordance with subsection (b), the Secretary may make the financial assistance described in subsection (c) available to such group or facility for the provision of capital assistance.

''(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if—

''(1) the applicant submits an application to the Secretary at such time and in such manner as the Secretary may reasonably require;

''(2) in the case of an isolated rural facility, such facility submits its application prior to January 1, 1999;

''(3) in the case of a project for construction, conversion, expansion or modernization of a facility, the applicant submits to the Secretary the following:

''(A) A description of the site.

''(B) Plans and specifications which meet requirements prescribed by the Secretary.

''(C) Information reasonably demonstrating that title to such site is vested in one or more of the entities filing the application (un-

less the agreement described in paragraph (4)(A) is made).

''(D) A specification of the type of financial assistance being requested under subsection (a);

''(4) in the case of a project for construction, conversion, expansion or modernization of a facility, the application is accompanied by the following agreements:

''(A) Title to such site will be vested in one or more of the entities filing the application (unless the assurance described in paragraph (3)(C) has been submitted under such paragraph).

''(B) Adequate financial support will be available for completion of the project and for its maintenance and operation when completed.

''(C) The facility will be made available to all persons seeking service regardless of their ability to pay;

''(5) the application is accompanied by the assurances described in paragraphs section 21611(c) to the same extent and in the same manner as such provisions apply to awards of grants and contracts under such paragraphs, except that if the applicant

is an isolated rural facility described in section 21602(d)(9) only the assurances described in paragraph (1) and subparagraphs (A), (B), (C), and (D) (if translation services are appropriate) of paragraph (2) of section 21611(c) shall apply; and

''(6) the application is accompanied by such additional assurances, agreements and other information as the Secretary may reasonably require.

''(c) FINANCIAL ASSISTANCE DESCRIBED.—The financial assistance that the Secretary may provide under subsection (a) consists of—

''(1) loans;

''(2) guarantees on the payment of principal and interest to Federal and non-Federal lenders on behalf of community health groups and isolated rural facilities; and

''(3) grants for urgent capital needs (in accordance with criteria for determining such needs to be developed by the Secretary).

''(d) PRIORITIES REGARDING AVAILABILITY OF FINANCIAL ASSISTANCE.—

''(1) AMOUNTS RESERVED FOR FACILITIES IN RURAL DESIGNATED AREAS.—At least 10 percent of the dollar value of financial assistance made under subsection (a) during any given year shall be allo-

cated to entities described in subsection (a) that serve rural underserved areas designated by the State and approved by the Secretary under section 21601(a) or designated by the Secretary under subsection (b) of such section, to the extent the Secretary receives a sufficient number of qualified applications made by such entities.

''(2) PREFERENCES.—In making financial assistance available under subsection (a), the Secretary shall give a greater degree of preference to applicants proposing to use such assistance—

''(A) for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards;

''(B) to avoid noncompliance with licensure or accreditation standards; or

''(C) to provide essential services.

''(3) LIMITATION.—The Secretary may authorize the use of amounts under subsection (a) for the construction of new buildings only if—

''(A) the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction of new buildings will cost less; and

''(B) the applicant demonstrates that it has secured assurances of State, local, or other non-Federal support of the project.

''(e) AMOUNT OF ASSISTANCE.—The principal amount of loans or loan guarantees under subsection (a) may, when added to any other assistance under this section, cover up to 100 percent of the costs involved.

''(f) USE OF ASSISTANCE.—

''(1) IN GENERAL.—An entity described in subsection (a) shall use the financial assistance described in such subsection for—

''(A) the acquisition, modernization, conversion, and expansion of facilities that will enhance the provision and accessibility of health care; and

''(B) except as provided in paragraph (2), for the purchase of major equipment, including hardware for information systems.

''(2) ISOLATED RURAL FACILITIES.—In the case of an isolated rural facility that receives financial assistance to purchase major equipment for the furnishing of telemedicine services, such facility may not use such assistance to purchase high-cost telemedicine technologies that—

''(A) incur high cost per minute of usage charges; or

''(B) require consultants to be available at the same time as the patient and the referring physician.

''(g) TERMS AND CONDITIONS.—

''(1) LOANS.—Any loan made under subsection (a) shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

''(A) Security.

''(B) Maturity date.

''(C) Amount and frequency of installments.

''(D) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

Notwithstanding the provisions of subparagraph (D), the Secretary shall have the discretion to pro-

vide for a rate of interest that is lesser than the rate of interest described in such subparagraph.

''(2) LOAN GUARANTEES.—The Secretary may not approve a loan guarantee under this section unless the Secretary determines that the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable. Such loan guarantees shall be subject to such further terms and conditions as the Secretary determines, in consultation with the Secretary of the Treasury, and subject to the Federal Credit Reform Act of 1990, to be necessary to ensure that the purposes of this section will be achieved.

''(h) DEFAULTS; RIGHT OF RECOVERY.—

''(1) DEFAULTS.—

''(A) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans or loan guarantees under this section including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the tem-

porary payment of the interest and principal on such a loan, and for other purposes.

''(B) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to this section, including selling real property pledged as security for such a loan or loan guarantee and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

''(C) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reason of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to this section except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

''(2) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY.—

''(A) IN GENERAL.—

''(i) LOANS AND LOAN GUARANTEES.—With respect to a facility for which a loan, or loan guarantee is to be made pursuant to this section, the Secretary may provide the loan or loan guarantee only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the loan or loan guarantee, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

''(I) ceases to be a facility utilized by a community health group, or by another public or nonprofit private entity that provides health services in one or more areas that are rural or urban underserved areas designated by the State and approved by the Secretary under section 21601(a), or designated by the Secretary under subsection (b) of such section; or

''(II) is sold or transferred to any entity other than an entity that is—

''(aa) a community health group or other entity described in subclause (I); and

''(bb) approved by the Secretary as a purchaser or transferee regarding the facility.

''(ii) DIRECT GRANTS.—With respect to a facility for which substantial capital costs are to be paid from a grant made pursuant to this section, an assurance that the applicant will be liable to the United States for the amount of the award expended for such costs, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

''(I) ceases to be a facility utilized by a community health group, isolated rural facility, or by another public or nonprofit private entity that provides health services in one or more rural or urban underserved areas designated by the State and approved by the Secretary under section

21601(a) or designated by the Secretary under subsection (b) of such section; or

''(II) is sold or transferred to any entity other than an entity that is—

''(aa) a community health group or other entity described in clause (i); and

''(bb) approved by the Secretary as a purchaser or transferee regarding the facility.

''(B) SUBORDINATION; WAIVERS.—The Secretary may subordinate or waive the right of recovery under clause (i) or (ii) of subparagraph (A), and any other Federal interest that may be derived by virtue of a loan, loan guarantee, or grant under subsection (a), if the Secretary determines that subordination or waiver will further the objectives of this section.

''(i) REPORTS AND AUDITS.—A community health group or isolated rural facility that receives a loan, loan guarantee, or grant under subsection (a) shall—

''(1) provide such reports and information on activities carried out under this section in a manner and form required by the Secretary; and

''(2) provide an annual organization-wide audit that meets applicable standards of the Secretary.

''(j) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in part III, the following amounts shall be available for a calendar year for making payments under subsection (a) from the Infrastructure Development Account in the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986:

''(1) In the case of calendar year 1995, $500,000,000.

''(2) In the case of calendar year 1996, $700,000,000.

''(3) In the case of calendar year 1997, $700,000,000.

''(4) In the case of calendar year 1998, $700,000,000.

''(5) In the case of calendar year 1999, $700,000,000.

''(6) In the case of subsequent calendar years, the amount made available under this subsection for the previous calendar year (without regard to any reduction in such amount under part III), updated through the midpoint of the year by the estimated percentage change in the Consumer Price Index for All Urban Consumers (United States city average)

during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this paragraph in the projected percentage change in such Consumer Price Index.

''(k) ADMINISTRATION OF PROGRAMS.—This subpart, and any other program of the Secretary that provides loans or loan guarantees, shall be carried out by a centralized loan unit established within the Department of Health and Human Services.

"PART II—DEMONSTRATION PROJECTS TO PROMOTE TELEMEDICINE AND OTHER USES OF THE TELECOMMUNICATIONS NETWORK IN RURAL AREAS

"SEC. 21621. DEMONSTRATION PROJECTS TO PROMOTE TELEMEDICINE AND OTHER USES OF THE NETWORK.

''(a) DEFINITIONS.—For purposes of this section:

''(1) RURAL HEALTH CARE PROVIDER.—The term 'rural health care provider' means any health care provider located in a rural area (as defined in section 1886(d)(2)(D)), including a rural referral center, rural clinic, area health center, migrant health center, rural community health center, local

health department, and isolated rural facility (as defined in section 21602(e)).

''(2) HEALTH RESOURCE PARTNER.—The term 'health resource partner' means a tertiary care center that is available for consultations 24–hours a day and for follow up care.

''(3) NONHEALTH CARE ENTITY.—The term 'nonhealth care entity' means any entity that is not involved in the provision of health care, including a business, educational institution, library, and prison.

''(b) ESTABLISHMENT.—The Secretary shall award grants to eligible entities to establish demonstration projects under which an eligible entity establishes a rural-based consortium that enables members of the consortium to utilize the telecommunications network—

''(1) to strengthen the delivery of health care services in the rural area through the use of telemedicine;

''(2) to provide for consultations involving transmissions of detailed data about the patient that serves as a reasonable substitute for face-to-face interaction between the patient and consultant; and

''(3) to make outside resources or business interaction more available to the rural area.

''(c) ELIGIBLE ENTITY.—An entity eligible to receive a grant under this section shall include as members at least—

''(1) one rural health care provider and a health resource partner; and

''(2) one nonhealth care entity located in the same rural area as the rural health care provider described in paragraph (1) and one other nonhealth care entity.

The Secretary may waive the membership requirement under paragraph (2) if the members described in paragraph (1) are unable to locate a nonhealth care entity located in the same rural area to participate in the demonstration project.

''(d) PREFERENCES.—The Secretary shall give greater preference in awarding grants under this section to—

''(1) applicants that are seeking to serve rural underserved areas designated by the State and approved by the Secretary under section 21601(a) or designated by the Secretary under subsection (b) of such section;

''(2) applicants that have integrated health care resources or plan to integrate such resources within the rural area to the maximum extent practicable in order to avoid redundancy of scarce technology; and

''(3) applicants that have coordinated usage of the telecommunications infrastructure with other potential telecommunications users in the area to take advantage of economies-of-scale pricing of telecommunications services.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity described in subsection (c) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the eligible entity would apply any amounts received under such grant, the source and amount of non-Federal funds the entity would pledge for the project, and a showing of the long-term sustainability of the project.

''(f) GRANTS.—Grants under this section shall be distributed in accordance with the following requirements:

''(1) GRANT LIMIT.—The Secretary may not make a grant to an eligible entity under this section in excess of $500,000 for each fiscal year in which an eligible entity conducts a project under this section.

''(2) MATCHING FUNDS.—

''(A) IN GENERAL.—The Secretary may not make a grant to an eligible entity under

this section unless the eligible entity agrees to provide non-Federal funds in an amount equal to not less than 20 percent of the total amount to be expended by the eligible entity in any fiscal year for the purpose of conducting the project under this section.

''(B) ADJUSTMENTS.—The Secretary shall make necessary adjustments to the amount that an eligible entity may receive in a subsequent fiscal year if the eligible entity does not meet the requirements of subparagraph (A) in the preceding fiscal year.

''(g) USE OF GRANT AMOUNTS.—

''(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be utilized for the development and operation of telemedicine systems that serve rural areas. All such grant funds must be used to further the provision of health services to rural areas.

''(2) RULES OF USE.—

''(A) PERMISSIBLE USAGES.—Grant funds awarded under this section—

''(i) shall primarily be used to support the costs of establishing and operating a

telemedicine system that provides specialty consultations to rural communities;

''(ii) may be used to demonstrate the application of telemedicine for preceptorship of medical students, residents, and other health professions students in rural training sites;

''(iii) may be used for transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners; and

''(iv) may be used to demonstrate the use of telemedicine to facilitate collaboration between non-physician primary care practitioners (including physician assistants, nurse practitioners, certified nurse-midwives, and clinical nurse specialists) and physicians.

''(B) PROHIBITED USE OF FUNDS.—Grant funds shall not be used by members of a rural-based consortium for any of the following:

''(i) Expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 40 percent of the total grant funds.

''(ii) In the case of a member of a consortium that is an isolated rural facility (as defined in section 21602(e)), purchase of high-cost telecommunications technologies for the furnishing of telemedicine services that—

''(I) incur high cost per minute of usage charges; or

''(II) require consultants to be available at the same time as the patient and the referring physician.

''(iii) Purchase or installation of transmission equipment or establishment or operation of a telecommunications common carrier network.

''(iv) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 20 percent of the total grant funds.

''(v) Construction (except for minor renovations related to the installation of equipment), or the acquisition or building of real property.

''(h) REIMBURSEMENT FOR TELEMEDICINE SERVICES UNDER THE MEDICARE PROGRAM.—

''(1) IN GENERAL.—In consultation with the Office of Rural Health Policy, the Secretary shall designate 4 demonstration projects that have been awarded grants under subsection (b) as projects in which the Health Care Financing Administration shall, in accordance with paragraph (2), reimburse providers for telemedicine services furnished to—

''(A) individuals who are eligible for benefits under part A of title XVIII; and

''(B) individuals who are eligible for benefits under part A and enrolled under part B of title XVIII.

''(2) DEVELOPMENT OF PAYMENT METHODOLOGY AND PAYMENT PROVIDED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the Health Care Financing Administration shall reimburse a provider of telemedicine services from funds made available under subsection (k) in accordance with one or more methodologies to be developed by the Secretary.

''(B) CRITERIA FOR DEVELOPING PAYMENT METHODOLOGIES.—In developing payment methodologies under subparagraph (A), the Secretary shall—

''(i) limit payment to services that would otherwise be paid for under the medicare program under title XVIII if such services were not telemedicine services;

''(ii) have the discretion to develop conditions for payment that protect the health and safety of the individuals described in paragraph (1), including limiting payment for services that cannot be furnished safely as telemedicine services;

''(iii) have the discretion to include appropriate payments for transmission costs in the payment methodology; and

''(iv) limit payment for telemedicine consultation services to consultation services specified by the Secretary that would otherwise be paid for under the medicare program under title XVIII if the patient and practitioner had a face-to-face consultation.

''(i) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this section shall supplement, and shall

not supplant, funds that are expended for similar purposes under any State, regional, or local program.

''(j) EVALUATIONS.—Each eligible entity that conducts a demonstration project under this section shall submit to the Secretary such information and interim evaluations as the Secretary may require. The Secretary shall provide the Interagency Task Force on Rural Telemedicine with such evaluations and information submitted under the previous sentence as the Task Force may require to carry out its duties under section 21622(b).

''(k) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in part III, $20,000,000 in each of the calendar years 1995 through 1997 shall be available for making payments under subsection (a) from the Infrastructure Development Account in the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986.

''SEC. 21622. FEDERAL INTERAGENCY TASK FORCE.

''(a) ESTABLISHMENT.—Not later than 90 days after the date of the enactment of this section, the Secretary of Health and Human Services shall establish a Federal interagency task force to be known as the 'Interagency Task Force on Rural Telemedicine' (hereafter in this section referred to as the 'Task Force').

''(b) DUTIES.—

''(1) IN GENERAL.—The Task Force shall—

''(A) identify specific uses for telemedicine that have been proven to be effective to be used in the evaluation of applications for federally funded telemedicine demonstration projects, including any application submitted under this part;

''(B) review and coordinate evaluations of all federally funded telemedicine and telecommunications infrastructure demonstration projects, including any demonstration project established under this part;

''(C) establish mechanisms to facilitate a local area needs assessment and consortium development process to assist entities conducting federally funded telemedicine demonstration projects, including demonstration projects under this part; and

''(D) review the policy of the Health Care Financing Administration relating to reimbursement for telemedicine services under the demonstration projects established under section 21622(b) and designated under subsection (g)(1) of such section.

''(2) PUBLICATION OF RESULTS.—Not later than 3 years after the Task Force is established, and every 3 years thereafter, the Task Force shall analyze and publish a report of its findings under subparagraphs (A) through (D) of paragraph (1) and shall make such publications available to the Congress and the general public.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Task Force shall consist of representatives of—

''(A) the Department of Health and Human Services;

''(B) the Rural Electrification Administration;

''(C) the National Telecommunications Information Agency;

''(D) the National Institutes of Health; and

''(E) other agencies and departments that have responsibility for overseeing telemedicine projects.

''(2) CHAIRPERSON.—A representative of the Department of Health and Human Services shall serve as the chairperson of the Task Force.

''(d) BASIC PAY.—Each member of the Task Force shall serve without pay.

''(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

''(f) QUORUM.—A majority of the members shall constitute a quorum for the transaction of business.

''(g) REPORT ON TERMINATION OF COMMISSION.—Not later than 5 years after the date on which the Task Force is established, the Task Force shall submit to the Congress a report that evaluates the penetration of telemedicine in the United States and recommends whether the Task Force should be terminated.

''PART III—INSUFFICIENT AMOUNTS IN THE TRUST FUND

''SEC. 21631. INSUFFICIENT AMOUNTS IN THE TRUST FUND ACCOUNT.

''If the sum of the amounts specified under sections 21611(f), 21612(e), 21613(j), and 21621(k) for a calendar year exceeds the amounts available for such calendar year in the Infrastructure Development Account in the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986, then each such amount shall be reduced by the amount which bears the same ratio to such amount as the amounts available bears to the sum of such amounts.

"Subtitle G—Automobile Insurance Coordination

"SEC. 21701. DEFINITIONS.

''In this subtitle:

''(1) INJURED INDIVIDUAL.—The term 'injured individual' means an individual who has a bodily injury or illness sustained in an automobile accident and who is entitled to receive automobile insurance medical services from a certified standard health plan.

''(2) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term 'automobile insurance medical services' means services and items covered by automobile insurance that are medically necessary or appropriate for treatment of bodily injuries or illnesses sustained in automobile accidents and that are within the scope of the benefits to which an injured individual who is enrolled in a certified standard health plan is entitled under such health plan.

''(3) AUTOMOBILE INSURANCE CARRIER.—The term 'automobile insurance carrier' means an insurance company, employer, or fund that is liable for payment for automobile insurance medical services based either on a direct contractual obligation to an injured individual or an obligation on behalf of a

person responsible for causation of an injured individual's bodily injury or illness.

''(4) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' has the meaning given to such term by section 21111(a)(2).

"PART I—REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE MEDICAL SERVICES

"SEC. 21711. PROVISION OF AUTOMOBILE INSURANCE MEDICAL SERVICES THROUGH HEALTH PLANS.

''(a) IN GENERAL.—

''(1) HEALTH PLANS.—An individual enrolled in a certified standard health plan shall receive automobile insurance medical services under the terms generally applicable to the provision (or arrangement for the provision) of such services by such health plan.

''(2) MEDICARE AND MEDICAID.—Paragraph (1) shall not prevent a participating State from requiring automobile insurance carriers to make direct payment to health care providers for automobile insurance medical services that are covered both by (i) medicare under title XVIII or a State medicaid program under title XIX, and (ii) an automobile insurance contract that is required by law and provides for direct payment of medical services regardless of

fault. Payment for automobile insurance medical services in such circumstances shall be made to the extent of the automobile insurance carrier's liability under the applicable contract.

''(b) ALTERNATIVE PERMITTED.—Subsection (a) shall not prevent an individual and an automobile insurance carrier from agreeing that treatment for bodily injury or illness sustained in an automobile accident shall be provided other than by or through the certified standard health plan in which the individual is enrolled.

"SEC. 21712. PAYMENT FOR AUTOMOBILE INSURANCE MEDICAL SERVICES.

''(a) PAYMENT TO HEALTH PLANS.—Each automobile insurance carrier that is liable for payment for automobile insurance medical services provided to an injured individual by a certified standard health plan shall make payment to such health plan for such services to the extent of its obligations under the applicable automobile insurance contract.

''(b) REIMBURSEMENT FOR COST-SHARING.—Each automobile insurance carrier shall be liable for the reimbursement or payment of any deductibles, copayments, or coinsurance paid or owed by an injured individual for automobile insurance medical services to the extent of the applicable automobile insurance contract.

''(c) LIMITATION OF LIABILITY.—Except as provided in subsections (a) and (b), nothing in this subtitle or any other provision of law shall require an automobile insurance carrier or any person insured by such a carrier to make any payment to a health plan, health care provider, or any other person for (1) automobile insurance medical services, or (2) other health care services or items used to treat an injury or illness sustained in an automobile accident that are not medically necessary or appropriate.

''(d) USE OF FEE SCHEDULES.—

''(1) IN GENERAL.—Irrespective of the type of health plan providing automobile insurance medical services, payment by automobile insurance carriers for such services shall be made to the plan exclusively in accordance with any fee schedule or schedules established by the plan or the participating State for health care services generally.

''(2) MEDICARE FEE SCHEDULES.—If the injured individual is a medicare beneficiary under title XVIII, an automobile insurance carrier may use the appropriate fee schedule for health care services established under such title.

''(3) ALTERNATIVE PAYMENT METHODOLOGIES.—Fee schedules shall not be required in any case in which an automobile insurance carrier and a

health plan have agreed on an alternative payment arrangement.

''(e) REIMBURSEMENT FOR PAYMENTS MADE.—Nothing in this subtitle or any other provision of law shall impair the right of a certified standard health plan or automobile insurance carrier to seek reimbursement from any individual liable for a bodily injury or illness sustained in an automobile accident for payments made for automobile insurance medical services to treat such injury or illness.

''(f) RIGHTS TO COVERAGE FOR ADDITIONAL TREATMENT.—Subject to the provisions of subsection (c), nothing in this subtitle shall impair any rights with respect to medically necessary or appropriate services and items to which an individual injured in an automobile accident is entitled that are not automobile insurance medical services as defined in this subtitle.

"PART II—ADMINISTRATION

"SEC. 21721. PAYMENT FACILITATION.

''(a) IN GENERAL.—Each participating State shall establish a system for payment of automobile insurance medical services by automobile insurance carriers to certified standard health plans, including mechanisms for prompt resolution of any issues or disputes that may arise in connection with such payment. Such systems shall re-

quire that automobile insurance carriers have an affirmative obligation to identify to such health plans the automobile insurance carrier or carriers liable for payment for automobile insurance medical services, through the use of computer data programs where appropriate and cost effective.

''(b) SANCTIONS.—Each participating State shall authorize appropriate sanctions for the failure of a health plan, automobile insurance carrier, or any other person to comply with the requirements established pursuant to subsection (a).

"Subtitle H—Remedies and Enforcement

"PART I—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

"Subpart A—General Rules

"SEC. 21801. HEALTH PLAN CLAIMS PROCEDURE.

''(a) DEFINITIONS.—For purposes of this section:

''(1) CLAIM.—The term 'claim' means a claim for payment or provision of benefits under a health plan, a request for preauthorization of items or services which is submitted to a health plan prior to receipt of the items or services, or the denial, reduction, or termination of any service or request for a referral or reimbursement.

''(2) INDIVIDUAL CLAIMANT.—The term 'individual claimant' means, with respect to a claim, any individual who submits the claim to a health plan in connection with the individual's enrollment under the plan, or on whose behalf the claim is submitted to the plan by a provider.

''(3) PROVIDER CLAIMANT.—The term 'provider claimant' means, with respect to a claim, any provider who submits the claim to a health plan with respect to items or services provided to an individual enrolled under the plan.

''(b) GENERAL RULES GOVERNING TREATMENT OF CLAIMS.—

''(1) ADEQUATE NOTICE OF DISPOSITION OF CLAIM.—

''(A) IN GENERAL.—In any case in which a claim is submitted in complete form to a health plan, the plan shall provide to the individual claimant and any provider claimant with respect to the claim a written notice of the plan's approval or denial of the claim within 15 days after the date of the submission of the claim. The notice to the individual claimant shall be written in plain and easily understood language.

''(B) DENIALS.—In the case of a denial of the claim, the notice shall—

''(i) be provided within 5 days after the date of the determination to deny the claim;

''(ii) set forth the specific reasons for the denial, including an explanation of such reasons and the facts underlying the decision to reduce or fail to provide services or pay the claim; and

''(iii) clearly explain the right to appeal the denial under paragraph (2) and contain a description of the process for appealing such decision sufficient to allow the claimant to initiate an appeal and submit evidence to the decision maker in support of the position of the claimant.

''(C) FAILURE TO DENY TREATED AS APPROVAL.—Failure by any plan to comply with the requirements of this paragraph with respect to any claim submitted to the plan shall be treated as approval by the plan of the claim.

''(2) PLAN'S DUTY TO REVIEW DENIALS UPON TIMELY REQUEST.—The plan shall review its denial of the claim if an individual claimant or provider

claimant with respect to the claim submits to the plan a written request for reconsideration of the claim after receipt of written notice from the plan of the denial. The plan shall allow any such claimant not less than 60 days, after receipt of written notice from the plan of the denial, to submit the claimant's request for reconsideration of the claim.

''(3) TIME LIMIT FOR REVIEW.—The plan shall complete any review required under paragraph (2), and shall provide the individual claimant and any provider claimant with respect to the claim written notice of the plan's decision on the claim after reconsideration pursuant to the review, within 30 days after the date of the receipt of the request for reconsideration.

''(4) DE NOVO REVIEWS.—Any review required under paragraph (2)—

''(A) shall be de novo,

''(B) shall be conducted by an individual who did not make the initial decision denying the claim and who is authorized to approve the claim, and

''(C) shall include review by a qualified physician in the same speciality as the treating

physician if the resolution of any issues involved requires medical expertise.

''(c) TREATMENT OF URGENT REQUESTS TO PLANS FOR PREAUTHORIZATION.—

''(1) IN GENERAL.—This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request for preauthorization of items or services which is accompanied by an attestation that—

''(A) failure to immediately provide the items or services could reasonably be expected to result in—

''(i) placing the health of the individual claimant (or, with respect to an individual claimant who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(ii) serious impairment to bodily functions, or

''(iii) serious dysfunction of any bodily organ or part,

or

''(B) immediate provision of the items or services is necessary because the individual claimant has made or is at serious risk of mak-

ing an attempt to harm such individual claimant or another individual.

''(2) SHORTENED TIME LIMIT FOR CONSIDERATION OF REQUESTS FOR PREAUTHORIZATION.—Notwithstanding subsection (b)(1), a health plan shall approve or deny any claim described in paragraph (1) within 12 hours after submission of the claim to the plan. Failure by the plan to comply with the requirements of this paragraph with respect to the claim shall be treated as approval by the plan of the claim.

''(3) EXPEDITED EXHAUSTION OF PLAN REMEDIES.—Any claim described in paragraph (1) which is denied by the plan shall be treated as a claim with respect to which all remedies under the plan provided pursuant to this section are exhausted, irrespective of any review provided under subsection (b)(2).

''(4) DENIAL OF PREVIOUSLY AUTHORIZED CLAIMS NOT PERMITTED.—In any case in which a health plan approves a claim described in paragraph (1)—

''(A) the plan may not subsequently deny payment or provision of benefits pursuant to the claim, unless the plan makes a showing of

an intentional misrepresentation of a material fact by the individual claimant, and

''(B) in the case of a violation of subparagraph (A) in connection with the claim, all remedies under the plan provided pursuant to this section with respect to the claim shall be treated as exhausted.

''(d) TIME LIMIT FOR DETERMINATION OF INCOMPLETENESS OF CLAIM.—For purposes of this section—

''(1) any claim submitted by an individual claimant and accepted by a provider serving under contract with a health plan and any claim described in subsection (b)(1) shall be treated with respect to the individual claimant as submitted in complete form, and

''(2) any other claim for benefits under the plan shall be treated as filed in complete form as of 10 days after the date of the submission of the claim, unless the plan provides to the individual claimant and any provider claimant, within such period, a written notice of any required matter remaining to be filed in order to complete the claim.

Any filing by the individual claimant or the provider claimant of additional matter requested by the plan pursuant

to paragraph (2) shall be treated for purposes of this section as an initial filing of the claim.

''(e) ADDITIONAL NOTICE AND DISCLOSURE REQUIREMENTS FOR HEALTH PLANS.—In the case of a denial of a claim for benefits under a health plan, the plan shall include, together with the specific reasons provided to the individual claimant and any provider claimant under subsection (b)(1)—

''(1) if the denial is based in whole or in part on a determination that the claim is for an item or service which is not covered by a benefits package established under subtitle C or exceeds payment rates under the plan, the factual basis for the determination,

''(2) if the denial is based in whole or in part on exclusion of coverage with respect to services because the services are determined to comprise an experimental treatment or investigatory procedure, the medical basis for the determination and a description of the process used in making the determination, and

''(3) if the denial is based in whole or in part on a determination that the treatment is not medically necessary or appropriate or is inconsistent with the plan's practice guidelines, the medical basis for

the determination, the guidelines used in making the determination, and a description of the process used in making the determination.

''(f) WAIVER OF RIGHTS PROHIBITED.—A health plan may not require any party to waive any right under the plan or this title as a condition for approval of any claim under the plan, except to the extent otherwise specified in a formal settlement agreement.

"SEC. 21802. REVIEW IN AREA COMPLAINT REVIEW OFFICES OF GRIEVANCES BASED ON ACTS OR PRACTICES BY HEALTH PLANS.

''(a) COMPLAINT REVIEW OFFICES.—

''(1) IN GENERAL.—Except as provided in paragraph (2), in accordance with rules which shall be prescribed by the Secretary, each participating State shall establish and maintain a complaint review office for each community rating area established by such State to serve all enrollees of health plans serving such area.

''(2) MULTISTATE PLANS.—Under regulations of the Secretary of Labor, in consultation with the Secretary, the complaint review office for a community rating area established by such State shall also serve as the complaint review office for multistate self-insured health plans operating in the State with

respect to individuals who are enrolled under such plans and who reside within the community rating area.

''(b) FILINGS OF COMPLAINTS BY AGGRIEVED PERSONS.—In the case of any person who is aggrieved by any act or practice engaged in by any health plan which consists of, or results in, denial of payment or provision of benefits under the plan or delay in the payment or provision of benefits, if the denial or delay is alleged to consist of a failure to comply with the terms of the plan (including the provision of benefits in full when due in accordance with the terms of the plan), or with the applicable requirements of this title, such person may file a complaint with the appropriate complaint review office.

''(c) EXHAUSTION OF PLAN REMEDIES.—Any complaint to which this section applies, including a claim to which section 21801 applies, may not be filed until the complainant has exhausted all remedies provided under the plan with respect to the claim.

''(d) FORM OF COMPLAINT.—Any complaint to which this section applies shall be in writing under oath or affirmation, shall set forth the complaint in a manner calculated to give notice of the nature of the complaint, and shall contain such information as may be prescribed in regulations of the Secretary.

''(e) NOTICE OF FILING.—The complaint review office shall serve by certified mail a notice of the complaint (including the date, place, and circumstances of the alleged violation) on the person or persons alleged in the complaint to have committed the violation within 10 days after the filing of the complaint.

''(f) TIME LIMITATION.—A complaint may not be brought under this section with respect to any violation later than one year after the date on which the complaining party knows, or reasonably should have known, that a violation has occurred. This subsection shall not prevent the subsequent amending of a complaint.

"SEC. 21803. INITIAL PROCEEDINGS IN COMPLAINT REVIEW OFFICES.

''(a) ELECTIONS.—Whenever a complaint is brought to the complaint review office under section 21802(b), the complaint review office shall provide the complainant with an opportunity, in such form and manner as shall be prescribed in regulations of the Secretary, to make an irrevocable election:

''(1) To forego further proceedings in the complaint review office and rely on remedies available in a court of competent jurisdiction with respect to any matter in the complaint.

''(2) To submit the complaint as a dispute under the Early Resolution Program established under subpart B and thereby suspend further review proceedings under this section pending termination of proceedings under the Program.

''(3) In any case in which an election under paragraph (1) or (2) is not made, or an election under paragraph (2) was made but resolution of all matters in the complaint was not obtained upon termination of proceedings pursuant to the election by settlement agreement or otherwise, to proceed, with the consent of the plan, with the complaint to a hearing in the complaint review office under section 21804 regarding the unresolved matters.

''(b) DUTY OF COMPLAINT REVIEW OFFICE.—The complaint review office shall provide (in a linguistically and culturally appropriate manner) an explanation to complainants bringing complaints to the office concerning the legal and other ramifications of each option available under this section.

''(c) EFFECT OF PARTICIPATION IN EARLY RESOLUTION PROGRAM.—Any matter in a complaint brought to the complaint review office which is included in a dispute which is timely submitted to the Early Resolution Program established under subpart B shall not be assigned

to a hearing under section 21804 unless the proceedings under the Program with respect to the dispute are terminated without settlement or resolution of the dispute with respect to such matter. Upon termination of any proceedings regarding a dispute submitted to the Program, the applicability of this section to any matter in a complaint which was included in the dispute shall not be affected by participation in the proceedings, except to the extent otherwise required under the terms of any settlement agreement or other formal resolution obtained in the proceedings.

"SEC. 21804. HEARINGS BEFORE HEARING OFFICERS IN COMPLAINT REVIEW OFFICES.

''(a) HEARING PROCESS.—

''(1) ASSIGNMENT OF COMPLAINTS TO HEARING OFFICERS AND NOTICE TO PARTIES.—

''(A) IN GENERAL.—In the case of an election under section 21803(a)(3)—

''(i) the complaint review office shall assign the complaint, and each motion in connection with the complaint, to a hearing officer employed by the participating State in the office; and

''(ii) the hearing officer shall have the power to issue and cause to be served upon

the plan named in the complaint a copy of the complaint and a notice of hearing before the hearing officer at a place fixed in the notice, not less than 5 days after the serving of the complaint.

''(B) QUALIFICATIONS FOR HEARING OFFICERS.—No individual may serve in a complaint review office as a hearing officer unless the individual meets standards which shall be prescribed by the Secretary. Such standards shall include experience, training, ability to communicate with the enrollee, affiliations, diligence, absence of actual or potential conflicts of interest, and other qualifications deemed relevant by the Secretary. At no time shall a hearing officer have any official, financial, or personal conflict of interest with respect to issues in controversy before the hearing officer.

''(2) AMENDMENT OF COMPLAINTS.—Upon the motion of the complainant, any complaint may, at the discretion of the hearing officer conducting the hearing, be amended at any time prior to the issuance of an order based thereon.

''(3) ANSWERS.—The party against whom the complaint is filed shall have the right to file an an-

swer to the original or amended complaint and to appear in person or otherwise and give testimony at the place and time fixed in the complaint.

''(b) ADDITIONAL PARTIES.—In the discretion of the hearing officer conducting the hearing, any other person may be allowed to intervene in the proceeding and to present testimony.

''(c) HEARINGS.—

''(1) DE NOVO HEARING.—Each hearing officer shall hear complaints and motions de novo.

''(2) TESTIMONY.—The testimony taken by the hearing officer shall be reduced to writing. Thereafter, the hearing officer, in the officer's discretion, may (after notice to the parties) provide for the taking of further testimony or the hearing of arguments.

''(3) AUTHORITY OF HEARING OFFICERS.—

''(A) IN GENERAL.—The hearing officer may compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing. In case of contumacy or refusal to obey a subpoena lawfully issued under this paragraph and upon application of the hearing officer, an appropriate district court of the United States may issue an order

requiring compliance with the subpoena and any failure to obey the order may be punished by the court as a contempt thereof. The hearing officer may also seek enforcement of the subpoena in a State court of competent jurisdiction.

''(B) EXPERT WITNESSES.—The hearing officer may use independent medical experts.

''(4) RULES OF EVIDENCE.—Formal rules of evidence shall apply to any hearing under this section.

''(5) EXPEDITED HEARINGS.—Notwithstanding section 21803 and the preceding provisions of this section, upon receipt of a complaint containing a claim described in section 21801(c)(1), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 21803(a)(3) and assignment to a hearing on the complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office and not later than 3 days after the receipt of a complaint, the complaint review office shall provide a decision.

''(d) DECISION OF HEARING OFFICER.—

''(1) IN GENERAL.—Except as provided in subsection (c)(4), not later than 120 days after the date on which a complaint is assigned under this section, the hearing officer shall decide if the preponderance of the evidence justifies the denial of services and whether to decide in favor of the complainant with respect to each alleged act or practice. Each such decision—

''(A) shall include the hearing officer's findings of fact, and

''(B) shall constitute the hearing officer's final disposition of the proceedings.

''(2) DECISIONS FINDING IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that any party named in the complaint has engaged in or is engaged in an act or practice which consists of, or results in, a denial or delay described in section 21802(b), the hearing officer shall issue and cause to be served on such party an order which requires such party—

''(A) to cease and desist from such act or practice,

''(B) to provide the benefits due under the terms of the plan and to otherwise comply with

the terms of the plan and the applicable requirements of this title,

''(C) to pay to the complainant prejudgment interest on the actual costs incurred in obtaining the items and services at issue in the complaint,

''(D) to pay to the prevailing complainant a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs and expenses relating to the hearing on the charges on which the complainant prevails, and

''(E) to provide other appropriate relief.

''(3) DECISIONS NOT IN FAVOR OF COMPLAINANT.—If the hearing officer's decision includes a determination that the party named in the complaint has not engaged in or is not engaged in an act or practice referred to in section 21802(b), the hearing officer—

''(A) shall include in the decision a dismissal of the charge in the complaint relating to the act or practice, and

''(B) upon a finding that such charge is frivolous, shall issue and cause to be served on the complainant an order which requires the complainant to pay to such party a reasonable

attorney's fee, reasonable expert witness fees, and other reasonable costs and expenses relating to the proceedings on such charge.

''(4) SUBMISSION AND SERVICE OF DECISIONS.—The hearing officer shall submit each decision to the complaint review office at the conclusion of the proceedings and the office shall cause a copy of the decision to be served on the parties to the proceedings.

''(e) REVIEW.—

''(1) IN GENERAL.—The decision of the hearing officer shall be final and binding upon all parties. Except as provided in paragraph (2), any party to the complaint may, within 30 days after service of the decision by the complaint review office, file an appeal of the decision with the State Health Plan Review Board established under section 21805 in such form and manner as may be prescribed by such Board.

''(2) EXCEPTION.—A decision in favor of the complainant in the case of an expedited hearing under subsection (c)(4) shall not be subject to review.

''(f) COURT ENFORCEMENT OF ORDERS.—

''(1) IN GENERAL.—If a decision of the hearing officer in favor of the complainant is not appealed under section 21805, the complainant may petition any court of competent jurisdiction for enforcement of the order. In any such proceeding, the order of the hearing officer shall not be subject to review.

''(2) AWARDING OF COSTS.—In any action for court enforcement under this subsection, a prevailing complainant shall be entitled to a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs and expenses relating to such action.

"SEC. 21805. REVIEW BY STATE HEALTH PLAN REVIEW BOARD.

''(a) ESTABLISHMENT AND MEMBERSHIP.—Each participating State shall establish a State Health Plan Review Board (hereafter in this subtitle referred to as the 'Review Board'). The Review Board shall be composed of individuals who by reason of training, education, or experience are qualified to carry out the functions of the Review Board under this subtitle, and who fairly represent all interested parties. The State shall prescribe such rules as are necessary for the orderly transaction of proceedings by the Review Board. Every official act of the Review Board shall be entered of record, and its hearings and

records shall be open to the public consistent with State law regarding individual privacy rights and the confidentiality of medical records subject to the proceedings.

''(b) REVIEW PROCESS.—The Review Board shall ensure that reasonable notice is provided for each appeal before the Review Board of a hearing officer's decision under section 21804, and shall provide for the orderly consideration of arguments by any party to the hearing upon which the hearing officer's decision is based. In the discretion of the Review Board, any other person may be allowed to intervene in the proceeding and to present written argument. The Secretary (or in the case of multistate self-insured health plans, the Secretary of Labor) may intervene in the proceeding as a matter of right.

''(c) SCOPE OF REVIEW.—The Review Board shall review the decision of the hearing officer from which the appeal is made, except that the review shall be only for the purposes of determining—

''(1) whether the determination is supported by substantial evidence on the record considered as a whole,

''(2) in the case of any interpretation by the hearing officer of contractual terms (irrespective of the extent to which extrinsic evidence was consid-

ered), whether the determination is supported by a preponderance of the evidence,

''(3) whether the determination is in excess of statutory jurisdiction, authority, or limitations, or is in violation of a statutory right, or

''(4) whether the determination is without observance of procedure required by law.

''(d) DECISION OF REVIEW BOARD.—The decision of the hearing officer as affirmed or modified by the Review Board (or any reversal by the Review Board of the hearing officer's final disposition of the proceedings) shall become the final order of the Review Board and binding on all parties, subject to review under subsection (e). The Review Board shall cause a copy of its decision to be served on the parties to the proceedings not later than 5 days after the date of the decision.

''(e) REVIEW OF FINAL ORDERS.—

''(1) IN GENERAL.—Not later than 60 days after the entry of the final order, any person aggrieved by any such final order may seek a review of the order under State procedures.

''(2) ENFORCEMENT DECREE IN ORIGINAL REVIEW.—If, upon appeal of an order under paragraph (1), the order is not reversed, the court shall have

the jurisdiction to make and enter a decree enforcing the order of the Review Board.

''(f) AWARDING OF ATTORNEYS' FEES AND OTHER COSTS AND EXPENSES.—In any proceeding before the Review Board under this section or any judicial proceeding under subsection (e), the Review Board or the court (as the case may be) shall award to a prevailing complainant a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs and expenses relating to the causes on which the complainant prevails.

"**SEC. 21806. CIVIL MONEY PENALTIES.**

''(a) DENIAL OR DELAY IN PAYMENT OR PROVISION OF BENEFITS.—The Secretary (or in the case of a multistate self-insured health plan, the Secretary of Labor) may assess a civil penalty against any health plan for unreasonable denial or delay in the payment or provision of benefits thereunder, in an amount not to exceed—

''(1) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the plan, and

''(2) in the case of a finding of a pattern or practice of such violations engaged in by the plan, $1,000,000 in addition to the total amount of penalties assessed under paragraph (1) with respect to such violations.

For purposes of paragraph (1), each violation with respect to any single individual shall be treated as a separate violation.

''(b) CIVIL ACTION TO ENFORCE CIVIL PENALTY.—The Secretary may commence a civil action in any court of competent jurisdiction to enforce a civil penalty assessed under subsection (a).

''(c) SUPPLEMENTAL PLANS.—Nothing in this section shall be construed to limit the rights and remedies available under State law with respect to supplemental health benefits plans.

''Subpart B—Early Resolution Programs

''SEC. 21811. ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

''(a) ESTABLISHMENT OF PROGRAMS.—Each participating State shall establish and maintain an Early Resolution Program in each complaint review office in such State. The Program shall include—

''(1) the establishment and maintenance of forums for mediation of disputes in accordance with this subpart, and

''(2) the establishment and maintenance of such forums for other forms of alternative dispute resolution (including binding arbitration) as may be prescribed in regulations of the Secretary.

Each State shall ensure that the standards applied in Early Resolution Programs administered in such State which apply to any form of alternative dispute resolution described in paragraph (2), and which relate to time requirements, qualifications of facilitators, arbitrators, or other mediators, and confidentiality, are at least equivalent to the standards which apply to mediation proceedings under this subpart.

''(b) DUTIES OF COMPLAINT REVIEW OFFICES.—Each complaint review office in a participating State—

''(1) shall administer its Early Resolution Program in accordance with regulations of the Secretary,

''(2) shall, pursuant to subsection (a)(1)—

''(A) recruit and train individuals to serve as facilitators for mediation proceedings under the Early Resolution Program from attorneys who have the requisite expertise for such service, which shall be specified in regulations of the Secretary,

''(B) provide meeting sites, maintain records, and provide facilitators with administrative support staff, and

''(C) establish and maintain attorney referral panels,

''(3) shall ensure that, upon the filing of a complaint with the office, the complainant is adequately apprised of the complainant's options for review under this part, and

''(4) shall monitor and evaluate the Program on an ongoing basis.

"SEC. 21812. INITIATION OF PARTICIPATION IN MEDIATION PROCEEDINGS.

''(a) ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.—A dispute may be submitted to the Early Resolution Program only if the following requirements are met with respect to the dispute:

''(1) NATURE OF DISPUTE.—The dispute consists of—

''(A) an assertion by an individual enrolled under a health plan of one or more claims against the health plan for payment or provision of benefits, based on alleged coverage under the plan; and

''(B) a denial by the plan of the claims or appropriate reimbursement based on the claims.

''(2) NATURE OF DISPUTED CLAIM.—Each claim consists of—

''(A) a claim for payment or provision of benefits under the plan; or

''(B) a request for information or documents the disclosure of which is required under this title (including claims of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

''(b) FILING OF ELECTION.—A complainant with a dispute which is eligible for submission to the Early Resolution Program may make the election under section 21803(a)(2) to submit the dispute to mediation proceedings under the Program not later than 15 days after the date the complaint is filed with the complaint review office under section 21802(b).

''(c) AGREEMENT TO PARTICIPATE.—

''(1) ELECTION BY CLAIMANT.—A complainant may elect participation in the mediation proceedings only by entering into a written participation agreement (including an agreement to comply with the rules of the Program and consent for the complaint review office to contact the health plan regarding the agreement), and by releasing plan records to the Program for the exclusive use of the facilitator assigned to the dispute.

''(2) PARTICIPATION BY PLANS OR HEALTH BENEFITS CONTRACTORS.—Each party whose participation in the mediation proceedings has been

elected by a claimant pursuant to paragraph (1) shall participate in, and cooperate fully with, the proceedings. The claims review office shall provide such party with a copy of the participation agreement described in paragraph (1), together with a written description of the Program. Such party shall submit the copy of the agreement, together with its authorized signature signifying receipt of notice of the agreement, to the claims review office, and shall include in the submission to the claims review office a copy of the written record of the plan claims procedure completed pursuant to section 21801 with respect to the dispute and all relevant plan documents. The relevant documents shall include all documents under which the plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and any fee or reimbursement schedules for health care providers.

"SEC. 21813. MEDIATION PROCEEDINGS.

''(a) ROLE OF FACILITATOR.—In the course of mediation proceedings under the Early Resolution Program, the facilitator assigned to the dispute shall prepare the parties for a conference regarding the dispute and serve

as a neutral mediator at such conference, with the goal of achieving settlement of the dispute.

''(b) PREPARATIONS FOR CONFERENCE.—In advance of convening the conference, the facilitator shall, after identifying the necessary parties and confirming that the case is eligible for the Program, analyze the record of the claims procedure conducted pursuant to section 21801 and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.

''(c) CONFERENCE.—Upon convening the conference, the facilitator shall assist the parties in identifying undisputed issues and exploring settlement. If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement. If no settlement is reached, the facilitator shall present the facilitator's evaluation, including an assessment of the parties' positions, the likely outcome of further administrative action or litigation, and suggestions for narrowing the issues in dispute.

''(d) TIME LIMIT.—The facilitator shall ensure that mediation proceedings with respect to any dispute under the Early Resolution Program shall be completed within 120 days after the election to participate. The parties may

agree to one extension of the proceedings by not more than 30 days if the proceedings are suspended to obtain an agency ruling or to reconvene the conference in a subsequent session.

''(e) INAPPLICABILITY OF FORMAL RULES.—Formal rules of evidence shall not apply to mediation proceedings under the Early Resolution Program. All statements made and evidence presented in the proceedings shall be admissible in the proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission. The parties to mediation proceedings under the Program shall not be required to make statements or present evidence under oath.

''(f) REPRESENTATION.—Parties may participate pro se or be represented by attorneys throughout the proceedings of the Early Resolution Program.

''(g) CONFIDENTIALITY.—

''(1) IN GENERAL.—Under regulations of the Secretary, rules similar to the rules under section 574 of title 5, United States Code (relating to confidentiality in dispute resolution proceedings), shall apply to the mediation proceedings under the Early Resolution Program.

''(2) CIVIL REMEDIES.—The Secretary may assess a civil penalty against any person who discloses

information in violation of the regulations prescribed pursuant to paragraph (1) in the amount of three times the amount of the claim involved. The Secretary may bring a civil action to enforce such civil penalty in any court of competent jurisdiction.

"SEC. 21814. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROCEEDINGS.

''(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings of the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the Program.

''(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in mediation proceedings under the Program, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties which is enforceable under section 21815.

''(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under subpart A, or any other right under this subtitle or the

plan, with respect to any person who is not a party to the settlement agreement.

"SEC. 21815. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

''(a) ENFORCEMENT.—Any party to a settlement agreement entered pursuant to mediation proceedings under this subpart may petition any court of competent jurisdiction for the enforcement of the agreement, by filing in the court a written petition praying that the agreement be enforced. In such a proceeding, the order of the hearing officer shall not be subject to review.

''(b) COURT REVIEW.—It shall be the duty of the court to advance on the docket, and to expedite to the greatest extent possible, the disposition of any petition filed under this section, with due deference to the role of settlement agreements under this subpart in achieving prompt resolution of disputes involving health plans.

''(c) AWARDING OF ATTORNEY'S FEES AND OTHER COSTS AND EXPENSES.—In any action by an individual enrolled under a health plan for court enforcement under this section, a prevailing plaintiff shall be entitled to a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs and expenses relating to the charges on which the plaintiff prevails.

"Subpart C—Funding

"SEC. 21816. AVAILABILITY OF TRUST FUND AMOUNTS.

''(a) IN GENERAL.—There shall be available $100,000,000 in fiscal 1995, $150,000,000 in each of the fiscal years 1996 through 1998, and $100,000,000 in each of the fiscal years 1999 through 2004 from the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986 to the Secretary to support participating States that have submitted applications in accordance with subsection (b) to establish and maintain complaint review systems and early resolution programs. The Secretary shall develop a formula for determining the appropriate awarding of funds to participating States submitting such applications.

''(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if the applicant submits the application to the Secretary at such time, in such manner, and containing such information and assurances as the Secretary may reasonably require.

"PART II—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

"SEC. 21821. CIVIL ENFORCEMENT.

''Unless otherwise provided in this title, the district courts of the United States shall have jurisdiction of civil actions brought by—

''(1) the Secretary to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this title; and

''(2) the Secretary of Labor, in consultation with the Secretary, to enforce any final order of such Secretary or to collect any civil monetary penalty assessed by such Secretary under this title.

"SEC. 21822. FACIAL CONSTITUTIONAL CHALLENGES.

''(a) JURISDICTION.—The United States District Court for the District of Columbia shall have original and exclusive jurisdiction of any civil action brought to invalidate any provision of, or amendment made by, the Health Security Act on the ground of its being repugnant to the Constitution of the United States on its face and for every purpose. In any action described in this subsection, the district court may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of any provision of, or amendment made by, the Health Security Act.

''(b) CONVENING OF THREE-JUDGE COURT.—An action described in subsection (a) shall be heard and determined by a district court of three judges in accordance with section 2284 of title 28, United States Code.

''(c) CONSOLIDATION.—When actions described in subsection (a) involving a common question of law or fact

are pending before a district court, the court shall order all the actions consolidated.

''(d) DIRECT APPEAL TO SUPREME COURT.—In any action described in subsection (a), an appeal may be taken directly to the Supreme Court of the United States from any final judgment, decree, or order in which the district court—

''(1) holds any provision of, or amendment made by, the Health Security Act invalid; and

''(2) makes a determination that its holding will materially undermine the application of such Act as a whole.

''(e) CONSTRUCTION.—This section does not limit—

''(1) the right of any person—

''(A) to litigation concerning any provision of, or amendment made by, the Health Security Act; or

''(B) to petition the Supreme Court for review of any holding of a district court by writ of certiorari at any time before the rendition of judgment in a court of appeals; or

''(2) the authority of the Supreme Court to grant a writ of certiorari for the review described in paragraph (1)(B).

''SEC. 21823. TREATMENT OF PLANS AS PARTIES IN CIVIL ACTIONS.

''A health plan may sue or be sued under this title as an entity.

''SEC. 21824. GENERAL NONPREEMPTION OF RIGHTS AND REMEDIES.

''Nothing in this subtitle shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person, except to the extent the right or remedy is inconsistent with this subtitle.

''SEC. 21825. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

''Federal payments under this title shall be treated as Federal financial assistance for purposes of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 303 of the Age Discrimination Act of 1975 (42 U.S.C. 6102), and section 601 of the Civil Rights Act of 1964 (42 U.S.C. 2000d).

Subtitle B—Coordination With Other Provisions of Law

SEC. 111. MCCARRAN-FERGUSON REFORM.

(a) IN GENERAL.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson Act, is amended by adding at the end the following:

''(c) Notwithstanding that the business of insurance is regulated by State law, nothing in this Act shall limit

the applicability of the following Acts to the business of insurance to the extent that such business relates to the provision of health benefits:

''(1) The Sherman Act (15 U.S.C. 1 et seq.).

''(2) The Clayton Act (15 U.S.C. 12 et seq.).

''(3) Federal Trade Commission Act (15 U.S.C. 41 et seq.).

''(4) The Act of June 19, 1936 (49 Stat. 1526; 15 U.S.C. 21a et seq.), known as the Robinson-Patman Antidiscrimination Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect with respect to causes of action arising on or after January 1, 1996.

SEC. 112. OFFICE OF RURAL HEALTH POLICY.

(a) APPOINTMENT OF ASSISTANT SECRETARY.—

(1) IN GENERAL.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended—

(A) by striking ''by a Director, who shall advise the Secretary'' and inserting ''by an Assistant Secretary for Rural Health (in this section referred to as the 'Assistant Secretary'), who shall report directly to the Secretary''; and

(B) by adding at the end the following new sentence: ''The Office shall not be a component

of any other office, service, or component of the Department.''.

(2) CONFORMING AMENDMENTS.—(A) Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended by striking ''the Director'' and inserting ''the Assistant Secretary''.

(B) Section 338J(a) of the Public Health Service Act (42 U.S.C. 254r(a)) is amended by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(C) Section 464T(b) of the Public Health Service Act (42 U.S.C. 285p–2(b)) is amended in the matter preceding paragraph (1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(D) Section 6213 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395x note) is amended in subsection (e)(1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(E) Section 403 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300ff–11 note) is amended in the matter preceding paragraph (1) of subsection (a) by striking

''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(3) AMENDMENT TO THE EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (5)'' and inserting ''Assistant Secretaries of Health and Human Services (6)''.

(b) EXPANSION OF DUTIES.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended by striking ''and access to (and the quality of) health care in rural areas'' and inserting ''access to, and quality of, health care in rural areas, and reforms to the health care system and the implications of such reforms for rural areas''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 113. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) REPORTING AND DISCLOSURE REQUIREMENTS APPLICABLE TO GROUP HEALTH PLANS.—

(1) IN GENERAL.—Part 1 of subtitle B of title I of such Act is amended—

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

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

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

''SPECIAL RULES FOR GROUP HEALTH PLANS

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

''(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—Such special rules may include rules providing for—

''(1) reductions in the periods of time referred to in this part,

''(2) increases in the frequency of reports and disclosures required under this part, and

''(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the

purposes of this part and the Health Security Act as they relate to group health plans.

''(c) GROUP HEALTH PLAN.—For purposes of this section, the term 'group health plan' means an employee welfare benefit plan which provides medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.''

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

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

(b) COORDINATION WITH HEALTH SECURITY ACT.—

(1) ENFORCEMENT.—Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(1)(B)) is amended by inserting ''except in the case of an action by any participant, beneficiary, or fiduciary to which subtitle H of title XXI of the Social Security Act applies,'' before ''to recover''.

(2) PREEMPTION OF STATE LAWS.—Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph:

''(9) Subsection (a) shall not apply to any law of any State which implements a State single-payer system under part II of subtitle A of title XXI of the Social Security Act.''

(c) REPEAL OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

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

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

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

TITLE II—COVERAGE

SEC. 201. COVERAGE.

The Social Security Act, as amended by section 101, is amended by adding at the end the following new title:

''TITLE XXII—COVERAGE

''TABLE OF CONTENTS

''SEC. 2201. NATIONAL HEALTH CARE COMMISSION.

''There is established a commission to be known as the National Health Care Commission (in this title referred to as the 'Commission').

''SEC. 2202. DUTIES OF COMMISSION.

''(a) IN GENERAL.—The general duties of the Commission are to monitor and respond to—

''(1) trends in health insurance coverage; and

''(2) changes in per-capita premiums and other indicators of health care inflation.

The Commission may be advised by individuals with expertise concerning the economic, demographic, and insurance market factors that affect the cost and availability of health insurance.

''(b) BIENNIAL REPORTS.—

''(1) IN GENERAL.—The Commission shall report to Congress biennially on January 1 (beginning in 1996) on the status of health insurance coverage in the nation and the national goal of universal coverage.

''(2) HEALTH INSURANCE COVERAGE.—For purposes of this title, the term 'health insurance coverage' means coverage under—

''(A) a certified standard health plan providing a standard benefits package or an alternative standard benefits package;

''(B) the medicare program under title XVIII;

''(C) the medicaid program under title XIX;

''(D) the health care program for active military personnel under title 10, United States Code;

''(E) the veterans health care program under chapter 17 of title 38, United States Code;

''(F) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code;

''(G) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);

''(H) a State single-payer system approved by the Secretary under section 21031; or

''(I) any governmental health care program for institutionalized individuals.

''(3) CONTENTS OF REPORT.—Each biennial report shall include the structure and performance measures of every community rating area, including the following:

''(A) Demographics of the uninsured individuals, and findings on why such individuals are uninsured.

''(B) Structure of delivery systems.

''(C) Number and organizational form of certified standard health plans described in paragraph (2)(A).

''(D) Level of enrollment in such certified standard health plans.

''(E) State implementation of responsibilities, including establishment of community rating areas, under title XXI.

''(F) Status of insurance reforms.

''(G) Development of purchasing cooperatives and other buyer reforms.

''(H) Success of market and other mechanisms of controlling health expenditures and premium costs in the community rating areas and nationally.

''(I) Status of medicaid-eligible individuals under the medicaid program under title XIX, the integration of such individuals into coverage by certified standard health plans providing standard benefits packages, and the transition of such program toward managed care.

''(J) Adequacy of subsidies for individuals under part B of title XIX.

''(K) Status of medicare-eligible individuals under the medicare program under title XVIII, the integration of such individuals into coverage by certified standard health plans providing standard benefits packages, and the transition of such program into medicare risk contracts.

''(L) Coverage progress among individuals who are employed, including status and level of voluntary employer contributions and participation rates in purchasing cooperatives and among large employers.

''(M) Percentage of individuals who are enrolled in certified standard health plans described in paragraph (2)(A), separated into categories of medicare-eligible individuals, medicaid-eligible individuals, employed individuals, and individuals eligible for subsidies.

''(N) Recommendations, specific to each community rating area, on how the area might increase coverage among the residents and further moderate growth in premiums.

''(4) PROHIBITED ACTIVITY.—In carrying out its duties, including the preparation of any biennial

report, the Commission may not address issues related to defining an employee for tax purposes, including discussing such issues with the Internal Revenue Service or the Department of the Treasury.

''(c) COVERAGE TRIGGER.—

''(1) IN GENERAL.—In the event the Commission determines that health insurance coverage of at least 95 percent of the resident population in the United States will not be attained by 2002, the Commission shall submit recommendations in its biennial report to Congress on January 1, 2002.

''(2) RECOMMENDATION REQUIREMENTS.—

''(A) IN GENERAL.—The recommendations of the Commission shall include methods to reach 95 percent health insurance coverage in community rating areas that have failed to meet that target. Such recommendations shall address all relevant parties, including States, employers, employees, unemployed and low-income individuals, and public program participants.

''(B) REQUIRED SEPARATE RECOMMENDATIONS.—In addition to any other recommendations the Commission submits, the Commission

shall make separate recommendations on the following:

''(i) A schedule of assessments or contribaaaaaaaautions to encourage employers who are not doing so to purchase coverage for their employees.

''(ii) A method of encouraging full coverage which does not require any assessments on or contributions from employers.

''(iii) Possible adjustments to the actuarial value of any of the benefits packages described in subsection (b)(2)(A).

''(iv) Possible adjustments to subsidies under part B of title XIX.

''(v) Possible adjustments to the tax treatment of health benefits.

The Commission shall inform the National Health Benefits Board of any recommendations relating to clause (iii).

''(3) IMPLEMENTING BILL.—The Commission shall submit to the Congress an implementing bill which contains such statutory provisions as the Commission determines are necessary or appropriate

to implement the recommendations developed under this subsection.

''(d) DEFINITIONS.—For purposes of aythis title—

''(1) ALTERNATIVE STANDARD BENEFITS PACKAGE.—The term 'alternative standard benefits package' means the alternative standard benefits package established under subtitle C of title XXI.

''(2) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' has the meaning given such term by section 21011(a)(2).

''(3) COMMUNITY RATING AREA.—The term 'community rating area' means an area established under section 21021.

''(4) PURCHASING COOPERATIVE.—The term 'purchasing cooperative' has the meaning given such term by section 21100(14).

''(5) RESIDENT POPULATION.—The term 'resident population' includes any individual who is residing in the United States and who is—

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

''(B) an alien permanently residing in the United States under color of law (as defined in section 1958(4)(C)).

''(6) STANDARD BENEFITS PACKAGE.—The term 'standard benefits package' means the standard benefits package established under subtitle C of title XXI.

''(7) UNITED STATES.—The term 'United States' means the various States (as defined in section 21100(16)).

"SEC. 2203. CONGRESSIONAL CONSIDERATION OF COMMISSION RECOMMENDATIONS.

''(a) IN GENERAL.—An implementing qbill described in section 2202(c)(3) shall be considered by Congress under the procedures for consideration described in subsection (b).

''(b) CONGRESSIONAL CONSIDERATION.—

''(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by Congress—

''(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in subsection (a), and supersedes other rules only to the ex-

tent that such rules are inconsistent therewith; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

''(2) INTRODUCTION AND REFERRAL.—On the day on which the implementing bill described in subsection (as) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the majority leaderyay of the House, for himself or herself, and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself or herself, and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in that House, as provided in the preceding sentence, on the

first day thereafter on which that House is in session. If the implementing bill is not introduced within 5 days of its transmission, any Member of the House and of the Senate may introduce such bill. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

''(3) PERIOD FOR COMMITTEE CONSIDERATION.—If the committee or committees of either House to which an implementing bill has been referred have not reported the bill at the close of July 1, 2002 (or if such House is not in session, the next day such House is in session), such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the appropriate calendar.

''(4) FLOOR CONSIDERATION IN THE SENATE.—

''(A) IN GENERAL.—Within 5 days after the implementing bill is placed on the calendar, the majority leader, at a time to be determined by the majority leader in consultation with the minority leader, shall proceed to the consideration of the bill. If on the sixth day after the bill is placed on the calendar, the Senate has

not proceeded to consideration of the bill, then the presiding officer shall automatically place the bill before the Senate for consideration. A motion in the Senate to proceed to the consideration of an implementing bill shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

''(B) TIME LIMITATION ON CONSIDERATION OF BILL.—

''(i) IN GENERAL.—Debate in the Senate on an implementing bill, and all amendments and debatable motions and appeals in connection therewith, shall be limited to not more than 30 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

''(ii) DEBATE OF AMENDMENTS, MOTIONS, POINTS OF ORDER, AND APPEALS.—In the Senate, no amendment which is not relevant to the bill shall be in order. Debate in the Senate on any amendment, debatable motion or appeal, or point

of order in connection with an implementing bill shall be limited to—

''(I) not more than 2 hours for each first degree relevant amendment,

''(II) one hour for each second degree relevant amendment, and

''(III) 30 minutes for each debatable motion or appeal, or point of order submitted to the Senate,

to be equally divided between, and controlled by, the mover and the manager of the implementing bill, except that in the event the manager of the implementing bill is in favor of any such amendment, motion, appeal, or point of order, the time in opposition thereto, shall be controlled by the minority leader or designee of the minority leader. The majority leader and minority leader, or either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any amendment, debatable motion or appeal, or point of order.

''(C) OTHER MOTIONS.—A motion to recommit an implementing bill is not in order.

''(D) FINAL PASSAGE.—Upon the expiration of the 30 hours available for consideration of the implementing bill, it shall not be in order to offer or vote on any amendment to, or motion with respect to, such bill. Immediately following the conclusion of debate in the Senate on an implementing bill that was introduced in the Senate, such bill shall be deemed to have been read a third time and the vote on final passage of such bill shall occur without any intervening action or debate.

''(E) DEBATE ON DIFFERENCES BETWEEN THE HOUSES.—Debate in the Senate on motions and amendments appropriate to resolve the differences between the Houses, at any particular stage of the proceedings, shall be limited to not more than 5 hours.

''(F) DEBATE ON CONFERENCE REPORT.—Debate in the Senate on the conference report shall be limited to not more than 10 hours.

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

''(A) PROCEED TO CONSIDERATION.—On the sixth day after the implementing bill is placed on the calendar, it shall be privileged for any Member to move without debate that the House resolve itself into the Committee of the Whole House on the state of the Union, for the consideration of the bill, and the first reading of the bill shall be dispensed with.

''(B) GENERAL DEBATE.—After general debate, which shall be confined to the implementing bill and which shall not exceed 4 hours, to be equally divided and controlled by the chairman and ranking minority member of the Committee or Committees to which the bill had been referred, the bill shall be considered for amendment by title under the 5-minute rule and each title shall be considered as having been read. The total time for considering all amendments shall be limited to 26 hours of which the total time for debating each amendment under the 5-minute rule shall not exceed one hour.

''(C) RISE AND REPORT.—At the conclusion of the consideration of the implementing bill for amendment, the Committee of the

Whole on the state of the Union shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and the amendments thereto, and the House shall proceed to vote on final passage without intervening motion except one motion to recommit.

''(6) COMPUTATION OF DAYS.—For purposes of this subsection, in computing a number of days in either House, there shall be excluded—

''(A) the days on which either House is not in session because of an adjournment of more than 3 days to a day certain, or an adjournment of the Congress sine die, and

''(B) any Saturday and Sunday not excluded under subparagraph (A) when either House is not in session.

"SEC. 2204. OPERATION OF THE COMMISSION.

''(a) MEMBERSHIP.—

''(1) IN GENERAL.—The Commission shall be composed of 7 members appointed by the President and confirmed by the Senate. Members shall be appointed not later than 90 days after the date of the enactment of this title.

''(2) CHAIRPERSON.—The President shall designate 1 individual described in paragraph (1) who shall serve as Chairperson of the Commission.

''(b) COMPOSITION.—The membership of the Commission shall include individuals with national recognition for their expertise in health markets. In appointing members of the Commission, the President shall ensure that no more than 4 members of the Commission are affiliated with the same political party.

''(c) TERMS.—

''(1) IN GENERAL.—The terms of members of the Commission shall be for 6 years, except that of the members first appointed, 2 shall be appointed for an initial term of 4 years and 2 shall be appointed for an initial term of 2 years.

''(2) CONTINUATION IN OFFICE.—Upon the expiration of a term of office, a member shall continue to serve until a successor is appointed and qualified.

''(d) VACANCIES.—

''(1) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner as the original appointment, but the individual appointed to fill the vacancy shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

''(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Commission does not impair the authority of the remaining members to exercise all of the powers of the Commission.

''(3) ACTING CHAIRPERSON.—The Commission may designate a member to act as Chairperson during any period in which there is no Chairperson designated by the President.

''(e) MEETINGS; QUORUM.—

''(1) MEETINGS.—The Chairperson shall preside at meetings of the Commission, and in the absence of the Chairperson, the Commission shall elect a member to act as Chairperson pro tempore.

''(2) QUORUM.—Four members of the Commission shall constitute a quorum thereof.

''(f) ADMINISTRATIVE PROVISIONS.—

''(1) FACA NOT APPLICABLE.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

''(2) PAY AND TRAVEL EXPENSES.—

''(A) PAY.—Each member shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each

day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

''(B) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) EXECUTIVE DIRECTOR.—

''(A) IN GENERAL.—The Commission shall, without regard to section 5311(b) of title 5, United States Code, appoint an Executive Director.

''(B) PAY.—The Executive Director shall be paid at a rate equivalent to a rate for the Senior Executive Service.

''(4) STAFF.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Commission, may appoint and fix the pay of additional personnel.

''(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid

without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

''(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this Act.

''(5) OTHER AUTHORITY.—

''(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

''(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the operation of the Commission.

TITLE III—PREMIUM AND COST-SHARING ASSISTANCE

SEC. 301. PREMIUM AND COST-SHARING ASSISTANCE.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 101(a), is amended—

(1) by striking ''and'' at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(64) provide for a State program furnishing premium and cost-sharing assistance in accordance with part B.''.

(b) STATE PROGRAMS FOR PREMIUM AND COST-SHARING ASSISTANCE.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new part:

"PART B—STATE PROGRAMS FOR PREMIUM AND COST-SHARING ASSISTANCE

"**SEC. 1951. REQUIREMENT TO OPERATE STATE PROGRAM.**

''(a) IN GENERAL.—A State with a State plan approved under part A shall have in effect a program—

''(1) for furnishing premium assistance under section 1952—

''(A) to individuals with incomes below certain income thresholds described in section 1952(a)(2)(A)(i) in calendar years beginning after 1996; and

''(B) to children and pregnant women described in section 1952(a)(2)(A)(ii) in calendar years beginning after 1995; and

''(2) for determining eligibility for cost-sharing assistance under section 1953 in calendar years beginning after 1996.

''(b) STATE OPTION.—A State may have in effect a program—

''(1) for furnishing premium assistance under section 1952 to individuals with incomes below certain income thresholds described in section 1952(a)(2)(A)(i) during 1996; and

''(2) for determining eligibility for cost-sharing assistance under section 1953 during 1996.

''(c) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this part.

"SEC. 1952. ASSISTANCE WITH CERTIFIED STANDARD HEALTH PLAN PREMIUMS.

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—An eligible individual (as defined in section 1958(3)) who has been determined by a State under section 1954 to be a premium subsidy eligible individual (as defined in paragraph (2)) shall be entitled to premium assistance in the amount determined under subsection (b).

''(2) PREMIUM SUBSIDY ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—For purposes of this part, the term 'premium subsidy eligible individual' means any of the following individuals:

''(i) INDIVIDUALS WITH INCOMES BELOW CERTAIN INCOME THRESHOLDS.—An eligible individual who has a family income determined under section 1958(2) which does not exceed the eligibility percentage specified in subparagraph (B) of the poverty line (as defined in section 1958(5)).

''(ii) CHILDREN AND PREGNANT WOMEN.—An eligible individual who is a child under 18 years of age or a pregnant woman (as defined in section 1958(6)) and

has a family income determined under section 1958(2) which does not exceed 240 percent of the poverty line.

''(iii) REDUCTION IN ELIGIBILITY PERCENTAGES.—For requirement that the President reduce the percentage of the poverty line applicable to an individual's family income for purposes of determining eligibility for premium assistance under this section, see section 801 of the Health Security Act.

''(B) ELIGIBILITY PERCENTAGE.—

''(i) IN GENERAL.—The eligibility percentage shall be determined under the following table:

"Calendar year:	Applicable eligibility percentage:
1996	100
1997	125
1998	150
1999	175
2000	200

''(b) AMOUNT OF ASSISTANCE.—

''(1) IN GENERAL.—

''(A) DETERMINATION OF AMOUNT.—Except as provided in paragraph (4), the amount of premium assistance for a month for a premium subsidy eligible individual is the lesser of—

''(i) the premium assistance amount determined under paragraph (2); or

''(ii) the amount of the premium for coverage under the certified standard health plan (as defined in section 1958(1)) in which the individual is enrolled that is not paid (or offered to be paid) on behalf of such individual by an employer.

''(B) SPECIAL RULE FOR DETERMINING AMOUNT OF EMPLOYER PAYMENTS.—If an employer makes a payment toward the premium for coverage under a certified standard health plan on behalf of a family (rather than any particular individual) such contribution shall be allocated ratably among the individuals in the family.

''(2) PREMIUM ASSISTANCE AMOUNT DETERMINED.—

''(A) IN GENERAL.—The premium assistance amount determined under this paragraph is an amount equal to the lesser of—

''(i) the subsidy percentage specified in paragraph (3) multiplied by 1/12th of the annual premium for coverage under the

certified standard health plan in which the individual is enrolled, or

''(ii) the subsidy percentage specified in paragraph (3) multiplied by 1/12th of the weighted average annual premium for the individual's class of enrollment (determined in accordance with subparagraph (B)) for all community-rated certified standard health plans offered in the community rating area in which the individual resides.

''(B) DETERMINATION OF WEIGHTED AVERAGE ANNUAL PREMIUM.—For purposes of subparagraph (A)(ii), the weighted average annual premium for a class of enrollment under community-rated certified standard health plans offered in a community rating area shall be based on the number of primary enrollees in such class enrolled in each of the plans.

''(3) SUBSIDY PERCENTAGE.—For purposes of paragraph (2)(A), the term 'subsidy percentage' means the following:

''(A) INDIVIDUALS WITH INCOMES BELOW CERTAIN INCOME THRESHOLDS.—

''(i) PERCENTAGE DETERMINED.—For a premium subsidy eligible individual described in subsection (a)(2)(A)(i)—

''(I) for 1997, 100 percent reduced (but not below zero) by the product of the applicable factor determined under clause (ii) multiplied by the number of percentage points (rounded to the nearest whole number) by which such individual's family income exceeds 100 percent of the poverty line; and

''(II) for succeeding years, 100 percent reduced (but not below zero) by 1 percentage point for each 1 percentage point by which such individual's family income exceeds 100 percent of the poverty line.

''(ii) APPLICABLE FACTOR.—The applicable factor determined under this clause for a calendar year is the number equal to the quotient of—

''(I) 100, divided by

''(II) the eligibility percentage for the year determined under subsection

(a)(2)(B) (expressed as a whole number) minus 100.

''(B) CHILDREN AND PREGNANT WOMEN.—For a premium subsidy eligible individual described in subsection (a)(2)(A)(ii)—

''(i) 100 percent if the individual's family income does not exceed 185 percent of the poverty line;

''(ii) 80 percent if the individual's family income exceeds 185 percent of the poverty line but does not exceed 200 percent of the poverty line;

''(iii) 60 percent if the individual's family income exceeds 200 percent of the poverty line but does not exceed 215 percent of the poverty line;

''(iv) 40 percent if the individual's family income exceeds 215 percent of the poverty line but does not exceed 230 percent of the poverty line; and

''(v) 20 percent if the individual's family income exceeds 230 percent of the poverty line but does not exceed 240 percent of the poverty line.

''(4) MINIMUM AMOUNT.—

''(A) IN GENERAL.—If the total amount determined under paragraph (1) with respect to all premium subsidy eligible individuals in a family for a year (determined as if the individuals were eligible for subsidies for the entire year) does not exceed the amount determined under subparagraph (B) the individuals shall not be eligible to receive premium assistance under this section.

''(B) AMOUNT DETERMINED.—The amount determined under this subparagraph shall be—

''(i) for 1996, $150; and

''(ii) for 1997 and succeeding years, an amount equal to the amount determined under this subparagraph for the previous year updated through the midpoint of the year by the estimated percentage change in the medical consumer price index (as defined in section 1958(4)) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the

projected percentage change in the medical consumer price index.

''(C) ROUNDING.—Any amount determined under subparagraph (B)(ii) for a year shall be rounded to the nearest multiple of $5.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The amount of the premium assistance available to a premium subsidy eligible individual under subsection (b) shall be paid by the State in which the individual resides directly to the certified standard health plan in which the individual is enrolled. Payments under the preceding sentence shall commence in the first month during which the individual is enrolled in a certified standard health plan and determined under section 1954 to be a premium subsidy eligible individual.

''(2) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium assistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"SEC. 1953. ASSISTANCE WITH CERTIFIED STANDARD HEALTH PLAN COST-SHARING.

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—An eligible individual who has been determined by a State under section 1954 to be a cost-sharing subsidy eligible individual (as defined in paragraph (2)) shall be eligible for cost-sharing assistance as described in subsection (b). If a State determines that an individual is a cost-sharing eligible individual, the State shall notify the certified standard health plan in which such individual is enrolled of such determination in a timely manner.

''(2) COST-SHARING SUBSIDY ELIGIBLE INDIVIDUAL.—For purposes of this part, the term 'cost-sharing subsidy eligible individual' means an eligible individual who has a family income determined under section 1958(2) which does not exceed 100 percent of the poverty line.

''(b) COST-SHARING ASSISTANCE.—In the case of a cost-sharing subsidy eligible individual who is enrolled in a certified standard health plan, the cost-sharing assistance under this subsection shall consist of the plan's reduction in the cost-sharing otherwise imposed under the plan to amounts that are determined appropriate by the National Health Benefits Board under section 21213(d).

''(c) TERMINATION OF COST-SHARING ASSISTANCE.—An individual's eligibility for cost-sharing assist-

ance under this section shall terminate the month immediately following a month in which the State determines that the individual is no longer a cost-sharing subsidy eligible individual.

"SEC. 1954. ELIGIBILITY DETERMINATIONS.

''(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this part with respect to determining eligibility for premium and cost-sharing assistance, including requirements with respect to—

''(1) application procedures;

''(2) information verification procedures;

''(3) timeliness of eligibility determinations;

''(4) procedures for applicants to appeal adverse decisions; and

''(5) any other matters determined appropriate by the Secretary.

''(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

''(1) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

''(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c).

''(3) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance through employers and appropriate public agencies.

''(4) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium assistance based on such a revised application.

''(5) PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.—A State program shall, in accordance with regulations promulgated by the Secretary, establish a system under which pregnant women may be determined presumptively eligible for assistance under this part for a period determined appropriate by the Secretary.

''(6) AFDC APPLICANTS.—A State program shall include a procedure under which individuals

applying for benefits under title IV shall have an opportunity to apply for assistance under this part in connection with such application.

''(7) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this part. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(c) ADMINISTRATION OF STATE PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this part which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

''(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

''(A) be simple in form and understandable to the average individual;

''(B) require the provision of information necessary to make a determination as to whether an individual is a premium or cost-sharing

subsidy eligible individual including a declaration of estimated income by the individual based, at the election of the individual—

''(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made, or

''(ii) on estimated income for the entire year for which the application is submitted; and

''(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(3) OUTREACH ACTIVITIES.—A State operating a program under this part shall conduct such outreach activities as the Secretary determines appropriate.

''(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM SUBSIDIES.—A determination by a State that an individual is a premium subsidy eligible individual shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(4) indicates that an individual is no longer eligible for premium assistance.

''(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

''(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this part shall be liable to the Federal Government for the amount any premium assistance and cost-sharing assistance received by individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium assistance and cost-sharing assistance received by individual on the basis of a misrepresentation.

''(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under paragraph (1) and submit 50 percent of such amount to the Secretary in a timely manner.

''SEC. 1955. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under

this part from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

''(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received premium assistance under this part from such State in any month during the year.

''(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

''(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium assistance that should have been provided under this part with respect to the individual for the year involved.

''(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the individual is liable to the State to pay

an amount equal to the amount of the excess payment. Any amount collected by a State under this paragraph shall be submitted to the Secretary in a timely manner.

''(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the State shall pay to the individual an amount equal to the amount of the deficit.

''(4) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments or underpayments of premium assistance determined under paragraphs (2) and (3) with respect to an individual for a year may be collected or paid, as appropriate, through adjustments to the premium assistance furnished to such individual in the succeeding year.

''(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this part, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement

under this section in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such individual shall not be eligible for premium assistance under this part until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

''(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 1954(e) for a misrepresentation of material fact described in such section.

''(f) NO RECONCILIATION FOR COST-SHARING REDUCTIONS.—No reconciliation statement is required under this section with respect to cost-sharing assistance provided under section 1953.

''SEC. 1956. PAYMENTS TO STATES.

''(a) IN GENERAL.—

''(1) PAYMENTS FOR PREMIUM ASSISTANCE.—A State operating a program for furnishing premium assistance under section 1952 shall be entitled to re-

ceive payments in an amount equal to the amount of premium assistance paid on behalf of premium subsidy eligible individuals. Such payments shall be made at such time and in such form as provided in regulations promulgated by the Secretary.

''(2) MATCHING PAYMENTS FOR ADMINISTRATIVE EXPENSES.—The Secretary shall pay to each State operating a program for furnishing premium assistance under section 1952 and determining eligibility for cost-sharing assistance under section 1953, for each quarter beginning with the quarter commencing January 1, 1996, an amount equal to 75 percent of the total amount expended by the State during the quarter as found necessary by the Secretary for the proper and efficient administration of the program.

''(3) STATE ENTITLEMENT.—This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States operating programs under this part in accordance with this subsection.

''(b) FUNDING.—The amount paid to States under subsection (a) shall be paid by the Secretary from—

''(1) amounts made available under the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986, or

''(2) if such amounts are insufficient, out of any funds in the Treasury of the United States not otherwise appropriated.

''(c) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this part.

''SEC. 1957. GRANT PROGRAM FOR PROVIDING COST-SHARING ASSISTANCE FOR CERTAIN INDIVIDUALS WITH INCOMES ABOVE 100 PERCENT OF THE POVERTY LINE.

''(a) ESTABLISHMENT.—The Secretary shall pay to a State which elects to operate a cost-sharing assistance program under this section beginning on or after January 1, 1997, the amount determined under subsection (c).

''(b) PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A program described in this subsection consists of a State providing cost-sharing assistance to individuals enrolled in certified standard health plans whose family income determined under section 1958(2) exceeds 100 percent but does not exceed 200 percent of the poverty line.

''(2) ELIGIBILITY AND ADMINISTRATION.—A State operating a program under this subsection shall be responsible for administering the program, including—

''(A) establishing eligibility requirements for individuals applying for assistance under the program; and

''(B) with respect to an eligible individual, determining the appropriate amount of cost-sharing that will be paid by the program.

''(3) PAYMENTS FOR COST-SHARING.—The amount of cost-sharing assistance available to an eligible individual under this section (as determined in accordance with paragraph (2)(B)) shall be paid by the State directly to the certified standard health plan in which the individual is enrolled.

''(c) FEDERAL PAYMENT AMOUNT.—

''(1) IN GENERAL.—The Secretary shall pay a State operating a program under this section during a quarter an amount equal to 50 percent of the sum of—

''(A) the amount demonstrated by the State to have been expended during the quarter for furnishing cost-sharing assistance under this section to eligible individuals; and

''(B) the amount expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the program.

''(2) LIMITATION ON FEDERAL PAYMENTS.—

''(A) IN GENERAL.—The total amount paid to a State under paragraph (1) for a fiscal year shall not exceed the amount determined under subparagraph (B).

''(B) AMOUNT DETERMINED.—

''(i) IN GENERAL.—Except as provided in clause (ii), the amount determined under this subparagraph for a State for a fiscal year is the product of—

''(I) $2,000,000,000; multiplied by

''(II) the ratio of the average population of the State during the fiscal year as estimated by the Secretary to the average population of all States during the fiscal year as estimated by the Secretary.

''(ii) SPECIAL RULE FOR FISCAL YEAR 1998.—The amount determined under this subparagraph for a State for fiscal year

1998 shall be an amount equal to 75 percent of the amount determined under clause (i) for such fiscal year.

''(iii) FUNDING.—The amount paid to a State under this subsection shall be paid by the Secretary from amounts made available under the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986.

''(3) ADDITIONAL LIMITATION ON PAYMENTS.—For requirement that the President reduce the payments to States under this subsection, see section 801 of the Health Security Act.

''(4) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this section.

''SEC. 1958. DEFINITIONS AND DETERMINATIONS OF INCOME.

''For purposes of this part:

''(1) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' means a certified health plan (within the meaning of section 21011(a)(1)) providing the standard benefits package as described in section 21201(a).

''(2) DETERMINATIONS OF INCOME.—

''(A) FAMILY INCOME.—The term 'family income' means, with respect to an individual who—

''(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

''(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and dependents of the other individual.

''(B) DEPENDENT.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

''(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

''(D) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross in-

come' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

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

''(ii) increased by—

''(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax,

''(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code, and

''(III) the amount of aid to families with dependent children received during the taxable year under part A of title IV to the extent not included in gross income under such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

''(3) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means an individual who is residing in the United States and who is—

''(i) a citizen or national of the United States; or

''(ii) an alien permanently residing in the United States under color of law (as defined in subparagraph (C)).

''(B) EXCLUSION.—The term 'eligible individual' shall not include an individual who is an inmate of a public institution (except as a patient of a medical institution).

''(C) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term 'alien permanently residing in the United States under color of law' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

''(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

''(ii) An alien who is granted asylum under section 208 of such Act.

''(iii) An alien whose deportation is withheld under section 243(h) of such Act.

''(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

''(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

''(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

''(4) MEDICAL CONSUMER PRICE INDEX.—The term 'medical consumer price index' means the medical care services component of the consumer price index (for urban consumers) as determined by the Bureau of Labor Statistics.

''(5) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

''(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

''(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

''(6) PREGNANT WOMAN.—The term 'pregnant woman' means a woman described in section 1902(l)(1)(A).

''(7) PREMIUM.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.''.

(c) CONFORMING AMENDMENTS.—(1) Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by striking the title and inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS AND STATE PROGRAMS FOR PREMIUM AND COST-SHARING ASSISTANCE

"PART A—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS".

(2) Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by striking each reference to ''this title'' and inserting ''this part''.

TITLE IV—ADMINISTRATIVE SIMPLIFICATION AND PRIVACY

SEC. 401. ADMINISTRATIVE SIMPLIFICATION.

(a) MEDICARE AND MEDICAID COVERAGE DATA BANK AND RELATED IDENTIFICATION PROCESSES.—

(1) DELAY OF EMPLOYER REPORTING REQUIREMENT.—

(A) IN GENERAL.—Section 1144(c)(1)(A) of the Social Security Act (42 U.S.C. 1320–14(c)(1)(A)) is amended by striking ''January 1, 1994'' and inserting ''January 1, 1996''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall be effective on the date of the enactment of this Act.

(2) REPEAL OF DATA BANK.—

(A) IN GENERAL.—Effective January 1, 1996, section 1144 of the Social Security Act (42 U.S.C. 1320b–14) and section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) are repealed.

(B) INTERNAL REVENUE CODE PROVISION.—Section 6103(*l*) of the Internal Revenue Code of 1986 is amended by striking paragraph (12).

(C) IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by striking paragraph (5).

(D) CONFORMING AMENDMENTS.—(i) Section 1902(a)(25)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking ''including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1144 and any additional measures''.

(ii) Subsection (a)(8)(B) of section 552a of title 5, United States Code, is amended—

(I) in clause (v), by inserting ''; or'' at the end;

(II) in clause (vi), by striking ''or'' at the end; and

(III) by striking clause (vii).

(E) EFFECTIVE DATE.—The amendments made by this paragraph shall be effective on and after January 1, 1996.

(b) HEALTH INFORMATION NETWORK.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new subtitle:

''Subtitle B—Administrative Simplification

''TABLE OF CONTENTS OF SUBTITLE

"PART I—PURPOSE AND DEFINITIONS

"SEC. 11701. PURPOSE.

''It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII and the medicaid program under title XIX, by encouraging the development of a health information network through the establishment of standards and requirements for the electronic transmission of certain health information.

"SEC. 11702. DEFINITIONS.

''For purposes of this subtitle:

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

''(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

''(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

''(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 11802), health researcher, public health authority (as defined in section 11802), employer, life insurer, school or university, or health information network service certified under section 11741; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

''(5) HEALTH INFORMATION NETWORK.—The term 'health information network' means the health information system that is formed through the application of the requirements and standards established under this subtitle.

''(6) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term 'health information protection organization' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

''(7) HEALTH INFORMATION NETWORK SERVICE.—The term 'health information network service'—

''(A) means a private entity or an entity operated by a State that enters into contracts to—

''(i) process or facilitate the processing of nonstandard data elements of health information into standard data elements;

''(ii) provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this subtitle, including the holding of standard data elements of health information;

''(iii) provide authorized access to health information through the health information network; or

''(iv) provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

''(B) includes a health information protection organization.

''(8) HEALTH PLAN.—The term 'health plan' has the meaning given such term in section 21004(a)(1) except that such term shall include subparagraphs (C), (D), (E), (F), and (H) of such section.

''(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term 'non-identifiable health informa-

tion' means health information that is not protected health information as defined in section 11802.

''(10) HEALTH RESEARCHER.—The term 'health researcher' shall have the meaning given such term under section 11802.

''(11) PATIENT MEDICAL RECORD INFORMATION.—The term 'patient medical record information' means health information derived from a clinical encounter that relates to the physical or mental condition of an individual.

''(12) STANDARD.—The term 'standard' when referring to an information transaction or to data elements of health information means the transaction or data elements meet any standard adopted by the Secretary under part II that applies to such information transaction or data elements.

"PART II—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

"SEC. 11711. GENERAL REQUIREMENTS ON SECRETARY.

''(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

''(1) consistent with the objective of reducing the costs of providing and paying for health care; and

''(2) in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI).

''(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subtitle.

''(c) FAILSAFE.—If the Secretary is unable to adopt standards or modified standards in accordance with subsection (a) that meet the requirements of this subtitle—

''(1) the Secretary may develop or modify such standards and, after providing public notice and after an adequate period for public comment, adopt such standards; and

''(2) if the Secretary adopts standards under paragraph (1), the Secretary shall submit a report to the appropriate committees of Congress on the actions taken by the Secretary under this subsection.

''(d) PAPER FORMATS.—The Secretary may develop methods by which a person may use the standards adopted by the Secretary under this subtitle with respect to health information that is in written rather than electronic form.

''SEC. 11712. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

''(a) IN GENERAL.—The Secretary shall adopt standards necessary to make data elements of the following health information uniform and compatible for electronic transmission through the health information network:

''(1) the health information that is appropriate for transmission in connection with transactions described in subsections (a), (b), and (d) of section 11721;

''(2) the information required to be submitted by a health plan to a State under section 21013; and

''(3) patient medical record information.

''(b) ADDITIONS.—The Secretary may make additions to the sets of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

''(c) CERTAIN DATA ELEMENTS.—

''(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall establish a system to provide for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. The personal health identifier for an individual shall be an encrypted

form of the social security account number assigned to the individual by the Secretary under section 205(c)(2).

''(2) CODE SETS.—

''(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

''(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

''(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

''(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to such code sets under section 11714(c).

"SEC. 11713. INFORMATION TRANSACTION STANDARDS.

''(a) IN GENERAL.—The Secretary shall adopt technical standards relating to the method by which data elements of health information that have been standardized under section 11712 may be transmitted electronically, including standards with respect to the format in which such data elements shall be transmitted.

''(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standards adopted by the Secretary under paragraph (1) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records of enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

''(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy State and Federal statutory requirements for written signatures with respect to information transactions required by this Act and written signatures on medical records and prescriptions.

''SEC. 11714. TIMETABLES FOR ADOPTION OF STANDARDS.

''(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

''(1) the data elements for the information described in section 11712(a)(1) not later than 9 months after the date of the enactment of this subtitle (except in the case of standards with respect to data elements for claims attachments which shall be

adopted not later than 24 months after the date of the enactment of this subtitle);

''(2) the data elements for the information described in section 11712(a)(2) not later than 9 months after the date of the enactment of this subtitle;

''(3) data elements for patient medical record information not earlier than 24 months and not later than 7 years after the date of the enactment of this subtitle; and

''(4) any addition to a set of data elements, in conjunction with making such an addition.

''(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 11713 not later than 9 months after the date of the enactment of this subtitle (except in the case of standards for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle).

''(c) MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subtitle and shall adopt modified standards as determined appropriate, but no more frequently than once every 6 months. Any modifica-

tion to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets to accommodate changes in biomedical science and health care delivery.

''(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the

modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''(d) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subtitle. Such process may include demonstration projects and analysis of the cost of implementing such standards and modifications.

"PART III—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

"SEC. 11721. REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION.

''(a) REQUIREMENTS ON PLANS AND PROVIDERS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a health care provider or a health plan conducts any of the following transactions, such transactions shall be standard transactions and the information trans-

mitted or received in connection with such transaction shall be in the form of standard data elements:

''(1) Claims (including coordination of benefits).

''(2) Claims attachments.

''(3) Responses to research inquiries by a health researcher.

''(4) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

''(b) REQUIREMENT ONLY ON PLANS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a person desires to conduct any of the following transactions with a health plan as a standard transaction, the health plan shall conduct such standard transaction and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

''(1) Enrollment and disenrollment.

''(2) Eligibility.

''(3) Payment and remittance advice.

''(4) Premium payments.

''(5) First report of injury.

''(6) Claims status.

''(7) Referral certification and authorization.

''(8) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

''(c) REQUIREMENT ON PLANS RELATING TO QUALITY INFORMATION.—Any information required to be submitted by a health plan to a State under section 21013 shall be in the form of standard data elements and the transmission of such data shall be in the form of a standard transaction.

''(d) REQUIREMENT ONLY ON PURCHASING COOPERATIVES.—If a person desires to conduct any of the following transactions with a purchasing cooperative (as defined in section 21100(14)) as a standard transaction, the cooperative shall conduct such standard transaction and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

''(1) Enrollment and disenrollment.

''(2) Premium payments.

''(e) REQUIREMENT WITH RESPECT TO DISCLOSURE OF INFORMATION.—

''(1) IN GENERAL.—A health plan or health care provider shall make the standard data elements transmitted or received by such plan or provider in connection with the transactions described in sub-

sections (a), (b), and (c) or acquired under section 11764(a) available for disclosure as authorized by this subtitle.

''(2) SPECIAL RULE.—In the case of a health care provider that does not file claims, such provider shall be responsible for making standard data elements for encounter information available for disclosure as authorized by this subtitle.

''(f) SATISFACTION OF REQUIREMENTS.—A health care provider, health plan, or consumer purchasing cooperative may satisfy the requirement imposed on such provider, plan, or cooperative under subsection (a), (b), (c), (d), or (e) by—

''(1) directly transmitting standard data elements;

''(2) submitting nonstandard data elements to a health information network service certified under section 11741 for processing into standard data elements and transmission; or

''(3) in the case of a provider, submitting data elements to a plan which satisfies the requirements imposed on such provider on the provider's behalf.

''(g) TIMELINESS.—A health care provider or health plan shall be determined to have satisfied a requirement imposed under this section only if the action required is

completed in a timely manner, as determined by the Secretary. In setting standards for timeliness, the Secretary shall take into consideration the age and the amount of information being requested.

"SEC. 11722. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

''(a) INITIAL COMPLIANCE.—

''(1) IN GENERAL.—Not later than 12 months after the date on which standards are adopted under part II with respect to a type of transaction or data elements for a type of health information, a health plan, health care provider, or purchasing cooperative shall comply with the requirements of this subtitle with respect to such transaction or information.

''(2) ADDITIONAL DATA ELEMENTS.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under part II, a health plan, health care provider, or purchasing cooperative shall comply with the requirements of this subtitle using such data elements.

''(b) COMPLIANCE WITH MODIFIED STANDARDS.—

''(1) IN GENERAL.—If the Secretary adopts a modified standard under part II, a health plan, health care provider, or purchasing cooperative shall

be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification.

''(2) SPECIAL RULE.—In the case of modifications to standards that do not occur within the 12-month period beginning on the date such standards are adopted, the time determined appropriate by the Secretary under paragraph (1) shall be no sooner than the last day of the 90-day period beginning on the date such modified standard is adopted and no later than the last day of the 12 month period beginning on the date such modified standard is adopted.

"PART IV—ACCESSING HEALTH INFORMATION

"SEC. 11731. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

''(a) IN GENERAL.—The Secretary shall adopt technical standards for appropriate persons, including health plans, health care providers, health information network services certified under section 11741, health researchers, and Federal and State agencies, to locate and access the health information that is available through the health information network due to the requirements of this subtitle. Such technical standards shall ensure that any request to

locate or access information shall be authorized under subtitle C.

''(b) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

''(1) IN GENERAL.—Health information protection organizations certified under section 11741 shall make available to a Federal or State agency pursuant to a Federal Acquisition Regulation (or an equivalent State system), any non-identifiable health information that is requested by such agency.

''(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection organization described in paragraph (1) needs information from a health plan or health care provider in order to comply with a request of a Federal or State agency that is necessary to comply with a requirement under this Act, such plan or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information. If requested, a health information protection organization that receives information under the preceding sentence must make such information available to any other such organization that is certified under section

11741 for a charge that does not exceed the reasonable cost of transmitting the information.

''(c) FUNCTIONAL SEPARATION.—The standards adopted by the Secretary under subsection (a) shall ensure that any health information disclosed under such subsection shall not, after such disclosure, be used or released for an administrative, regulatory, or law enforcement purpose unless such disclosure was made for such purpose.

''(d) PUBLIC USE FUNCTIONS.—Nothing in this subtitle shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use functions.

"SEC. 11732. RESPONDING TO ACCESS REQUESTS.

''(a) IN GENERAL.—The Secretary may adopt, and modify as appropriate, standards under which a health care provider or health plan shall respond to requests for access to health information consistent with this subtitle and subtitle C.

''(b) STANDARDS DESCRIBED.—The standards under subsection (a) shall provide—

''(1) for a standard format under which a provider or plan will respond to each request either by satisfying the request or responding with an explanation of the specific restriction which results in a failure to satisfy the request; and

''(2) that any restrictions will not prevent a plan or provider from responding to a request in a timely manner taking into account the age and amount of the information being requested.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as permitting a health care provider or health plan to refuse to disclose any health information that is required to be disclosed by law.

"SEC. 11733. LENGTH OF TIME INFORMATION SHOULD BE ACCESSIBLE.

''The Secretary shall adopt standards with respect to the length of time any standard data elements for a type of health information should be accessible through the health information network.

"SEC. 11734. TIMETABLES FOR ADOPTION OF STANDARDS AND COMPLIANCE.

''(a) INITIAL STANDARDS.—The Secretary shall adopt standards under this part not later than 9 months after the date of the enactment of this subtitle and such standards shall be effective upon adoption.

''(b) MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this part and shall adopt modified standards as determined appropriate, but no more

frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance. Any modifications to standards adopted under this part shall be effective upon adoption.

''(2) SPECIAL RULE.—The Secretary shall not adopt modifications to any standards adopted under this part during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the requirements of this part.

"PART V—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

"SEC. 11741. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

''(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that—

''(1) such services develop, operate, and cooperate with one another to form the health information network;

''(2) such services meet all of the requirements under subtitle C that are applicable to such services;

''(3) such services make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

''(4) such services have security procedures that are consistent with the privacy requirements under subtitle C, including secure methods of access to and transmission of data;

''(5) such services, if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

''(b) CERTIFICATION BY THE SECRETARY.—

''(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this subtitle, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this subtitle and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a

manner that minimizes the costs and delays of operations for such services.

''(2) APPLICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

''(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this subtitle, subtitle C, and the standards established by the Secretary under this section.

''(4) RECERTIFICATION.—A health information network service must be recertified under this subsection at least every 3 years.

''(c) LOSS OF CERTIFICATION.—

''(1) MANDATORY TERMINATION.—Except as provided in paragraph (3), if a health information network service violates a requirement imposed on such service under subtitle C, its certification under this section shall be terminated unless the Secretary

determines that appropriate corrective action has been taken.

''(2) DISCRETIONARY TERMINATION.—If a health information network service violates a requirement or standard imposed under this subtitle and a penalty has been imposed under section 11751, the Secretary shall review the certification of such service and may terminate such certification.

''(3) CONDITIONAL CERTIFICATION.—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraphs (1) or (2). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

''(d) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

"SEC. 11742. ENSURING AVAILABILITY OF INFORMATION.

''The Secretary shall establish a procedure under which a health plan or health care provider which does not have the ability to transmit standard data elements directly or does not have access to a health information network service certified under section 11741 shall be able to make health information available for disclosure as authorized by this subtitle.

"PART VI—PENALTIES

"SEC. 11751. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

''(a) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person that violates a requirement or standard imposed under this subtitle a penalty of not more than $1,000 for each violation. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under section 1128A.

''(b) LIMITATIONS.—

''(1) NONCOMPLIANCE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—A penalty may not be imposed under subsection (a) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by

exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in subsection (a).

''(2) FAILURES DUE TO REASONABLE CAUSE.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), a penalty may not be imposed under subsection (a) if—

''(i) the failure to comply was due to reasonable cause and not to willful neglect; and

''(ii) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(ii) ASSISTANCE.—If the Secretary determines that a health plan, health care provider, or purchasing cooperative failed

to comply because such person was unable to comply, the Secretary may provide technical assistance to such person. Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(3) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (2) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"PART VII—MISCELLANEOUS PROVISIONS

"SEC. 11761. IMPOSITION OF ADDITIONAL REQUIREMENTS.

''(a) DATA ELEMENT STANDARDS.—A person may not impose a standard on another person that is in addition to the standards adopted by the Secretary under section 11712 unless—

''(1) such person voluntarily agrees to such standard; or

''(2) a waiver is granted under subsection (c) to impose such standard.

''(b) TRANSACTIONS AND ACCESS STANDARDS.—A person may not impose a standard on another person that is in addition to the standards adopted by the Secretary

under section 11713 or 11731 unless such person voluntarily agrees to such standard.

''(c) CONDITIONS FOR WAIVERS.—

''(1) IN GENERAL.—A person may request a waiver from the Secretary in order to require another person to comply with a standard that is in addition to the standards adopted by the Secretary under section 11712.

''(2) CONSIDERATION OF WAIVER REQUESTS.—No waiver may be granted unless the Secretary determines that the value of the data to be exchanged for research or other purposes significantly outweighs the administrative cost of the additional standard taking into consideration the burden of the timing of the imposition of the additional standard.

''(3) ANONYMOUS REPORTING.—If a person attempts to impose a standard in addition to the standards adopted by the Secretary under section 11712, the person on whom such additional standard is being imposed may contact the Secretary. The Secretary shall develop a procedure under which the contacting person shall remain anonymous. The Secretary shall notify the person imposing the additional standard that the additional standard may not be imposed unless the other person voluntarily

agrees to such standard or a waiver is obtained under this subsection.

"SEC. 11762. EFFECT ON STATE LAW.

''(a) IN GENERAL.—A provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law, including—

''(1) a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, and

''(2) a provision of State law which provides for requirements or standards that are more stringent than the requirements or standards under this subtitle;

except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"SEC. 11764. HEALTH INFORMATION CONTINUITY.

''(a) INFORMATION HELD BY HEALTH PLANS AND PROVIDERS.—If a health plan or health care provider takes any action that would threaten the continued availability of the standard data elements of health information held by such plan or provider, such data elements shall be obtained by the State in which such plan or provider is located. The State shall ensure that such data elements are transferred to a health plan or health care provider in accordance with procedures established by the Secretary.

''(b) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under section 11741 loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another health information network service certified under section 11741, as designated by the Secretary.

"SEC. 11765. PROTECTION OF COMMERCIAL INFORMATION.

''In adopting standards under this subtitle, the Secretary shall not require disclosure of trade secrets and confidential commercial information by entities operating in the health information network except as required by law.

''SEC. 11766. PAYMENT FOR HEALTH CARE SERVICES OR HEALTH PLAN PREMIUMS.

''Nothing in this subtitle shall be construed to prohibit payments for health care services or health plan premiums from being made by debit, credit, or other payment cards or numbers or other electronic payment means.

''SEC. 11767. HEALTH SECURITY CARDS.

''(a) IN GENERAL.—The Secretary shall establish standards relating to the form of health security cards issued by health plans and the information to be encoded electronically on such cards.

''(b) FORM DESCRIBED.—The standard form for a health security card shall be a card which—

''(1) is made of plastic or a similar durable material with a useful life of at least 5 years;

''(2) is resistant to counterfeiting;

''(3) can store information that can be encoded and retrieved electronically;

''(4) can be produced in a cost-effective manner and used in all types of health care locations; and

''(5) specifies on its face the social security account number assigned to the individual who is the cardholder by the Secretary under section 205(c)(2).

''(c) INFORMATION DESCRIBED.—The information electronically encoded on a health security card shall include the identity of the individual to whom the card was

issued, including such individual's personal health identifier specified under section 11712(c)(1), and may include any other information that the Secretary determines may be useful in order for the card to serve the purpose of easing access to and paying for health care services. A health plan shall make available to an individual cardholder, upon demand by such individual, a printed copy of all information electronically encoded on such individual's health security card.

"SEC. 11768. MISUSE OF HEALTH SECURITY CARD OR PERSONAL HEALTH IDENTIFIER.

''(a) HEALTH SECURITY CARD.—A person who—

''(1) requires the display of, requires the use of, or uses a health security card for any purpose other than obtaining or paying for health care;

''(2) falsely makes, forges, counterfeits or alters a health security card;

''(3) without lawful authority prints, photographs, or makes any impression in the likeness of any health security card; or

''(4) sells, transfers, or otherwise delivers a false, forged, counterfeited, or altered health security card knowing that the card is false, forged, counterfeited, or altered;

shall be fined not more than $25,000, imprisoned not more than 2 years, or both.

''(b) PERSONAL HEALTH IDENTIFIER.—A person who requires the disclosure of, requires the use of, or uses an individual's personal health identifier for any purpose that is not authorized by the Secretary, shall be fined not more than $25,000, imprisoned not more than 2 years, or both.

"SEC. 11769. DIRECT BILLING FOR CLINICAL LABORATORY SERVICES.

''(a) IN GENERAL.—

''(1) REQUIREMENT.—Except as provided in paragraph (2), in the case of a claim for payment for a clinical diagnostic laboratory test for which payment may otherwise be made, payment may be made only to the person who, or entity which, performed or supervised the test.

''(2) EXCEPTIONS.—Payment for a clinical diagnostic laboratory test may be made to a physician with whom the physician who performed the test shares a practice.

''(b) ADDITIONAL EXCEPTIONS.—The Secretary may, by regulation, establish exceptions to the requirement under subsection (a)(1) that are in addition to the

exceptions under subsection (a)(2). In establishing such exceptions the Secretary shall take into account—

''(1) circumstances in which an individual's privacy might be violated; or

''(2) the need for confidentiality on the part of the person furnishing the test.

"SEC. 11770. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subtitle.

"PART VIII—ASSISTANCE TO THE SECRETARY

"SEC. 11771. GENERAL REQUIREMENT ON SECRETARY.

''In complying with any requirements imposed under this subtitle, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 11772 and shall consult with appropriate Federal agencies.

"SEC. 11772. HEALTH INFORMATION ADVISORY COMMITTEE.

''(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

''(b) DUTY.—

''(1) IN GENERAL.—The committee shall—

''(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this subtitle and subtitle C;

''(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

''(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

''(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall receive technical assistance from appropriate Federal agencies.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this subtitle. The President shall designate 1 member as the Chair.

''(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee.

''(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of no more than 3 members expire at one time.

''(4) VACANCIES.—

''(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

''(d) MEETINGS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

''(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the committee have been appointed, the committee shall hold its first meeting.

''(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

''(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

''(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

''(g) REPORTS.—

''(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

''(A) the status of the health information network established under this subtitle, includ-

ing whether the network is fulfilling the purpose described in section 11701;

''(B) the savings and costs of the network;

''(C) the activities of health information network services certified under section 11741, health care providers, health plans, and other entities using the network to exchange health information;

''(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this subtitle and working together to form an integrated network that meets the needs of its users;

''(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of subtitle C;

''(F) the number and types of penalties assessed for noncompliance with the standards adopted under this subtitle;

''(G) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under the Health Security Act;

''(H) any problems with respect to implementation of the network;

''(I) the extent to which timetables under this subtitle for the adoption and implementation of standards are being met; and

''(J) any legislative recommendations related to the health information network.

''(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public unless such information may not be disclosed by law.

''(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

''PART IX—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL INFORMATION SYSTEMS

''SEC. 11781. GRANTS FOR DEMONSTRATION PROJECTS.

''(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

''(b) APPLICATIONS.—

''(1) SUBMISSION.—To apply for a grant under this part for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

''(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary regarding the following:

''(A) USE OF EXISTING TECHNOLOGY.—Funds received under this part will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and

confidentiality of information relating to the physical or mental condition of an individual.

''(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this part will be used—

''(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

''(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

''(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

''(C) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

''(c) GEOGRAPHIC DIVERSITY.—In making any grants under this part, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

''(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this part with the provisions of this part. The Secretary shall establish a procedure for determining whether such a person has failed to comply substantially within the provisions of this part and the sanctions to be imposed for any such noncompliance.

''(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this part.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(2) Conforming amendments.—(A) Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

"Subtitle A—General Provisions and Peer Review"

(B) Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking each reference to ''this title'' and inserting ''this subtitle''.

SEC. 402. PRIVACY OF HEALTH INFORMATION UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401, is amended by adding at the end the following new subtitle:

"Subtitle C—Privacy of Health Information

''TABLE OF CONTENTS OF SUBTITLE

"PART I—FINDINGS AND DEFINITIONS

"SEC. 11801. FINDINGS AND PURPOSES.

''(a) FINDINGS.—The Congress finds as follows:

''(1) The improper disclosure of individually identifiable health care information may cause significant harm to an individual's interests in privacy, health care, and reputation and may unfairly affect the ability of an individual to obtain employment, education, insurance, and credit.

''(2) The movement of people and health care related information across State lines, the availability of, access to, and exchange of health care related information with Federally funded health care systems, the medicare program under title XVIII, and the medicaid program under title XIX, through automated data banks and networks, and the emergence of other multistate health care providers and payors create a need for a uniform Federal law governing the disclosure of health care information.

''(b) PURPOSE.—The purpose of this subtitle is to establish effective mechanisms to protect the privacy of indi-

viduals with respect to individually identifiable health care information that is created or maintained as part of health treatment, enrollment, payment, testing, or research processes.

"SEC. 11802. DEFINITIONS.

''(a) TERMS RELATING TO PROTECTED HEALTH INFORMATION.—In this subtitle:

''(1) PROTECTED HEALTH INFORMATION.—The term 'protected health information' means any information, including demographic information collected from an individual, whether oral or recorded in any form or medium, that—

''(A) is created or received by a health care provider, health plan, health oversight agency, health researcher, public health authority, employer, life insurer, school or university, or certified health information network service; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

''(i) identifies an individual; or

''(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

''(2) DISCLOSE.—The term 'disclose', when used with respect to protected health information, means to provide access to the information, but only if such access is provided to a person other than the individual who is the subject of the information.

''(b) TERMS RELATING TO HEALTH CARE SYSTEM PARTICIPANTS.—In this subtitle:

''(1) HEALTH INFORMATION TRUSTEE.—The term 'health information trustee' means—

''(A) a health care provider, health plan, health oversight agency, certified health information network service, employer, life insurer, or school or university insofar as it creates, receives, maintains, uses, or transmits protected health information;

''(B) any person who obtains protected health information under section 11823, 11832, 11833, 11841, 11842, 11851, or 11854; and

''(C) any employee or agent of a person covered under subparagraphs (A) or (B).

''(2) HEALTH CARE.—The term 'health care'—

''(A) means—

''(i) a preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

''(I) with respect to the physical or mental condition of an individual; or

''(II) affecting the structure or function of the human body or any part of the human body; or

''(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

''(B) does not include any item or service that is not furnished for the purpose of examining, maintaining, or improving the health of an individual.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession.

''(4) HEALTH OVERSIGHT AGENCY.—The term 'health oversight agency' means a person who—

''(A) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers; or

''(B)(i) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for, health care or relating to health care fraud or fraudulent claims for payment regarding health; and

''(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State law governing the assessment, evaluation, determination, or investigation described in clause (i).

''(5) HEALTH PLAN.—The term 'health plan' shall have the meaning given such term under section 11702.

''(6) HEALTH RESEARCHER.—The term 'health researcher' means a person who conducts a biomedical, public health, epidemiological, health services, or health statistics research project or a research project on social and behavioral factors relating to health.

''(7) INSTITUTIONAL REVIEW BOARD.—The term 'institutional review board' means—

''(A) a board established in accordance with regulations of the Secretary under section 491(a) of the Public Health Service Act;

''(B) a similar board established by the Secretary for the protection of human subjects in research conducted by the Secretary; or

''(C) a similar board established under regulations of a Federal Government authority other than the Secretary.

''(8) PUBLIC HEALTH AUTHORITY.—The term 'public health authority' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is (A) responsible for public health matters; and (B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

''(c) REFERENCES TO CERTIFIED ENTITIES.—In this subtitle:

''(1) CERTIFIED HEALTH INFORMATION NETWORK SERVICE.—The term 'certified health information network service' means a health information service (as defined under section 11702) that is certified under section 11741.

''(2) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATION.—The term 'certified health information protection organization' means a health information protection organization (as defined in section 11702) that is certified under section 11741.

''(d) OTHER TERMS.—In this subtitle:

''(1) INDIVIDUAL REPRESENTATIVE.—The term 'individual representative' means any individual legally empowered to make decisions concerning the provision of health care to an individual (where the individual lacks the legal capacity under State law to make such decisions) or the administrator or executor of the estate of a deceased individual.

''(2) LAW ENFORCEMENT INQUIRY.—The term 'law enforcement inquiry' means an investigation or official proceeding inquiring into whether there is a violation of, or failure to comply with, any criminal

or civil statute or any regulation, rule, or order issued pursuant to such a statute.

''(3) PERSON.—The term 'person' includes an authority of the United States, a State, or a political subdivision of a State.

"PART II—AUTHORIZED DISCLOSURES

"Subpart A—General Provisions

"SEC. 11811. GENERAL RULES REGARDING DISCLOSURE.

''(a) GENERAL RULE.—A health information trustee may disclose protected health information only for a purpose that is authorized under this subtitle.

''(b) DISCLOSURE WITHIN A TRUSTEE.—A health information trustee may disclose protected health information to an officer, employee, or agent of the trustee, but only for a purpose that is compatible with and related to the purpose for which the information was collected or received by that trustee.

''(c) SCOPE OF DISCLOSURE.—

''(1) IN GENERAL.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

''(2) REGULATIONS.—The Secretary, after notice and opportunity for public comment, may issue

regulations under paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting disclosure.

''(d) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle that permits a disclosure of health information shall be construed to require such disclosure.

''(e) USE AND REDISCLOSURE OF INFORMATION.—The protected health information received under a disclosure permitted by the subtitle may not be used or disclosed unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not otherwise prohibited by law. Protected health information about an individual that is disclosed under this subtitle may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual unless specifically permitted by this subtitle.

''(f) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—

''(1) IN GENERAL.—Except with respect to protected health information that is disclosed under section 11823 and except as provided in paragraph (2), a health information trustee may not disclose protected health information unless such information is

clearly identified as protected health information that is subject to this subtitle.

''(2) ROUTINE DISCLOSURES SUBJECT TO WRITTEN AGREEMENT.—A health information trustee who routinely discloses protected health information to a person may satisfy the identification requirement in paragraph (1) through a written agreement between the trustee and the person with respect to the protected health information.

''(g) CONSTRUCTION.—Nothing in this subtitle shall be construed to limit the ability of a health information trustee to charge a reasonable fee for the disclosure or reproduction of health information.

''(h) INFORMATION IN WHICH PROVIDERS ARE IDENTIFIED.—The Secretary, after notice and opportunity for public comment, may issue regulations protecting information identifying providers in order to promote the availability of health care services.

"SEC. 11812. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

''(a) WRITTEN AUTHORIZATIONS.—A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information, if each of the following requirements is met:

''(1) WRITING.—The authorization is in writing, signed by the individual who is the subject of the information, and dated on the date of such signature.

''(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

''(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

''(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

''(5) STATEMENT OF INTENDED DISCLOSURES.—The authorization contains an acknowledgment that the individual who is the subject of the information has read a statement of the disclosures that the person to receive the protected health information intends to make, which statement shall be in writing, on a form that is distinct from the authorization for disclosure, and which statement must be

received by the individual authorizing the disclosure on or before such authorization is executed.

''(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

''(7) EXPIRATION DATE SPECIFIED.—The authorization specifies a date or event upon which the authorization expires, which shall not exceed 2 years from the date of the execution of the authorization.

''(8) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

''(9) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

''(b) AUTHORIZATIONS REQUESTED IN CONNECTION WITH PROVISION OF HEALTH CARE.—

''(1) IN GENERAL.—A health information trustee may not request that an individual provide to any other person an authorization described in subsection (a) on a day on which—

''(A) the trustee provides health care to the individual requested to provide the authorization; or

''(B) in the case of a trustee that is a health facility, the individual is admitted into

the facility as a resident or inpatient in order to receive health care.

''(2) EXCEPTION.—Paragraph (1) does not apply if a health information trustee requests that an individual provide an authorization described in subsection (a) for the purpose of assisting the individual in obtaining counseling or social services from a person other than the trustee.

''(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

''(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(8), an authorization is timely received if it is received by the trustee during—

''(A) the 1-year period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person who provides health counseling or social services to individuals; or

''(B) the 30-day period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

''(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(9), a disclosure is timely made if it occurs before the date or event specified in the authorization upon which the authorization expires.

''(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

''(1) IN GENERAL.—An individual may in writing revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except when—

''(A) disclosure of protected health information has been authorized to permit validation of expenditures for health care; or

''(B) action has been taken in reliance on the authorization.

''(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information pursuant to an authorization that has been revoked shall not be subject to any liability or penalty under this subtitle if—

''(A) the reliance was in good faith;

''(B) the trustee had no notice of the revocation; and

''(C) the disclosure was otherwise in accordance with the requirements of this subtitle.

''(e) DECEASED INDIVIDUAL.—The Secretary shall develop and establish through regulation a procedure for obtaining protected health information relating to a deceased individual when there is no individual representative for such individual.

''(f) MODEL AUTHORIZATIONS.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate model written authorizations of the type described in subsection (a) and model statements of intended disclosures of the type described in subsection (a)(5).

''(g) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

"SEC. 11813. CERTIFIED HEALTH INFORMATION NETWORK SERVICES.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a certified health information network service acting as an agent of the trustee for any purpose permitted by this subtitle. Such a service, acting as an agent of a trustee, may disclose protected health information to another person as permitted under this subtitle to facilitate the completion

of the purpose for which such information was disclosed to the service.

''(b) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATIONS.—A health information trustee may disclose protected health information to a certified health information protection organization for the purpose of creating non-identifiable health information (as defined in section 11702).

"Subpart B—Specific Disclosures Relating to Patient

"SEC. 11821. DISCLOSURES FOR TREATMENT AND FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

''(a) HEALTH CARE TREATMENT.—A health care provider, health plan, employer, or person who receives protected health information under section 11823, may disclose protected health information to a health care provider for the purpose of providing health care to an individual if the individual who is the subject of the information has not previously objected in writing to the disclosure.

''(b) DISCLOSURE TO HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health care provider or employer may disclose protected health information to a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

''(c) DISCLOSURE BY HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health plan may disclose protected health information to a health care provider or a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

"SEC. 11822. NEXT OF KIN AND DIRECTORY INFORMATION.

''(a) NEXT OF KIN.—A health care provider or person who receives protected health information under section 11823 may disclose protected health information to the next of kin, an individual representative of the individual who is the subject of the information, or an individual with whom that individual has a close personal relationship if—

''(1) the individual who is the subject of the information—

''(A) has been notified of the individual's right to object and has not objected to the disclosure;

''(B) is not competent to be notified about the right to object; or

''(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

''(2) the information disclosed relates to health care currently being provided to that individual.

''(b) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information under section 11823 may disclose protected health information to any person if—

''(1) the information does not reveal specific information about the physical or mental condition of the individual who is the subject of the information or health care provided to that person;

''(2) the individual who is the subject of the information—

''(A) has been notified of the individual's right to object and has not objected to the disclosure;

''(B) is not competent to be notified about the right to object; or

''(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

''(3) the information consists only of 1 or more of the following items:

''(A) The name of the individual who is the subject of the information.

''(B) If the individual who is the subject of the information is receiving health care from a health care provider on a premises controlled by the provider—

''(i) the location of the individual on the premises; and

''(ii) the general health status of the individual, described as critical, poor, fair, stable, or satisfactory or in terms denoting similar conditions.

''(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—A health care provider, health plan, employer, or life insurer, may disclose protected health information if necessary to assist in the identification of a deceased individual.

"**SEC. 11823. EMERGENCY CIRCUMSTANCES.**

''(a) IN GENERAL.—A health care provider, health plan, employer, or person who receives protected health information under this section may disclose protected health information in emergency circumstances when necessary to protect the health or safety of an individual from imminent harm.

''(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be lim-

ited to persons who need the information to take action to protect the health or safety of the individual.

''Subpart C—Disclosure for Oversight, Public Health, and Research Purposes

''SEC. 11831. OVERSIGHT.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a health oversight agency for an oversight function authorized by law.

''(b) USE IN ACTION AGAINST INDIVIDUALS.—Notwithstanding section 11811(e), protected health information about an individual that is disclosed under this section may be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information if the action or investigation arises out of and is directly related to receipt of health care or payment for health care or an action involving a fraudulent claim related to health.

''SEC. 11832. PUBLIC HEALTH.

''A health care provider, health plan, public health authority, employer, or person who receives protected health information under section 11823 may disclose protected health information to a public health authority or other person authorized by law for use in a legally authorized—

''(1) disease or injury reporting;

''(2) public health surveillance; or

''(3) public health investigation or intervention.

"SEC. 11833. HEALTH RESEARCH.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher if an institutional review board determines that the research project engaged in by the health researcher—

''(1) requires use of the protected health information for the effectiveness of the project; and

''(2) is of sufficient importance to outweigh the intrusion into the privacy of the individual who is the subject of the information that would result from the disclosure.

''(b) RESEARCH REQUIRING DIRECT CONTACT.—A health information trustee may disclose protected health information to a health researcher for a research project that includes direct contact with an individual who is the subject of protected health information if an institutional review board determines that—

''(1) the research project meets the requirements of paragraphs (1) and (2) of subsection (a);

''(2) direct contact is necessary to accomplish the research purpose; and

''(3) the direct contact will be made in a manner that minimizes the risk of harm, embarrassment, or other adverse consequences to the individual.

''(c) USE OF HEALTH INFORMATION NETWORK.—

''(1) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher using the health information network (as defined in section 11702) only if an institutional review board certified by the Secretary under paragraph (2) determines that the research project engaged in by the health researcher meets the requirements of this section.

''(2) CERTIFICATION OF INSTITUTIONAL REVIEW BOARDS.—

''(A) REGULATIONS.—The Secretary, after notice and opportunity for public comment, shall issue regulations establishing certification requirements for institutional review boards under this subtitle. Such regulations shall be based on regulations issued under section 491(a) of the Public Health Service Act and shall ensure that institutional review boards certified under this paragraph have the qualifications to access and protect the confidentiality of research subjects.

''(B) CERTIFICATION.—The Secretary shall certify an institutional review board that meets the certification requirements established by the Secretary under subparagraph (A).

''(d) OBLIGATIONS OF RECIPIENT.—A person who receives protected health information pursuant to subsection (a)—

''(1) shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable an individual to be identified, unless—

''(A) an institutional review board has determined that there is a health or research justification for retention of such identifiers; and

''(B) there is an adequate plan to protect the identifiers from disclosure that is inconsistent with this section; and

''(2) shall use protected health information solely for purposes of the health research project for which disclosure was authorized under this section.

"Subpart D—Disclosure For Judicial, Administrative, and Law Enforcement Purposes

"SEC. 11841. JUDICIAL AND ADMINISTRATIVE PURPOSES.

A health care provider, health plan, health oversight agency, or employer may disclose protected health information—

''(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which the individual who is the subject of the information is a party and in which the individual has placed the individual's physical or mental condition in issue;

''(2) to a court, and to others ordered by a court, if the protected health information is developed in response to a court-ordered physical or mental examination; or

''(3) pursuant to a law requiring the reporting of specific medical information to law enforcement authorities.

"SEC. 11842. LAW ENFORCEMENT.

''(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 11823 may disclose protected health information to a law en-

forcement agency (other than a health oversight agency governed by section 11831) if the information is requested for use—

''(1) in an investigation or prosecution of a health information trustee;

''(2) in the identification of a victim or witness in a law enforcement inquiry; or

''(3) in connection with the investigation of criminal activity committed against the trustee or on premises controlled by the trustee.

''(b) CERTIFICATION.—When a law enforcement agency (other than a health oversight agency) requests that a health information trustee disclose protected health information under this section, the law enforcement agency shall provide the trustee with a written certification that—

''(1) specifies the information requested;

''(2) states that the information is needed for a lawful purpose under this section; and

''(3) is signed by a supervisory official of a rank designated by the head of the agency.

''(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—Notwithstanding section 11811(e), protected health information about an individual that is disclosed to a law enforcement agency under this section may be used in, or

disclosed for, an administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the action or investigation for which the information was obtained.

"Subpart E—Disclosure Pursuant to Government Subpoena or Warrant

"SEC. 11851. GOVERNMENT SUBPOENAS AND WARRANTS.

''(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 11823 may disclose protected health information under this section if the disclosure is pursuant to—

''(1) a subpoena issued under the authority of a grand jury, and the trustee is provided a written certification by the grand jury seeking the information that the grand jury has complied with the applicable access provisions of section 11852;

''(2) an administrative subpoena or a judicial subpoena or warrant, and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 11852; or

''(3) an administrative subpoena or a judicial subpoena or warrant, and the disclosure otherwise

meets the conditions of section 11831, 11832, 11841, or 11842.

''(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

''(1) ACTIONS OR INVESTIGATIONS.—Notwithstanding section 11811(c), protected health information about an individual that is received under subsection (a) may be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the inquiry for which the information was obtained.

''(2) SPECIAL RULE.—Protected health information about an individual that is received under subsection (a)(3) may not be disclosed by the recipient unless the recipient complies with the conditions and restrictions on disclosure with which the recipient would have been required to comply if the disclosure had been made under section 11831, 11832, 11841, or 11842.

''SEC. 11852. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.

''(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an individual under paragraph (1) or (2) of section 11851(a) for use in a law enforcement inquiry un-

less there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

''(b) WARRANTS.—A government authority that obtains protected health information about an individual under circumstances described in subsection (a) and pursuant to a warrant shall, not later than 30 days after the date the warrant was executed, serve the individual with, or mail to the last known address of the individual, a notice that protected health information about the individual was so obtained, together with a notice of the individual's right to challenge the warrant in accordance with section 11853.

''(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about an individual under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served on the individual on or before the date of return of the subpoena, together with a notice of the individual's right to challenge the subpoena in accordance with section 11853, and—

''(1) 15 days have passed since the date of service on the individual and within that time period the

individual has not initiated a challenge in accordance with section 11853; or

''(2) disclosure is ordered by a court after challenge under section 11853.

''(d) APPLICATION FOR DELAY.—

''(1) IN GENERAL.—A government authority may apply ex parte and under seal to an appropriate court to delay (for an initial period of not longer than 90 days) serving a notice or copy of a subpoena required under subsection (b) or (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

''(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

''(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying or extending the delay of notice, an order prohibiting the disclosure of the request for, or disclosure of, the protected health information, and an order requiring the disclosure of the protected health information if the court finds that—

''(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

''(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry;

''(C) the government authority's need for the information outweighs the privacy interest of the individual who is the subject of the information; and

''(D) there is reasonable ground to believe that receipt of notice by the individual will result in—

''(i) endangering the life or physical safety of any individual;

''(ii) flight from prosecution;

''(iii) destruction of or tampering with evidence or the information being sought; or

''(iv) intimidation of potential witnesses.

"SEC. 11853. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT WARRANTS AND SUBPOENAS.

''(a) MOTION TO QUASH.—Within 15 days after the date of service of a notice of execution or a copy of a subpoena of a government authority seeking protected health information about an individual under paragraph (1) or (2) of section 11851(a), the individual may file a motion to quash—

''(1) in the case of a State judicial warrant or subpoena, in the court which issued the warrant or subpoena;

''(2) in the case of a warrant or subpoena issued under the authority of a State that is not a State judicial warrant or subpoena, in a court of competent jurisdiction; or

''(3) in the case of any other warrant or subpoena issued under the authority of a Federal court or the United States, in the United States district court for the district in which the individual resides or in which the warrant or subpoena was issued.

''(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by registered or certified mail.

''(c) PROCEEDINGS.—The government authority may file with the court such papers, including affidavits and other sworn documents, as sustain the validity of the war-

rant or subpoena. The individual may file with the court reply papers in response to the government authority's filing. The court, upon the request of the individual or the government authority or both, may proceed in camera. The court may conduct such proceedings as it deems appropriate to rule on the motion, but shall endeavor to expedite its determination.

''(d) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds there is probable cause to believe the protected health information is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need by the government authority for the information.

''(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In reaching its determination, the court shall consider—

''(1) the particular purpose for which the information was collected;

''(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

''(3) the effect of the disclosure on the individual's future health care;

''(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

''(5) any other factor deemed relevant by the court.

''(f) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the government authority a reasonable attorney's fee and other litigation costs (including expert's fees) reasonably incurred.

''(g) NO INTERLOCUTORY APPEAL.—A ruling denying a motion to quash under this section shall not be deemed to be a final order, and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protected health information disclosed.

''Subpart F—Disclosure Pursuant to Private Party Subpoena

''SEC. 11854. PRIVATE PARTY SUBPOENAS.

''A health care provider, health plan, employer, or person who receives protected health information under section 11823 may disclose protected health information under this section if the disclosure is pursuant to a subpoena issued on behalf of a private party who has complied with the access provisions of section 11855.

''SEC. 11855. ACCESS PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

''A private party may not obtain protected health information about an individual pursuant to a subpoena unless a copy of the subpoena together with a notice of the individual's right to challenge the subpoena in accordance with section 11856 has been served upon the individual on or before the date of return of the subpoena, and—

''(1) 15 days have passed since the date of service on the individual, and within that time period the individual has not initiated a challenge in accordance with section 11856; or

''(2) disclosure is ordered by a court under section 11856.

''SEC. 11856. CHALLENGE PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

''(a) MOTION TO QUASH SUBPOENA.—Within 15 days after service of a copy of the subpoena seeking protected health information under section 11854, the individual who is the subject of the protected health information may file in any court of competent jurisdiction a motion to quash the subpoena and serve a copy of the motion on the person seeking the information.

''(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the respondent demonstrates that—

''(1) there is reasonable ground to believe the information is relevant to a lawsuit or other judicial or administrative proceeding; and

''(2) the need of the respondent for the information outweighs the privacy interest of the individual.

''(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (b) whether the need of the respondent for the information outweighs the privacy interest of the individual, the court shall consider—

''(1) the particular purpose for which the information was collected;

''(2) the degree to which disclosure of the information would embarrass, injure, or invade the privacy of the individual;

''(3) the effect of the disclosure on the individual's future health care;

''(4) the importance of the information to the lawsuit or proceeding; and

''(5) any other relevant factor.

''(d) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the respondent a reasonable attorney's fee and other litigation costs and expenses (including expert's fees) reasonably incurred.

"PART III—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

"Subpart A—Establishment of Safeguards

"SEC. 11861. ESTABLISHMENT OF SAFEGUARDS.

''(a) IN GENERAL.—A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards—

''(1) to ensure the integrity and confidentiality of protected health information created or received by the trustee; and

''(2) to protect against any anticipated threats or hazards to the security or integrity of such information.

''(b) REGULATIONS.—The Secretary shall promulgate regulations regarding security measures for protected health information.

"SEC. 11862. ACCOUNTING FOR DISCLOSURES.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO CREATE OR MAINTAIN RECORD.—A health information trustee shall create and maintain, with respect to any protected health information disclosed in exceptional circumstances (as described in paragraph (2)), a record of—

''(A) the date and purpose of the disclosure;

''(B) the name of the person to whom or to which the disclosure was made;

''(C) the address of the person to whom or to which the disclosure was made or the location to which the disclosure was made; and

''(D) the information disclosed, if the recording of the information disclosed is practicable, taking into account the technical capabilities of the system used to maintain the record and the costs of such maintenance.

''(2) EXCEPTIONAL CIRCUMSTANCES DESCRIBED.—For purposes of paragraph (1) protected health information is disclosed in exceptional circumstances if the disclosure—

''(A) is not a routine part of doing business, as determined in accordance with guidelines promulgated by the Secretary; or

''(B) is permitted under sections 11823 and 11832.

''(b) DISCLOSURE RECORD PART OF INFORMATION.—A record created and maintained under paragraph (a) shall be maintained as part of the protected health information to which the record pertains.

"Subpart B—Review of Protected Health Information By Subjects of the Information

"SEC. 11871. INSPECTION OF PROTECTED HEALTH INFORMATION.

''(a) IN GENERAL.—Except as provided in subsection (c), a health care provider or health plan—

''(1) shall permit an individual who is the subject of protected health information to inspect any such information that the provider or plan maintains;

''(2) shall permit the individual to have a copy of the information;

''(3) shall permit a person who has been designated in writing by the individual who is the subject of the information to inspect, or to have a copy of, the information on behalf of the individual or to accompany the individual during the inspection; and

''(4) may offer to explain or interpret information that is inspected or copied under this subsection.

''(b) ADDITIONAL REQUESTS.—Except as provided in subsection (c), a health plan or health care provider shall, upon written request of an individual—

''(1) determine the identity of previous providers to the individual; and

''(2) obtain protected health information regarding the individual.

''(c) EXCEPTIONS.—A health care provider or health plan is not required by this section to permit inspection or copying of protected health information if any of the following conditions apply:

''(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the notes would cause sufficient harm to the individual

who is the subject of the notes so as to outweigh the desirability of permitting access, and the provider or plan has not disclosed the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

''(2) INFORMATION ABOUT OTHERS.—The information relates to an individual other than the individual seeking to inspect or have a copy of the information and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the information would cause sufficient harm to 1 or both of the individuals so as to outweigh the desirability of permitting access.

''(3) ENDANGERMENT TO LIFE OR SAFETY.—The provider or plan determines that disclosure of the information could reasonably be expected to endanger the life or physical safety of any individual.

''(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of a person (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning the individual who is the subject of the information.

''(5) ADMINISTRATIVE PURPOSES.—The information—

''(A) is used by the provider or plan solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information; and

''(B) has not been disclosed by the provider or plan to any other person.

''(d) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health care provider or health plan shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (c).

''(e) CONDITIONS.—A health care provider or health plan may require a written request for the inspection and copying of protected health information under this subsection. The health care provider or health plan may require a cost reimbursement for such inspection and copying.

''(f) STATEMENT OF REASONS FOR DENIAL.—If a health care provider or health plan denies a request for inspection or copying under this section, the provider or plan shall provide the individual who made the request (or the individual's designated representative) with a written statement of the reasons for the denial.

''(g) DEADLINE.—A health care provider or health plan shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date on which the provider or plan receives the request.

"SEC. 11872. AMENDMENT OF PROTECTED HEALTH INFORMATION.

''(a) IN GENERAL.—A health care provider or health plan shall, within the 45-day period beginning on the date on which the provider or plan receives from an individual a written request that the provider or plan correct or amend the information—

''(1) make the correction or amendment requested;

''(2) inform the individual of the correction or amendment that has been made; and

''(3) inform any person who is identified by the individual, who is not an officer, employee or agent of the provider or plan, and to whom the uncorrected or unamended portion of the information was previously disclosed, of the correction or amendment that has been made.

''(b) REFUSAL TO CORRECT.—If the provider or plan refuses to make the corrections, the provider or plan shall inform the individual of—

''(1) the reasons for the refusal of the provider or plan to make the correction or amendment;

''(2) any procedures for further review of the refusal; and

''(3) the individual's right to file with the provider or plan a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the provider or plan.

''(c) BASES FOR REQUEST TO CORRECT OR AMEND.—An individual may request correction or amendment of protected health information about the individual under paragraph (a) if the information is not timely, accurate, relevant to the system of records, or complete.

''(d) STATEMENT OF DISAGREEMENT.—After an individual has filed a statement of disagreement under paragraph (b)(3), the provider or plan, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a copy of the individual's statement; and

''(2) may include a concise statement of the reasons of the provider or plan for not making the requested correction or amendment.

''(e) RULE OF CONSTRUCTION.—This section shall not be construed to require a health care provider or

health plan to conduct a formal, informal, or other hearing or proceeding concerning a request for a correction or amendment to protected health information the provider or plan maintains.

''(f) CORRECTION.—For purposes of paragraph (a), a correction is deemed to have been made to protected health information when information that is not timely, accurate, relevant to the system of records, or complete is clearly marked as incorrect or when supplementary correct information is made part of the information.

"SEC. 11873. NOTICE OF INFORMATION PRACTICES.

''(a) PREPARATION OF WRITTEN NOTICE.—A health care provider or health plan shall prepare a written notice of information practices describing the following:

''(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—The rights under this subpart of an individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

''(2) PROCEDURES OF PROVIDER OR PLAN.—The procedures established by the provider or plan

for the exercise of the rights of individuals about whom protected health information is maintained.

''(3) AUTHORIZED DISCLOSURES.—The disclosures of protected health information that are authorized.

''(b) DISSEMINATION OF NOTICE.—A health care provider or health plan—

''(1) shall, upon request, provide any individual with a copy of the notice of information practices described in subsection (a); and

''(2) shall make reasonable efforts to inform individuals in a clear and conspicuous manner of the existence and availability of the notice.

''(c) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate a model notice of information practices for use by health care providers and health plans under this section.

"Subpart C—Standards for Electronic Disclosures

"SEC. 11882. STANDARDS FOR ELECTRONIC DISCLOSURES.

''The Secretary shall promulgate standards for disclosing protected health information in accordance with this subtitle in electronic form. Such standards shall include standards relating to the creation, transmission, re-

ceipt, and maintenance, of any written document required or authorized under this subtitle.

"PART IV—SANCTIONS

"Subpart A—No Sanctions for Permissible Actions

"SEC. 11891. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.

''A health information trustee who makes a disclosure of protected health information about an individual that is permitted by this subtitle shall not be liable to the individual for the disclosure under common law.

"SEC. 11892. NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.

''If the members of an institutional review board make a determination in good faith that—

''(1) a health research project is of sufficient importance to outweigh the intrusion into the privacy of an individual; and

''(2) the effectiveness of the project requires use of protected health information,

the members, the board, and the parent institution of the board shall not be liable to the individual as a result of the determination.

"SEC. 11893. RELIANCE ON CERTIFIED ENTITY.

''If a health information trustee contracts with a certified health information network service to make a disclo-

sure of any protected health information on behalf of such trustee in accordance with this subtitle and such service makes a disclosure of such information that is in violation of this subtitle, the trustee shall not be liable for to the individual who is the subject of the information for such unlawful disclosure.

''Subpart B—Civil Sanctions

''SEC. 11901. CIVIL PENALTY.

''(a) VIOLATION.—Any health information trustee who the Secretary determines has substantially failed to comply with this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $10,000 for each such violation.

''(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

''SEC. 11902. CIVIL ACTION.

''(a) IN GENERAL.—An individual who is aggrieved by conduct in violation of this subtitle may bring a civil action to recover—

''(1) the greater of actual damages or liquidated damages of $5,000;

''(2) punitive damages;

''(3) a reasonable attorney's fee and expenses of litigation;

''(4) costs of litigation; and

''(5) such preliminary and equitable relief as the court determines to be appropriate.

''(b) LIMITATION.—No action may be commenced under this section more than 3 years after the date on which the violation was or should reasonably have been discovered.

"Subpart C—Criminal Sanctions

"SEC. 11911. WRONGFUL DISCLOSURE OF PROTECTED HEALTH INFORMATION.

''(a) OFFENSE.—A person who knowingly—

''(1) obtains protected health information relating to an individual in violation of this subtitle; or

''(2) discloses protected health information to another person in violation of this subtitle,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''PART V—ADMINISTRATIVE PROVISIONS

''SEC. 11921. RELATIONSHIP TO OTHER LAWS.

''(a) STATE LAW.—Except as provided in subsections (b), (c), and (d), this subtitle preempts State law.

''(b) LAWS RELATING TO PUBLIC OR MENTAL HEALTH.—Nothing in this subtitle shall be construed to preempt or operate to the exclusion of any State law relating to public health or mental health that prevents or regulates disclosure of protected health information otherwise allowed under this subtitle.

''(c) PRIVILEGES.—Nothing in this subtitle is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This subtitle does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States. Authorizations

pursuant to section 11812 shall not be construed as a waiver of any such privilege.

''(d) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This subtitle shall not be construed to preempt, supersede, or modify the operation of—

''(1) any law that provides for the reporting of vital statistics such as birth or death information;

''(2) any law requiring the reporting of abuse or neglect information about any individual;

''(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases); or

''(4) any Federal law or regulation governing confidentiality of alcohol and drug patient records.

"**SEC. 11922. RIGHTS OF INCOMPETENTS.**

''(a) EFFECT OF DECLARATION OF INCOMPETENCE.—Except as provided in section 11923, if an individual has been declared to be incompetent by a court of competent jurisdiction, the rights of the individual under this subtitle shall be exercised and discharged in the best interests of the individual through the individual's representative.

''(b) NO COURT DECLARATION.—Except as provided in section 11923, if a health care provider determines that

an individual, who has not been declared to be incompetent by a court of competent jurisdiction, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure may be exercised and discharged in the best interest of the individual by the individual's representative.

"SEC. 11923. EXERCISE OF RIGHTS.

''(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

''(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual; or

''(2) who, acting alone, has the legal right, as determined by State law, to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such examination, care, or treatment.

''(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

''(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

''(2) 14, 15, 16, or 17 years of age, the rights of inspection and amendment, and the right to authorize disclosure of protected health information of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.''.

(b) CONFORMING AMENDMENT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401, is amended by striking the title and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND PRIVACY"

TITLE V—MALPRACTICE AND FRAUD

Subtitle A—Federal Tort Reform

SEC. 501. FEDERAL TORT REFORM.

(a) IN GENERAL.—Part A of subtitle A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401, is amended by inserting after section 1128B the following new section:

"SEC. 1129. FEDERAL TORT REFORM.

''(a) APPLICABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (3), this section shall apply with respect to any medical malpractice claim or medical malpractice liability action brought in any Federal or State court, except that this section shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

''(2) PREEMPTION.—The provisions of this section shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this section shall not preempt any State law that provides for defenses in addition to those contained in this section, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions on non-economic or punitive damages than those provided in this section.

''(3) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this section shall be construed to—

''(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

''(B) waive or affect any defense of sovereign immunity asserted by the United States;

''(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

''(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

''(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

''(4) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this section shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

''(b) DEFINITIONS.—In this section, the following definitions apply:

''(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term 'alternative dispute resolution system' or 'ADR' means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

''(2) CLAIMANT.—The term 'claimant' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

''(3) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

''(5) INJURY.—The term 'injury' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

''(6) MEDICAL MALPRACTICE LIABILITY ACTION.—The term 'medical malpractice liability action' means a civil action brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the claim is based) in which the plaintiff alleges a medical malpractice claim.

''(7) MEDICAL MALPRACTICE CLAIM.—

''(A) IN GENERAL.—The term 'medical malpractice claim' means a claim brought against a health care provider or health care professional in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, including health care services provided under a health care plan described in subparagraph (B), except that such term does not include—

''(i) any claim based on an allegation of an intentional tort; or

''(ii) any claim based on an allegation that a product is defective that is brought

against any individual or entity that is not a health care professional or health care provider.

''(B) HEALTH CARE PLAN DESCRIBED.—A health care plan described in this subparagraph includes—

''(i) a certified standard or non-standard health plan;

''(ii) a certified supplemental health benefits plan;

''(iii) a certified long-term care policy;

''(iv) a State health care program (as defined in section 1128(h)); and

''(v) the medicare program under title XVIII.

''(8) PARTICIPATING STATE.—The term 'participating State' means a participating State under title XXI.

''(c) ALTERNATIVE DISPUTE RESOLUTION.—

''(1) ADR IN PARTICIPATING STATES.—Each participating State shall—

''(A) establish an alternative dispute resolution system for the determination of medical malpractice claims (including the tolling of any

applicable statute of limitations during any action under such system); and

''(B) require that State health care programs and certified standard and nonstandard health plans disclose to enrollees (and potential enrollees), in accordance with standards established by the Secretary—

''(i) the availability of procedures for consumer grievances under the program or plan;

''(ii) the alternative dispute resolution method or methods adopted by the State under this subsection for its alternative dispute resolution system and the procedures for filing actions under such system;

''(iii) the consequences of, and alternatives to, participation in such system.

''(2) APPLICATION TO MEDICAL MALPRACTICE CLAIMS.—In the case of any medical malpractice claim, no medical malpractice liability action may be brought with respect to such claim in a participating State until the final resolution of the claim under the alternative dispute resolution system established by the State under paragraph (1).

''(3) ADOPTION OF MECHANISM BY PARTICIPATING STATES.—Each participating State shall adopt at least one of the methods of alternative dispute resolution specified under paragraph (4) or (5) for the resolution of medical malpractice claims.

''(4) SPECIFICATION OF PERMISSIBLE ADR METHODS.—

''(A) IN GENERAL.—The Secretary shall, by regulation, develop alternative dispute resolution methods for use by participating States in resolving medical malpractice claims under paragraph (1). Such methods shall include at least the following:

''(i) BINDING ARBITRATION.—The use of binding arbitration.

''(ii) FAULT-BASED SYSTEMS.—The use of fault-based administrative systems, expedited review, and dismissal of claims when not adequately supported.

''(iii) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties have the option to make early offers of settlement.

''(iv) CATASTROPHIC SYSTEMS.—The use of catastrophic injury compensation systems.

''(B) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subparagraph (A), the Secretary shall assure that the methods promote the resolution of medical malpractice claims in a manner that—

''(i) is affordable for the parties involved;

''(ii) provides for timely resolution of claims;

''(iii) provides for the consistent and fair resolution of claims; and

''(iv) provides for reasonably convenient access to the alternative dispute resolution system for individuals enrolled in certified standard and nonstandard health plans.

''(5) STATE INITIATED ALTERNATIVE.—A participating State will be permitted to operate a method of alternative dispute resolution (other than a method described in paragraph (4)) that otherwise complies with this section if such system—

''(A) is determined by the Secretary to accomplish the purposes and otherwise meet the requirements of this section; and

''(B) is certified by the Secretary as an appropriate alternative dispute resolution method.

''(d) PROCEDURES FOR FILING ACTIONS.—

''(1) CONTESTING OF ADR DECISION.—If either party to a decision issued with respect to an alternative dispute resolution method applied under subsection (c) is dissatisfied with such decision, such party may (to the extent otherwise permitted by State law) contest such decision after it is issued and seek a rehearing of the medical malpractice claim involved in a court of competent jurisdiction.

''(2) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice claim under an alternative dispute resolution system established by a participating State under subsection (c), each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

''(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term 'court of competent jurisdiction' means—

''(A) with respect to actions filed in a State court, the appropriate State trial court; and

''(B) with respect to actions filed in a Federal court, the appropriate United States district court.

''(4) LEGAL EFFECT OF UNCONTESTED ALTERNATIVE DISPUTE RESOLUTION SYSTEM DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to paragraph (1).

''(e) TREATMENT OF ATTORNEYS' FEES AND OTHER COSTS.—

''(1) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

''(A) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant

in a medical malpractice claim or medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with such claim or action in excess of the following amount recovered by judgment or settlement under such claim or action:

''(i) 33⅓ percent of the first $150,000 (or portion thereof) recovered, based on after-tax recovery, plus

''(ii) 25 percent of any amount in excess of $150,000 recovered, based on after-tax recovery.

''(B) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subparagraph (A) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

''(2) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEYS' FEES AND OTHER COSTS.—

''(A) IN GENERAL.—The court in a medical malpractice liability action shall require a party that (pursuant to subsection (d)(1)) contests the ruling of the alternative dispute resolution system of a participating State with respect to the medical malpractice claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorneys' fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

''(i) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action is less than 66⅔ percent of the amount of damages awarded to the party under the alternative dispute resolution system; and

''(ii) in the case of an action in which the party that contested the ruling is the

defendant, the amount of damages assessed against the party under the action is greater than the amount of damages assessed under the alternative dispute resolution system.

''(B) EXCEPTION.—Subparagraph (A) shall not apply if the court finds that the application of such subparagraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such subparagraph that specifies the grounds for the court's decision.

''(C) LIMIT ON ATTORNEYS' FEES PAID.—Attorneys' fees that are required to be paid under subparagraph (A) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

''(3) CONTINGENCY FEE DEFINED.—As used in this subsection, the term 'contingency fee' means any fee for professional legal services which is, in

whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

''(f) SCOPE OF LIABILITY.—

''(1) IN GENERAL.—With respect to punitive and noneconomic damages, the liability of each defendant in a medical malpractice claim or medical malpractice liability action shall be several only and may not be joint. Such a defendant shall be liable only for the amount of punitive or noneconomic damages allocated to the defendant in direct proportion to such defendant's percentage of fault or responsibility for the injury suffered by the claimant.

''(2) DETERMINATION OF PERCENTAGE OF LIABILITY.—The trier of fact in a medical malpractice claim or medical malpractice liability action shall determine the extent of each defendant's fault or responsibility for injury suffered by the claimant, and shall assign a percentage of responsibility for such injury to each such defendant.

''(g) REFORM OF DAMAGES.—

''(1) LIMITATION ON NONECONOMIC DAMAGES.—

''(A) IN GENERAL.—With respect to a medical malpractice claim or medical mal-

practice liability action brought in any forum, the total amount of damages that may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury alleged under such claim or action may not exceed the amount determined under subparagraph (B), regardless of the number of health care professionals, health care providers, and other defendants against whom the action is brought or the number of actions brought with respect to the injury. With respect to actions heard by a jury, the jury may not be informed of the limitation contained in this paragraph. If the jury's damage award exceeds such limitation, a reduction in such award shall be made by the court.

''(B) LIMITATION AMOUNT.—The amount determined under this subparagraph shall be equal to—

''(i) in 1995, $250,000; and

''(ii) in subsequent years, the amount determined under this subparagraph in the previous year, updated by the estimated percentage change in the Consumer Price Index for All Urban Consumers (United

States city average) during the previous calendar year, adjusted by any previous over estimations or under estimations under this subparagraph.

''(2) PUNITIVE DAMAGES.—

''(A) FUND.—Each participating State shall establish a health care safety and policy program, to be approved by the Secretary, and a fund consisting of such amounts as are transferred to the fund under subparagraph (B).

''(B) TRANSFER OF AMOUNTS.—Each participating State shall require that 75 percent of all awards of punitive damages resulting from all medical malpractice claims or medical malpractice liability actions in that State be transferred to the fund established under subparagraph (A) in the State.

''(C) OBLIGATIONS FROM FUND.—The chief executive officer of a participating State shall obligate such sums as are available in the fund established in that State under subparagraph (A) to—

''(i) license and certify health care professionals in the State;

''(ii) implement health care quality assurance programs;

''(iii) carry out public education programs to increase awareness of the availability of comparative value information on certified standard health plans distributed in accordance with the State consumer information program established under section 21025; and

''(iv) carry out programs to reduce malpractice-related costs for health care providers volunteering to provide health care services in medically underserved areas.

''(h) NO-FAULT LIABILITY DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—The Secretary may provide funds (in such amount as the Secretary considers appropriate) to one or more eligible participating States to establish no-fault medical liability system demonstration projects to replace the common law tort liability system for medical injuries.

''(2) ELIGIBILITY OF STATE.—A participating State is eligible to participate in the demonstration project established under paragraph (1) if the State

submits an application to the Secretary at such time, in such manner, and containing such information and assurances as the Secretary may require.

''(3) WAIVERS.—The Secretary may waive any provision of this section that the Secretary determines is necessary for a State to conduct a demonstration project established under paragraph (1).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the demonstration projects under this subsection.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical malpractice claims arising on or after January 1, 1995.

Subtitle B—Expanded Efforts To Control Health Care Fraud and Abuse Affecting Federal Outlay Programs

PART I—IMPROVED ENFORCEMENT

SEC. 511. HEALTH CARE FRAUD AND ABUSE AFFECTING FEDERAL OUTLAY PROGRAMS.

(a) IN GENERAL.—Part A of subtitle A of title XI of the Social Security Act, as amended by section 501, is amended by inserting after section 1128B (42 U.S.C. 1320a-7b) the following new sections:

''HEALTH CARE FRAUD AND ABUSE AFFECTING FEDERAL OUTLAY PROGRAMS

''SEC. 1128C. (a) IN GENERAL.—Not later than January 1, 1996, the Secretary and the Attorney General of the United States shall establish a joint program—

''(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse affecting Federal outlay programs,

''(2) to prosecute health care matters (through criminal, civil, and administrative proceedings);

''(3) to conduct investigations (including consumer complaint investigations), audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

''(4) to conduct financial and performance audits of health care programs and operations;

''(5) to conduct inspections and other evaluations;

''(6) to provide rewards paid under section 1128F;

''(7) to facilitate the enforcement of sections 1128 through 1128G and other statutes applicable to health care fraud and abuse.

''(8) to provide health care provider and consumer education (including the provision of advi-

sory opinions) regarding compliance with the provisions of sections 1128 through 1128G.

Not more than 20 percent of the amounts available in the Federal Outlay Program Fraud and Abuse Control Account for any fiscal year shall be used for the purposes described in paragraph (8).

''(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data and resources with, Federal, State, and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

''(c) COORDINATION WITH PURCHASING COOPERATIVES AND CERTIFIED HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of purchasing cooperatives and certified health plans.

''(d) AUTHORITIES OF ATTORNEY GENERAL AND SECRETARY.—In carrying out duties under subsection (a), the Attorney General and the Secretary are authorized—

''(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections,

and evaluations relating to the program established under such subsection;

''(2) to have access (including on-line access as requested and available) to all records available to purchasing cooperatives and certified health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under part II of subtitle B of this title); and

''(3) to issue advisory opinions, fraud alerts, and other appropriate educational material to assist in compliance with the provisions of sections 1128 through 1128G.

''(e) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or the Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of this subtitle.

''(f) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out duties and responsibilities under the program established under subsection (a), the Inspector General is authorized to exercise all powers

granted under the Inspector General Act of 1978 to the same manner and extent as provided in that Act.

''(g) DEFINITIONS.—In this subtitle:

''(1) CERTIFIED HEALTH PLANS; PURCHASING COOPERATIVES.—The terms 'certified health plan' and 'purchasing cooperative' have the meanings given such terms by sections 21011(a)(1) and 21100(14), respectively.

''(2) FEDERAL OUTLAY PROGRAMS.—The term 'Federal outlay programs' means—

''(A) any program under title XVIII, and

''(B) any State health care program (as defined in section 1128(h).

''(3) INSPECTOR GENERAL.—The term 'Inspector General' means the Inspector General of the Department of Health and Human Services.''.

(b) STATE HEALTH CARE PROGRAM DEFINED.—Section 1128(h) of the Social Security Act (42 U.S.C. 1320a-7(h)) is amended by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and by inserting after paragraph (1) the following new paragraph:

''(2) any participating State program approved under title XXI (including any program established by the Secretary of Labor with respect to multistate self-insured health plans) and any standard or non-

standard health plan, supplemental health benefits plan, or long-term care policy certified under such program,''.

SEC. 512. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

Subtitle A of title XI of the Social Security Act, as amended by section 511, is amended by inserting after section 1128C the following new section:

''FEDERAL HEALTH CARE OFFENSE DEFINED

''SEC. 1128D. For purposes of this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

''(2) section 1128B;

''(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

''(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

''(5) sections 301, 303(a)(2), or 303 (b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.''.

SEC. 513. USE OF FUNDS BY INSPECTOR GENERAL.

Subtitle A of title XI of the Social Security Act, as amended by section 512, is amended by inserting after section 1128D the following new section:

''USE OF FUNDS BY INSPECTOR GENERAL

''SEC. 1128E. (a) REIMBURSEMENTS FOR INVESTIGATIONS.—

''(1) IN GENERAL.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

''(3) EXCEPTION FOR FORFEITURES.—This subsection does not apply to investigative costs paid to the Inspector General from the Department of Justice Asset Forfeiture Fund, which monies shall be deposited and expended in accordance with subsection (b).

''(b) HHS OFFICE OF INSPECTOR GENERAL ASSET FORFEITURE PROCEEDS FUND.—

''(1) IN GENERAL.—There is hereby established the 'HHS Office of Inspector General Asset Forfeiture Proceeds Fund,' to be administered by the Inspector General, which shall be available to the Inspector General without fiscal year limitation for expenses relating to the investigation of matters within the jurisdiction of the Inspector General.

''(2) DEPOSITS.—There shall be deposited in the Fund all proceeds from forfeitures that have been transferred to the Inspector General from the Department of Justice Asset Forfeiture Fund under section 524 of title 28, United States Code.''.

SEC. 514. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Subtitle A of title XI of the Social Security Act, as amended by section 513, is amended by inserting after section 1128E the following new section:

''REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION

''SEC. 1128F. (a) IN GENERAL.—In special circumstances, the Secretary and the Attorney General of the United States may jointly make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution of

a Federal health care offense (as defined in section 1128D).

''(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

''(1) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

''(2) the person knowingly participated in the offense;

''(3) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(A) in a criminal, civil, or administrative proceeding;

''(B) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

''(C) by the news media, unless the person is the original source of the information; or

''(4) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(c) DEFINITION.—For the purposes of subsection (b)(3)(C), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.''.

PART II—CIVIL PENALTIES AND RIGHTS OF ACTION

SEC. 521. CIVIL MONETARY PENALTIES.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)) is amended by adding at the end the following new sentence: ''Any amounts recovered under this subsection with respect to a certified health plan (as defined in section 21011(a)) or certified long-term care policy (as defined in section 21013(a)(2)) shall be paid to the Secretary and such portions of the amounts recovered as is determined to have been improperly paid from a certified health plan or certified long-term care policy for the delivery of or payment for health care items or services shall be repaid to such plan or policy (and enrollees of such plan or policy as appropriate) and

the remainder of the amounts recovered shall be deposited in the Federal Outlays Program Fraud and Abuse Control Account established under section 9551 of the Internal Revenue Code of 1986.''.

(b) ADDITIONAL OFFENSES.—

(1) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraphs (1) and (2);

(B) by striking the comma at the end of paragraph (2) and inserting a semicolon; and

(C) by inserting after paragraph (3) the following new paragraphs:

''(4) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)), that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;

''(5) in the case of a person who is not an organization, agency, or other entity, who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156 and who, during the period of exclusion, retains either a direct or indirect ownership or control interest of 5 percent or more in, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;

''(6) engages in a practice that circumvents a payment methodology intended to reimburse for two or more discreet medical items or services at a single or fixed amount, including but not limited to, multiple admissions or readmission to hospitals and other institutions reimbursed on a diagnosis reimbursement grouping basis;

''(7) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including

but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

''(8) substantially fails to cooperate with a quality assurance program or a utilization review activity;

''(9) fails substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a certified health plan (as defined in section 21011(a)) or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual;

''(10) employs or contracts with any individual or entity who is excluded from participating in a program under title XVIII or a State health care program in accordance with this section, section 1128, or section 1156, for the provision of any services (including but not limited to health care, utilization review, medical social work, or administrative), or employs or contracts with any entity for the direct or indirect provision of such services, through such an excluded individual or entity; or

''(11) submits false or fraudulent statements, data or information, or claims to the Secretary, the Secretary of Labor, any other Federal agency, a State health care agency, a purchasing cooperative (under subtitle D of title XXI), or any other Federal, State or local agency charged with implementation or oversight of a certifed health plan under this Act or a public program that the person knows or should know is fraudulent;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver of coinsurance or deductible amounts by a person or entity, if—

''(A) the waiver is not offered as part of any advertisement or solicitation;

''(B) the person does not routinely waive coinsurance or deductible amounts; and

''(C) the person—

''(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is indigent;

''(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.''.

(3) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of such Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(A) in subparagraph (A), by striking ''claimed,'' and inserting the following: ''claimed, including any person who presents or causes to be presented a claim for an item or service which includes a procedure or diagnosis code that the person knows or should know will result in a greater payment to the person than the code applicable to the item or service actually provided or actual patient medical condition,'';

(B) in subparagraph (C), by striking ''or'' at the end;

(C) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary or appropriate; or''.

(c) PENALTIES INCREASED.—

(1) GENERAL RULE.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking ''$2,000'' and inserting ''$10,000''; and

(B) by striking ''twice the amount claimed'' and inserting ''3 times the amount claimed''.

(2) INTEREST ON PENALTIES.—Section 1128A(f) of such Act (42 U.S.C. 1320a-7a(f)) is amended by adding after the first sentence the following: ''Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination be-

comes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where such penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of such penalties and assessments owed to cover the costs of collection.''.

(d) AUTHORITY OF SECRETARY OF LABOR TO IMPOSE PENALTIES, ASSESSMENTS, AND EXCLUSIONS.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended by adding at the end the following new subsection:

''(m)(1) The Secretary of Labor may initiate an action to impose a civil monetary penalty, assessment, or exclusion under this section with respect to actions relating to a certified multistate self-insured health plan (as defined on section 21051(b)) pursuant to regulations promulgated by the Secretary of Health and Human Services, in consultation with the Attorney General.

''(2) Under the regulations promulgated under paragraph (1), the Attorney General and the Secretary shall

review an action proposed by the Secretary of Labor, and not later than 60 days after receiving notice of the proposed action from the Secretary of Labor, shall—

''(A) approve the proposed action to be taken by the Secretary of Labor;

''(B) disapprove the proposed action; or

''(C) assume responsibility for initiating a criminal, civil, or administrative action based on the information provided in the notice.

''(3) If the Attorney General and the Secretary fail to respond to a proposed action by the Secretary of Labor within the period described in paragraph (2), the Attorney General and the Secretary shall be deemed to have approved the proposed action to be taken by the Secretary of Labor.''.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a), as amended by subsection (d), is amended by adding at the end the following new subsection:

''(n) Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33))

that such a penalty, assessment, or exclusion has become final and the reasons therefor.''.

SEC. 522. PERMITTING PARTIES TO BRING ACTIONS ON OWN BEHALF.

Subtitle A of title XI of the Social Security Act, as amended by section 514, is amended by inserting after section 1128F the following new section:

''PRIVATE RIGHTS OF ACTION

''SEC. 1128G. (a) IN GENERAL.—Subject to subsections (b) and (c), a certified health plan (as defined in section 21011(b)) or experience-rated employer (as defined in section 21004(d)(4)) that suffers harm or monetary loss exceeding the sum or value of $10,000 (excluding interest) as a result of any activity of an individual or entity which makes the individual or entity subject to a civil monetary penalty under section 1128A may, in a civil action against the individual or entity in the United States District Court, obtain treble damages and costs including attorneys' fees against the individual or entity and such equitable relief as is appropriate.

''(b) REQUIREMENTS FOR BRINGING ACTION.—A person may bring a civil action under this section only if—

''(1) the person provides the Secretary with written notice of—

''(A) the person's intent to bring an action under this section,

''(B) the identities of the individuals or entities the person intends to name as defendants to the action, and

''(C) all information the person possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under section 1128A against the defendants, and

''(2) one of the following conditions is met:

''(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (1), the Secretary does not notify the person that the Secretary intends to initiate an investigation to determine whether to impose a civil monetary penalty under section 1128A against the defendants.

''(B) The Secretary notifies the person during the 60-day period described in subparagraph (A) that the Secretary intends to initiate an investigation to determine whether to impose a civil monetary penalty under such section against the defendants, and the Secretary subsequently notifies the person that the Secretary no longer intends to initiate an investigation or

proceeding to impose a civil monetary penalty against the defendants.

''(C) After the expiration of the 1-year period that begins on the date written notice is provided to the Secretary, the Secretary has not initiated a proceeding to impose a civil monetary penalty against the defendants.

''(c) TREATMENT OF EXCESS AWARDS.—If a person is awarded any amounts in an action brought under this section that are in excess of the damages suffered by the person as a result of the defendant's activities, 20 percent of such amounts shall be withheld from the person for payment into the Federal Outlays Program Fraud and Abuse Control Account established under section 1128C(a).

''(d) STATUTE OF LIMITATIONS.—No action may be brought under this section more than 6 years after the date of the activity with respect to which the action is brought.

''(e) NO LIMITATION ON OTHER ACTIONS.—Nothing in this section shall limit the right of any person to pursue any other right of action or remedy available under the law.

''(f) PENDANT JURISDICTION.—Nothing in this section shall be construed, by reason of a claim arising under

this section, to confer on the Courts of the United States jurisdiction over any State law claim.''.

SEC. 523. EXCLUSION FROM PROGRAM PARTICIPATION.

(a) MANDATORY EXCLUSION.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7) is amended—

(1) by inserting ''(1)'' before ''The'';

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively; and

(3) by adding at the end the following:

''(C) CONVICTION OF CRIMINAL OFFENSE.—Any individual or entity that has been convicted after the date of the enactment of this subparagraph, under Federal or State law, in connection with the delivery of a health care item or service of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

''(D) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity has been convicted after such date, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

''(2) WAIVER PERMITTED.—

''(A) IN GENERAL.—When, in the opinion of the Secretary, mandatory exclusion under paragraph (1) of an individual or entity would significantly harm the public health or pose a significant risk to the public health, the Secretary may waive such exclusion and shall apply such other appropriate penalties as authorized under this subtitle.

''(B) APPLICATION FOR WAIVER OF EXCLUSION.—

''(i) IN GENERAL.—An individual or entity subject to mandatory exclusion under this subsection may apply to the Secretary, in a manner specified by the Secretary in regulations, for waiver of the exclusion.

''(ii) SECRETARIAL RESPONSE.—The Secretary may waive the exclusion for the reasons described in subparagraph (A).''.

(b) PERMISSIVE EXCLUSION.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a-7) is amended—

(1) in paragraph (1), by inserting ''consisting of a misdemeanor'' after ''offense''; and

(2) in paragraph (3), by inserting ''consisting of a misdemeanor'' after ''offense''.

(c) PERIOD OF EXCLUSION.—

(1) MINIMUM PERIOD FOR MANDATORY EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a-7(c)(3)(B)) is amended by striking ''five years'' and inserting ''two years''.

(2) MINIMUM PERIOD FOR CERTAIN PERMISSIVE EXCLUSIONS.—Section 1128(c)(3) of such Act (42 U.S.C. 1320a-7(c)(3)) is amended by adding the following new subparagraph:

''(D)(i) In the case of an exclusion of an individual excluded from participation in a public program under, or is otherwise described in, paragraph (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 1 year, unless the Secretary determines that a longer period is necessary because of aggravating circumstances.

''(ii) In the case of an exclusion of an individual or entity excluded from participation in a public program under, or is otherwise described in, paragraph (4), (5)(A), or (5)(B) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(iii) In the case of an exclusion of an individual or entity described in paragraph (6)(B) of subsection (b), the period of the exclusion shall be not less than 1 year.''.

(d) NOTICE TO ENTITIES ADMINISTERING PUBLIC PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR HEALTH CARE ITEMS OR SERVICES.—Section 1128(d) of the Social Security Act (42 U.S.C. 1320a-7(d)) is amended—

(1) in paragraph (1), by inserting ''and all certified health plans certified under such program for the delivery of or payment for health care items or services'' after ''participate'';

(2) in paragraph (2), by inserting ''and each sponsor of a certified health plan'' after ''program''.

(e) EXPANDED OPPORTUNITY FOR ADMINISTRATIVE HEARINGS.—Section 1128(f)(2) of the Social Security Act (42 U.S.C. 1320a-7(f)(2)) is amended by striking ''subsection (b)(7)'' and inserting ''paragraphs (6)(B), (7), (8), (9), (11), (12), or (14) of subsection (b)''.

(f) NOTIFICATION OF TERMINATION OF EXCLUSION.—Section 1128(g)(3)) of the Social Security Act (42 U.S.C. 1320a-7(g)(3)) is amended by inserting ''and each sponsor of a certified health plan'' after ''program''.

(g) REQUEST FOR EXCLUSION.—Section 1128(d) of the Social Security Act (42 U.S.C. 1320a-7(d)) is amended by adding at the end the following new paragraph:

''(4)(A) The sponsor of any certified health plan, the board of any purchasing cooperative, and the Secretary of Labor in the case of a multistate self-insured health plan may request that the Secretary of Health and Human Services exclude an individual or entity with respect to actions under a certified health plan in accordance with this section.

''(B) Notwithstanding any other provision of this title and title XXI, no payment may be made under a certified health plan for the delivery of or payment for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

''(i) by an individual or entity during the period when such individual or entity is excluded pursuant to this section from participation in a certified health plan; or

''(ii) at the medical direction or on the prescription of a physician during the period when the physician is excluded pursuant to this section from participation in a certified health plan and the person furnishing the item or service knew or had reason to

know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).''.

PART III—AMENDMENTS TO CRIMINAL LAW

SEC. 531. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any purchasing cooperative, certified health plan, certified long-term care policy, or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any purchasing cooperative, certified health plan, certified long-term care policy, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily

injury (as defined in section 1365 of this title) such person shall be imprisoned for any term of years.

''(b) As used in this section—

''(1) the terms 'purchasing cooperative', 'certified health plan', and 'certified long-term care policy' have the meanings given those terms in sections 21100(14), 21011(a)(1), and 21011(b)(2) of the Social Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 532. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 668. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a purchasing cooperative, certified health plan, certified long-term care policy, or of any fund connected with such a cooperative, plan, or policy, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) As used in this section, the terms 'purchasing cooperative', 'certified health plan', and 'certified long-term care policy' have the meanings given those terms in sections 21100(14), 21011(a)(1), and 21011(b)(2) of the Social Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''668. Theft or embezzlement in connection with health care.''.

SEC. 533. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1033. False statements relating to health care matters

''(a) Whoever, in any matter involving a purchasing cooperative, certified health plan, or certified long-term care policy, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the terms 'purchasing cooperative', 'certified health plan', and 'certified long-

term care policy' have the meanings given those terms in sections 21100(14), 21011(a)(1), and 21011(b)(2) of the Social Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''1033. False statements relating to health care matters.''.

SEC. 534. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''§ 226. Bribery and graft in connection with health care

''(a) Whoever—

''(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

''(A) to influence any of the health care official's actions, decisions, or duties relating to a purchasing cooperative, certified health plan, or certified long-term care policy;

''(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the

commission of any fraud, on a purchasing cooperative, certified health plan, or certified long-term care policy; or

''(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

''(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection;

shall be fined under this title or imprisoned not more than 15 years, or both.

''(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a purchasing cooperative, certified health plan, or certified long-term care policy, shall be fined under this title or imprisoned not more than two years, or both.

''(c) As used in this section—

''(1) the term 'health care official' means—

''(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee

of any purchasing cooperative, certified health plan, or certified long-term care policy;

''(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any purchasing cooperative, certified health plan, or certified long-term care policy;

''(C) an official or employee of a State agency having regulatory authority over any purchasing cooperative, certified health plan, or certified long-term care policy;

''(D) an officer, counsel, agent, or employee of a health care sponsor;

''(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a certified health plan for purposes of title XXI of the Social Security Act, and includes the joint board of trustees or other similar body used by two or more employers to administer a certified health plan for purposes of such Act; and

''(3) the terms 'purchasing cooperative', 'certified health plan', and 'certified long-term care policy' have the meanings given those terms in sections 21100(14), 21011(a)(1), and 21011(b)(2) of the Social Security Act, respectively.''.

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''226. Bribery and graft in connection with health care.''.

SEC. 535. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 1128D of the Social Security Act);''.

SEC. 536. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

''(c) A person who is privy to grand jury information concerning a health law violation—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 1128D of the Social Security Act).''.

SEC. 537. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 1128D of the Social Security Act) that results in serious bodily injury (as defined in section 1365 of this title), shall order such person to forfeit to the United States any property, real or personal, constituting or traceable to the gross proceeds obtained, directly or indirectly, as a result of the commission of the offense.''.

PART IV—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 541. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting ''or to a certified health plan or certified long-term care policy'' after ''property to the Government'';

(2) in the matter following subsection (a)(7), by inserting ''or certified health plan or certified long-term care policy'' before ''sustains because of the act of that person,'';

(3) at the end of the first sentence of subsection (a), by inserting ''or certified health plan or certified long-term care policy'' before ''sustains because of the act of the person.'';

(4) in subsection (c)—

(A) by inserting ''the term'' after ''section,''; and

(B) by adding at the end the following: ''The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a certified health plan or certified long-term care policy.''; and

(5) by adding at the end the following:

''(f) CERTIFIED HEALTH PLAN AND CERTIFIED LONG-TERM CARE POLICY DEFINED.—For purposes of this section, the terms 'purchasing cooperative', 'certified health plan', and 'certified long-term care policy' have the

meanings given those terms in sections 21100(14), 21011(a)(1), and 21011(b)(2) of the Social Security Act, respectively.''.

PART V—EFFECTIVE DATE

SEC. 551. EFFECTIVE DATE.

Except as otherwise provided in this subtitle, the provisions of, and amendments made by, this subtitle shall be effective on and after January 1, 1996.

TITLE VI—MEDICARE, MEDICAID EDUCATION, AND MEDICAID

SEC. 600. REFERENCES TO SOCIAL SECURITY ACT.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Medicare

PART I—RISK CONTRACTING ENTITIES

SEC. 601. IMPROVEMENTS OF RISK CONTRACTS.

(a) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended to read as follows:

''PAYMENTS TO CERTAIN CERTIFIED STANDARD HEATH PLANS

''SEC. 1876. (a) IN GENERAL.—

''(1) GENERAL PERMISSION TO CONTRACT.—

''(A) RISK CONTRACTS.—The Secretary may enter into a risk contract with any certified standard health plan (as defined in paragraph (4)(A)) in a service area (as defined in paragraph (4)(B)) if—

''(i) the plan has at least 5,000 enrollees (except that the Secretary may enter into such a contract with a certified standard health plan that has fewer enrollees if the plan primarily serves members residing outside of urbanized areas); and

''(ii) the plan—

''(I) meets the requirements of this section with respect to individuals enrolled under this section; and

''(II) meets the requirements necessary to maintain its status as a certified standard health plan with respect to individuals enrolled under this section that do not conflict with any of the requirements under this section.

''(B) REASONABLE COST REIMBURSEMENT CONTRACTS.—The Secretary may enter into a reasonable cost reimbursement contract (as de-

fined in paragraph (4)(C)) with any certified standard health plan in a service area if—

''(i)(I) the plan so elects;

''(II) the Secretary is not satisfied that the plan has the capacity to bear the risk of potential losses under a risk contract under this section, or

''(III) the plan has an insufficient number of individuals enrolled to be eligible to enter into a risk contract; and

''(ii) the Secretary is otherwise satisfied that the plan is able to perform its contractual obligations effectively and efficiently.

''(2) AVAILABILITY OF PLANS.—

''(A) IN GENERAL.—Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B shall be eligible to enroll under this section with any certified standard health plan with a contract under this section which serves the service area in which the individual resides, except that an employer-sponsored plan may limit its enrollment to certain classes of individ-

uals, as designated by the Secretary in regulations.

''(B) ENROLLMENT BY AN INDIVIDUAL.—An individual may enroll under this section with a certified standard health plan with a contract under this section in such manner as may be prescribed in regulations (including enrollment through a third party) and the individual may terminate enrollment—

''(i) during an annual period as prescribed by the Secretary, and

''(ii) as specified by the Secretary if the plan is financially insolvent, if the individual moves from the service area served by the plan, or if other special circumstances exist, as prescribed by the Secretary.

''(C) INFORMATION.—

''(i) DISTRIBUTION BY PLANS.—The Secretary may prescribe the procedures and conditions under which a certified standard health plan with a contract under this section may provide individuals eligible to enroll under this section with information about the plan. No brochures, applica-

tion forms, or other promotional or informational material may be distributed by a plan to (or for the use of) individuals eligible to enroll with the plan under this section unless—

''(I) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review, and

''(II) the Secretary has not disapproved the distribution of the material.

The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(ii) DISTRIBUTION BY THE SECRETARY.—The Secretary shall develop and distribute comparative materials to individuals eligible to enroll under this section regarding all certified standard health plans with contracts under this section.

''(3) PAYMENTS.—

''(A) PAYMENTS IN LIEU OF NORMAL PAYMENTS.—Subject to subsection (i)(3), payments under a contract to a certified standard health plan under this section shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the plan to individuals enrolled with the plan under this section.

''(B) SOURCE OF PAYMENT.—The payment to a certified standard health plan under this section for individuals enrolled under this section with the plan and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the plan for a month to be paid by each trust fund shall be determined as follows:

''(i) With respect to expenditures by certified standard health plans with risk contracts under this section, the allocation shall be determined each year by the Secretary based on the ratio of expenditures from each trust fund for the preceding

year to the expenditures from both trust funds for the preceding year.

''(ii) With respect to expenditures by a certified standard health plan with a reasonable cost reimbursement contract under this section, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

''(4) DEFINITIONS.—For purposes of this section:

''(A) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' shall have the meaning given such term in section 21011(a)(2).

''(B) SERVICE AREA.—The term 'service area' means the service areas designated by a State under section 21128.

''(C) REASONABLE COST REIMBURSEMENT CONTRACT.—The term 'reasonable cost reimbursement contract' means a contract with a certified standard health plan pursuant to which such plan is reimbursed on the basis of its reasonable cost (as defined in section

1861(v)) in the manner prescribed in subsection (c)(2).

''(b) PAYMENT RULES UNDER RISK CONTRACTS.—

''(1) IN GENERAL.—

''(A) PAYMENTS.—Except as provided in subparagraph (C), with respect to any calendar year, each certified standard health plan with a risk contract under this section shall receive a payment under this title with respect to each individual enrolled with the plan for each month such individual is enrolled equal to the average medicare per capita rate determined under paragraph (2) for the plan's service area adjusted by the rate factor determined under subparagraph (B) for the class of such individual.

''(B) DETERMINATION OF CLASSES OF INDIVIDUALS AND RATE FACTORS FOR SUCH CLASSES.—

''(i) DETERMINATION OF CLASSES.—For purposes of this section, the Secretary shall define appropriate classes of individuals, based on age, disability status, and such other factors as the Secretary determines to be appropriate.

''(ii) RATE FACTORS.—The Secretary shall annually determine the rate factors for each class of individuals defined in clause (i) reflecting the differences in the average per capita spending for benefits under parts A and B among individuals in such classes. The Secretary shall announce such rate factors (in a manner intended to provide notice to interested parties) not later than July 1 before the calendar year concerned.

''(C) BUDGET NEUTRALITY.—The Secretary shall reduce the amount of payments to be made to certified standard health plans under subparagraph (A) for a year by an amount the Secretary determines necessary so that such payments do not exceed an amount equal to the total amount that would have been paid under this section for the year if section 601 of the Health Security Act had not been enacted.

''(2) DETERMINATION OF AVERAGE MEDICARE PER CAPITA RATE.—

''(A) DETERMINATION BY SECRETARY.—

''(i) IN GENERAL.—The Secretary shall annually determine under subparagraph (B), and shall announce (in a manner intended to provide notice to interested parties) not later than October 1 before the calendar year concerned, the average medicare per capita rate of payment for each service area.

''(B) FORMULA FOR AVERAGE MEDICARE PER CAPITA RATE.—

''(i) IN GENERAL.—The monthly average medicare per capita rate of payment for a service area served by a certified standard health plan shall be equal to the sum of—

''(I) the plan component determined under clause (ii); and

''(II) the fee-for-service component determined under clause (iii).

''(ii) PLAN COMPONENT.—The amount determined under this clause is the sum of the following amounts determined with respect to each certified standard health plan—

''(I) the amount of the uniform monthly premium submitted by the plan to the Secretary under subparagraph (C), adjusted by a factor determined by the Secretary to normalize the difference in the distribution of individuals projected to be enrolled in the plan among the various classes of individuals defined by the Secretary to the national distribution of all individuals in the program under this title among such classes; multiplied by

''(II) a fraction (expressed as a percentage), the numerator of which is the number of all individuals enrolled in the plan (as projected by the plan using either historical experience or some other methodology developed by the Secretary), and the denominator of which is the number of all medicare eligible individuals in the service area.

''(iii) FEE-FOR-SERVICE COMPONENT.—The amount determined under this clause is—

''(I) the projected average monthly per capita fee-for-service costs (as defined in subparagraph (D)) for the service area for individuals not enrolled in certified standard health plans with contracts under this section, adjusted by the factor described in clause (ii)(I); multiplied by

''(II) a fraction (expressed as a percentage), the numerator of which is equal to the number of all medicare eligible individuals in the service area minus the number of individuals who are enrolled in certified standard health plans with risk contracts under this section (as determined in accordance with subclause (I)), and the denominator of which is the number of all medicare eligible individuals in the service area.

''(C) UNIFORM MONTHLY PREMIUMS; PREMIUM FOR ADDITIONAL SERVICES.—

''(i) IN GENERAL.—Each certified standard health plan with a risk contract under this section shall, not later than Au-

gust 1 of each year, submit to the Secretary a bid for the next calendar year for each service area with respect to which the plan has a risk contract. A bid with respect to a service area shall include the following:

''(I) UNIFORM MONTHLY PREMIUM.—A statement of the uniform monthly premium amount that the plan intends to charge for individuals enrolled under this section with the plan and entitled to benefits under part A and enrolled in part B and a projection of the plan's enrollment by class for such services in the service area.

''(II) PREMIUM FOR ADDITIONAL SERVICES.—A statement of the premium amount that the plan intends to charge for each class of individuals enrolled under this section with the plan for the additional mandatory services described in subparagraphs (A)(ii) and (B) of subsection (d)(1).

''(III) PREMIUM FOR ADDITIONAL HEALTH CARE SERVICES.—A statement of the premium amount that the plan intends to charge for each package of additional health care services offered by the plan.

''(ii) NOTICE BEFORE BID SUBMISSIONS.—At least 45 days before the date for submitting bids under clause (ii) for a year, the Secretary shall provide for notice to certified standard health plans with risk contracts of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous calendar year and shall provide such plans an opportunity to comment on such proposed changes.

''(D) PROJECTED AVERAGE MONTHLY PER CAPITA FEE-FOR-SERVICE COSTS.—

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'projected average monthly per capita fee-for-service costs' means, with respect to a service area, the amount, prorated to be expressed

as a monthly amount, that the Secretary estimates in advance would be payable in any contract year for services covered under parts A and B and types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than a certified standard health plan with a risk contract under this section.

''(ii) BASIS FOR ESTIMATES.—The estimate made by the Secretary under clause (i) shall be made on the basis of actual experience of the service area or, if the Secretary determines that the data in that service area are inadequate to make an accurate estimate, the Secretary may use the actual experience of a similar area, with appropriate adjustments to assure actuarial equivalence, including adjustments the Secretary may determine appropriate to adjust for demographics, health status, and the presence of specific medical conditions.

''(3) PAYMENT RULES.—

''(A) AMOUNT OF PREMIUM.—Each certified standard health plan with a contract under this section must provide to individuals enrolled with the plan under this section, for the duration of such enrollment during each contract period, a fixed monthly premium equal to the sum of the uniform monthly premium amount determined by the plan with respect to the individual under paragraph (2)(C) and the premium amount determined under such paragraph for the additional mandatory services described in subparagraphs (A)(ii) and (B) of subsection (d)(1). An individual enrolled in the plan shall be responsible for paying to the plan the difference between the fixed monthly premium amount described in the preceding sentence and the average medicare per capita rate paid to the plan in accordance with subparagraph (B).

''(B) AVERAGE MEDICARE PER CAPITA RATE.—

''(i) IN GENERAL.—The Secretary shall make monthly payments in advance and in accordance with the rate deter-

mined under paragraph (2) to each certified standard health plan with a risk contract under this section for each individual enrolled with the plan under this section.

''(ii) ADJUSTMENTS.—

''(I) IN GENERAL.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(II) SPECIAL RULE.—The Secretary may make retroactive adjustments under subclause (I) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a certified standard health plan with a risk contract under this section under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer

(or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days. No adjustment may be made under the preceding sentence with respect to any individual who does not certify that the plan provided the individual with the explanation described in subsection (e)(6) at the time the individual enrolled with the plan.

''(iii) PAYMENT TO PLAN ONLY.—Subject to subsection (i)(3), if an individual is enrolled under this section with a certified standard health plan with a risk contract under this section, only the plan shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''(C) PAYMENT GREATER THAN FIXED MONTHLY PREMIUM.—If, with respect to any

individual enrolled in a certified standard health plan with a risk contract under this section, the average medicare per capita rate paid under this section to the plan exceeds the fixed monthly premium amount described in subparagraph (A), the plan shall pay such excess to the individual, at the election of the plan, in the form of cash or as a contribution to a premium for any policy for additional health care services.

''(c) PAYMENT RULES FOR REASONABLE COST REIMBURSEMENT CONTRACTS.—

''(1) REIMBURSEMENT.—

''(A) IN GENERAL.—A certified standard health plan with a reasonable cost reimbursement contract under this section may, at the option of such plan, provide that the Secretary—

''(i) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such plan, and

''(ii) will deduct the amount of such reimbursement from payment which would otherwise be made to such plan.

''(B) DIRECT PAYMENTS.—If a certified standard health plan with a reasonable cost reimbursement contract under this section pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such plan demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the plan.

''(2) PAYMENTS TO PLANS.—Payments made to a certified standard health plan with a reasonable cost reimbursement contract under this section shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such plan is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing

services covered under this title to individuals enrolled in the plan.

''(3) REPORTS BY PLANS.—A certified standard health plan with a reasonable cost reimbursement contract under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the plan (and in such form and in such detail) as the Secretary may prescribe—

''(A) that the plan report to the Secretary in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services under parts A and B, including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such plan;

''(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

''(C) that in any case in which a plan is related to another plan by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the plan by related plans and owners) issued by the Secretary; and

''(D) that in any case in which compensation is paid by a plan substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

''(d) COVERAGE OF BENEFITS.—

''(1)IN GENERAL.—

''(A) SERVICES PROVIDED.—A certified standard health plan with a contract under this section must provide to individuals enrolled in the plan under this section, through providers

and other persons that meet the applicable requirements of this title and part A of title XI—

''(i) except as provided in subparagraph (B), the services covered under parts A and B of this title; and

''(ii) preventive care services, as defined by the Secretary.

''(B) ADDITIONS TO PART A COVERAGE.—For purposes of subparagraph (A)(i)—

''(i) inpatient hospital services shall not be limited to 150 days pursuant to section 1812(a)(1); and

''(ii) the requirement that an individual be an inpatient in a hospital for 3 consecutive days prior to the individual's receipt of post-hospital extended care services pursuant to section 1861(i) shall not apply.

''(2) PROVISION OF MEDICALLY NECESSARY CARE.—Each certified standard health plan with a contract under this section must—

''(A) make the services described in paragraph (1) (and such other health care services as enrolled individuals have contracted for)—

''(i) available and accessible to enrolled individuals within the service area with reasonable promptness and in a manner which assures continuity, and

''(ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

''(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the plan, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(ii) it was not reasonable given the circumstances to obtain the services through the plan.

''(3) SPECIAL EXCEPTION.—If there is a national coverage determination made in the period beginning on the date for the submission of bids under subsection (b)(2)(C) and ending on the next such date of submission that the Secretary projects will result in a significant change in the costs to a certified standard health plan with a risk contract

under this section of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the bid for such period, and if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3)(A) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period, unless otherwise required by law.

''(4) COST SHARING.—

''(A) IN GENERAL.—Each certified standard health plan with a contract under this section must provide to individuals enrolled under this section with respect to the services described in paragraph (1), cost sharing requirements that are no greater than the cost sharing requirements for such services under the plan for individuals not enrolled in the plan under this section.

''(B) COST SHARING FIXED DURING CONTRACT PERIOD.—Each certified standard plan must provide to individuals enrolled under this section, for the duration of such enrollment

during each contract period, cost sharing that is fixed during the duration of the contract period.

''(e) ENROLLMENT PERIODS.—

''(1) IN GENERAL.—Each certified standard health plan with a contract under this section must have an open enrollment period (which may be specified by the Secretary), for the enrollment of individuals under this section, of at least 30 days duration every year and for the additional periods specified under paragraphs (2) through (4), and must provide that at any time during which enrollments are accepted, the plan will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll in the plan in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the service area served by the plan.

''(2) NONRENEWAL OR TERMINATION.—

''(A) IN GENERAL.—If a contract under this section is not renewed or is otherwise terminated, certified standard health plans with contracts under this section and serving the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination.

''(B) OPEN ENROLLMENT PERIOD.—The open enrollment periods required under subparagraph (A) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

''(C) EFFECTIVENESS OF ENROLLMENT.—Enrollment under this paragraph shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

''(3) SPECIAL RULE.—Each certified standard health plan with a contract under this section shall have an open enrollment period for each individual who enrolls in a plan during any enrollment period specified by section 1837 that applies to that indi-

vidual. Enrollment under this clause shall be effective as specified by section 1838.

''(4) RESIDENTS OUTSIDE SERVICE AREA.—Each certified standard health plan with a contract under this section shall have an open enrollment period for each individual eligible to enroll in such a plan who has previously resided outside the service area. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that service area and shall end at the end of the following month. Enrollment under this subparagraph shall be effective as of the first of the month following the month in which the individual enrolls.

''(5) CONTINUED ENROLLMENT PROTECTED.—Each certified standard health plan with a contract under this section must provide assurances to the Secretary that it will not expel or refuse to re-enroll any enrolled individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

''(6) NOTICE OF RIGHTS, ETC.—Each certified standard health plan with a contract under this section shall provide each enrollee, at the time of enroll-

ment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

''(A) the enrollee's rights to benefits from the plan,

''(B) the restrictions on payments under this title for services furnished other than by or through the plan,

''(C) out-of-area coverage provided by the plan,

''(D) the plan's coverage of emergency services and urgently needed care,

''(E) appeal rights of enrollees, and

''(F) the health care providers with whom the plan has entered into contracts for the provision of services.

''(7) CONTINUATION OF COVERAGE.—Each certified standard plan that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the plan ceases to provide such items and services, the plan shall provide or arrange for supplemental coverage of benefits under this title related to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the plan who re-

ceive benefits under this title, for the lesser of six months or the duration of such period.

''(8) NOTICE OF RIGHT OF TERMINATION.—

''(A) IN GENERAL.—Each certified standard health plan with a risk contract under this section shall notify individuals eligible to enroll with the plan under this section and individuals enrolled with the plan under this section that—

''(i) the plan is authorized by law to terminate or refuse to renew the contract, and

''(ii) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the plan under this section.

''(B) PLACEMENT OF NOTICE.—The notice required by subparagraph (A) shall be included in—

''(i) any marketing materials described in subsection (a)(2)(C) that are distributed by a plan to individuals eligible to enroll under this section with the plan, and

''(ii) any explanation provided to enrollees by the plan pursuant to paragraph (6).

''(f) MEMBERSHIP ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Each certified standard health plan with a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

''(2) WAIVER.—

''(A) IN GENERAL.—The Secretary may modify or waive the requirement imposed by paragraph (1) if the plan demonstrates that it provides for an adequate quality of care for beneficiaries by—

''(i) meeting the quality standards for plans with contracts under this section;

''(ii) meeting the fiscal soundness requirements under title XIII of the Public Health Service Act and any such requirements necessary to remain a certified standard health plan for at least the 3 years immediately preceding an application for a waiver under this paragraph;

''(iii) demonstrating successful operational experience as a certified standard health plan with a contract under this section for at least the 3 years immediately preceding an application for a waiver under this paragraph; and

''(iv) demonstrating that the number of individuals enrolled in the plan or its parent organization is at least 50,000 at the time of application for a waiver under this paragraph.

''(B) STANDARDS.—In reviewing a plan's quality performance, the Secretary may accept quality performance standards as measured by private organizations acceptable to the Secretary or organizations designated by the Secretary, including peer review organizations.

''(3) SUSPENSION OF ENROLLMENT.—If the Secretary determines that a certified standard health plan with a contract under this section has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the plan under this section for individuals newly

enrolled with the plan, after the date the Secretary notifies the plan of such noncompliance.

''(4) TERMINATION OF REQUIREMENT.—The Secretary may terminate the requirement under paragraph (1) when the Secretary determines that health plans have established alternative quality assurance mechanisms that effectively provide sufficient quality safeguards.

''(g) PAYMENT RULES FOR PLANS.—

''(1) SUBROGATION RIGHTS.—Notwithstanding any other provision of law, each certified standard health plan with a contract under this section may (in the case of the provision of services to an individual enrolled under this section by a primary plan under section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(2) PROMPT PAYMENT REQUIREMENT.—

''(A) IN GENERAL.—A risk contract under this section shall require the certified standard health plan to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the plan and the provider or supplier.

''(B) FAILURE.—In the case of a plan which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the plan under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

''(h) DURATION, TERMINATION, EFFECTIVE DATE, AND TERMS OF CONTRACT; POWERS AND DUTIES OF SECRETARY.—

''(1) DURATION AND TERMINATION.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(B) EXCEPTION.—The Secretary may terminate a contract at any time (after such reasonable notice and opportunity for hearing to the certified standard health plan involved as the Secretary may provide in regulations), if the Secretary finds that the plan—

''(i) has failed substantially to carry out the contract,

''(ii) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

''(iii) no longer substantially complies with the requirements of this section.

''(2) EFFECTIVE DATE.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

''(3) TERMS.—Each contract under this section—

''(A) shall provide that the Secretary, or any person or organization designated by the Secretary—

''(i) shall have the right to inspect or otherwise evaluate—

''(I) the quality, appropriateness, and timeliness of services performed under the contract, and

''(II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(ii) shall have the right to audit and inspect any books and records of the certified standard health plan that pertain—

''(I) to the ability of the plan to bear the risk of potential financial losses, or

''(II) to services performed or determinations of amounts payable under the contract;

''(B) shall require the plan with a contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the plan; and

''(C)(i) shall require the plan to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

''(ii) shall require the plan to provide and supply information determined appropriate by the Secretary in the manner determined appropriate by the Secretary;

''(iii) shall require the plan to notify the Secretary of loans and other special financial arrangements which are made between the plan and subcontractors, affiliates, and related parties; and

''(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(4) PERIOD OF DISQUALIFICATION.—The Secretary may not enter into a risk contract with a certified standard health plan if a previous risk contract with that plan under this section was terminated at the request of the plan within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) DISREGARD OF CERTAIN INCONSISTENT LAWS, ETC.—The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(6) FINDINGS OF FAILURE.—

''(A) IN GENERAL.—If the Secretary determines that a certified standard health plan with a contract under this section—

''(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

''(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

''(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the plan whose medical condition or history indicates a need for substantial future medical services;

''(v) misrepresents or falsifies information that is furnished—

''(I) to the Secretary under this section, or

''(II) to an individual or to any other entity under this section;

''(vi) fails to comply with the requirements of subsection (g)(2)(A) or paragraph (8);

''(vii) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; or

''(viii) substantially fails to cooperate with the utilization and quality control peer review organization;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

''(B) REMEDIES.—The remedies described in this subparagraph are—

''(i) civil money penalties of not more than $ 25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $ 100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $ 15,000 for each individual not enrolled as a result of the practice involved,

''(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the plan of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(iii) suspension of payment to the plan under this section for individuals en-

rolled after the date the Secretary notifies the plan of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(7) AGREEMENT WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION.—

''(A) IN GENERAL.—Each risk contract with a certified standard health plan under this section shall provide that the plan will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed

under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the plan, for which payment may be made under this title.

''(B) COST OF SERVICES.—For purposes of payment under this title, the cost of such agreement to the plan shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the review organization on behalf of such plan in accordance with a schedule established by the Secretary.

''(C) SOURCE OF PAYMENTS.—Such payments—

''(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

''(ii) shall not be less in the aggregate for such plans for a fiscal year than the

amounts the Secretary determines to be sufficient to cover the costs of such plans' conducting activities described in subparagraph (A) with respect to such plans under part B of title XI.

''(i) OTHER GENERAL REQUIREMENTS ON PLANS.—

''(1) GRIEVANCE PROCEDURES.—Each certified standard health plan with a contract under this section must provide meaningful procedures for hearing and resolving grievances between the plan (including any entity or individual through which the plan provides health care services) and individuals enrolled with the plan under this section.

''(2) APPEALS.—An individual enrolled with a certified standard health plan under this section who is dissatisfied by reason of the individual's failure to receive any health service to which the individual believes the individual is entitled and at no greater charge than the individual believes the individual is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the plan a party. If the amount in controversy is $1,000 or more, the individual or plan

shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the plan shall be entitled to be parties to that judicial review.

''(3) ADVANCE DIRECTIVES.—A contract under this section shall provide that the certified standard health plan shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''4) SPECIAL REQUIREMENT RELATING TO SUBSECTION (d) HOSPITALS.—A risk contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(A) enrollment with such plan under this section—

''(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the plan,

''(ii) the plan shall not be financially responsible for payment for such services

until the date after the date of the individual's discharge, and

''(iii) the plan shall nonetheless be paid the full amount otherwise payable to the plan under this section; or

''(B) termination of enrollment with a plan under this section—

''(i) the plan shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(ii) payment for such services during the stay shall not be made under section 1886(d), and

''(iii) the plan shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

''(j) LIMIT ON CHARGES FOR CERTAIN SERVICES.—

''(1) IN GENERAL.—(A) In the case of physicians' services or renal dialysis services described in paragraph (2) which are furnished by a participating physician to an individual enrolled with a certified standard health plan under this section and enrolled under part B, the applicable participation agreement

is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible plan the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with a plan under this section.

''(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

''(2) SERVICES DESCRIBED.—The 'physicians' services described in this paragraph are physicians' services which are furnished to an enrollee of a certified standard health plan under this section by a physician, provider of services, or renal dialysis facility who is not under a contract with the plan.

''(k) STUDY ON CERTIFIED STANDARD HEALTH PLANS.—

''(1) IN GENERAL.—The Prospective Payment Assessment Commission (established under section 1886(e)(2)) and the Physician Payment Review Commission (established under section 1845) shall study and make recommendations to Congress on the matters described in paragraph (2).

''(2) MATTERS DESCRIBED.—The matters described in this paragraph include—

''(A) ways in which enrollment in certified standard health plans with risk contracts under this section could be increased;

''(B) alternatives to the current payment methodology that might encourage more health plans to enter into certified standard health plans with risk contracts under this section and encourage more individuals to enroll in such plans;

''(C) whether the demographic characteristics and health status of beneficiaries enrolled in certified standard health plans with risk contracts under this section differs from other individuals entitled to benefits under part A and enrolled under part B; and

''(D) whether the volume and quality of care rendered to individuals enrolled in certified

standard health plans with risk contracts under this section differs from that rendered to other individuals entitled to benefits under part A and enrolled under part B.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—The Secretary of Health and Human Services shall, within 90 days of the date of the enactment of this section, submit to the appropriate committees of Congress, a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to contracts entered into on or after January 1, 1996.

PART II—PROVISIONS RELATED TO PART A

SEC. 611. INPATIENT HOSPITAL SERVICES UPDATE FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

''(XII) for fiscal years 1997 through 2000, the market basket percentage minus 2.0 percentage points for hospitals in all areas, and''; and

(2) in subclause (XIII), by striking ''1998'' and inserting ''2001''.

SEC. 612. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN BASE PAYMENT RATES FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Health Security Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpa-

tient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2003.''.

SEC. 613. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

(2) by adding at the end the following new clauses:

''(ix) Notwithstanding any other provision of this subparagraph, the Secretary shall reduce the amount of any additional payment made to a hospital under this subparagraph for discharges occurring on or after October 1, 1997, by 25 percent.

''(x) Not later than July 1, 1996, the Secretary and the Prospective Payment Assessment Commission shall submit to the Congress a recommendation on a methodol-

ogy for measuring and allocating funds for hospitals that receive an additional payment under this paragraph including a replacement for the fraction described in clause (vi)(II).''.

SEC. 614. REVISED PAYMENT METHODOLOGY FOR REHABILITATION AND LONG-TERM CARE HOSPITALS.

(a) REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(1) DEFINITION.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''In defining a rehabilitation hospital and a rehabilitation unit of a hospital which is a distinct part of a hospital, the Secretary shall take into account the impact of new technologies, survival rates, and changes in the practice of rehabilitation medicine.''.

(2) TARGET AMOUNT CALCULATION FOR REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(A) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(i) in subparagraph (A), by striking ''(D), and (E)'' and inserting ''(D), (E), and (F)'';

(ii) in subparagraph (B)(ii), by striking ''and (E)'' and inserting ''(E), and (F)''; and

(iii) by adding at the end the following new subparagraph:

''(F)(i) Subject to clause (ii), for cost reporting periods beginning on or after October 1, 1994, in the case of a hospital described in subsection (d)(1)(B)(ii) or a rehabilitation unit described in such subparagraph, the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital or unit—

''(aa) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital or unit for the 12-month cost reporting period (in this subparagraph referred to as the 'base cost reporting period') preceding the first cost reporting period for which this subparagraph was in effect with respect to

such hospital, increased (in a compounded manner), by

''(bb) the applicable percentage increases applied to such hospital or unit under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

''(II) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B).

There shall be substituted for the allowable average costs of inpatient hospital services determined under subclause (I)(aa), the average of the allowable average costs of inpatient hospital services (as so defined) recognized under this title for the hospital or unit for cost reporting periods beginning during fiscal years 1990 and 1991 (if any).

''(ii)(I) Notwithstanding the provisions of clause (i), in the case of a hospital or unit to which the last sentence of clause (i) applies, the

hospital or unit's target amount under such clause for a cost reporting period shall be—

''(aa) not less than 70 percent of the national weighted average of all target amounts calculated under such clause for all hospitals and units described in such clause (as determined by the Secretary), and

''(bb) not less than the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) for such hospital or unit in the base cost reporting period (including any payments made to such hospital or unit pursuant to paragraph (1)(A)), multiplied by the applicable percentage increase for such cost reporting period under subparagraph (B).

''(II) Notwithstanding the provisions of clause (i), in the case of a hospital or unit that is not described in subclause (I), the hospital or unit's target amount under such clause for a cost reporting period shall be—

''(aa) not less than the amount described in subclause (I)(aa), and

''(bb) not greater than 110 percent of the national weighted average of all target amounts calculated under clause (i) for all hospitals and units described in such clause (as determined by the Secretary).''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply with respect to cost reporting periods beginning on or after October 1, 1994.

(3) DEVELOPMENT OF NATIONAL PROSPECTIVE RATES FOR REHABILITATION HOSPITALS AND DISTINCT PART UNITS.—

(A) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary'') shall develop a proposal to replace the current system under which rehabilitation hospitals and rehabilitation units of a hospital which are a distinct part of a hospital (as described in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receive payment for the operating and capital-related costs of inpatient hospital services under part A of title XVIII of such Act with a prospective payment system. In developing any

proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall develop a system that provides for—

(i) a payment on a per-discharge basis, and

(ii) an appropriate weighting of such payment amount as it relates to the classification of the discharge.

(B) REPORTS.—Not later than October 1, 1996, the Secretary shall submit the proposal developed under subparagraph (A) to the Congress.

(b) ASSIGNMENT OF NEW BASE YEAR FOR CERTIFIED LONG-STAY HOSPITALS THAT ALSO SERVE A SIGNIFICANT PROPORTION OF LOW-INCOME PATIENTS.—

(1) REBASING FOR LONG-TERM HOSPITALS.—

(A) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by subsection (a), is further amended—

(i) in subparagraph (A), by striking ''(E), and (F)'' and inserting ''(E), (F), and (G)'';

(ii) in subparagraph (B)(ii), by striking ''(E), and (F)'' and inserting ''(E), (F), and (G)''; and

(iii) by inserting after subparagraph (F) the following new subparagraph:

''(G)(i) For cost reporting periods beginning on or after October 1, 1994, in the case of a hospital described in subsection (d)(1)(B)(iv) that—

''(I) has not received the additional payment amount described in paragraph (1)(A) for at least the preceding 2 consecutive 12-month cost reporting periods; and

''(II) for which the sum of the amounts described in subclauses (I) and (II) of subsection (d)(5)(F)(vi) during the period described in clause (I) exceeds 25 percent,

the term 'target amount' has the meaning given such term by clause (ii).

''(ii) In the case of a hospital described in clause (i), the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

''(aa) the average allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital during cost reporting periods of the hospital beginning during fiscal years 1990 and 1991 for such hospital (in this subparagraph referred to as the 'base cost reporting period'), increased (in a compounded manner), by

''(bb) the applicable percentage increases applied to such hospital or under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting periods, or

''(II) with respect to a subsequent 12-month cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B).

''(iii) Notwithstanding clause (ii)(II), if, after 2 consecutive 12-month cost reporting periods, a hospital continues to be described in subclauses (I) and (II) of clause (i), there shall be substituted for the base cost reporting period described in clause (ii)(I)(aa) the most recent preceding 2 12-month cost reporting periods of the hospital for which data is available (as determined by the Secretary), but only if such substituting results in an increase in the target amount for the hospital. The substitution under the preceding sentence may not occur more often than every 2 years.

''(iv) Effective October 1, 1994, the Secretary shall take into account the enactment of this subparagraph in making available to the hospital the payments described in section 1815(e)(2), and, shall increase such payments as if the target amount of the hospital had been established pursuant to this subparagraph as of such date.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall be effective with respect to cost reporting periods beginning on or after October 1, 1994.

SEC. 615. MORATORIUM ON DESIGNATION OF NEW LONG-TERM HOSPITALS.

Effective October 1, 1994, notwithstanding clause (iv) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days shall not be treated as a hospital described in such clause for purposes of such title unless such hospital was treated as a hospital described in such clause for purposes of such title as of the date of the enactment of this Act.

SEC. 616. EXTENSION OF FREEZE ON UPDATES TO ROUTINE SERVICE COST LIMITS FOR SKILLED NURSING FACILITIES.

(a) PAYMENTS BASED ON COST LIMITS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''112 percent'' each place it appears and inserting ''100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)''.

(b) ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by inserting the following sentence at the end: ''The effect of the amendment made by section 616(a) of the Health Security Act shall not be

considered by the Secretary in making adjustments pursuant to this subsection.''

(c) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Section 1888(d)(2)(B) (42 U.S.C. 1395yy(d)(2)(B)) is amended by striking ''105 percent'' and inserting ''100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(b) of the Omnibus Budget Reconciliation Act of 1993)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply to cost reporting periods beginning on or after October 1, 1995.

SEC. 617. PAYMENTS FOR SOLE COMMUNITY HOSPITALS WITH TEACHING PROGRAMS AND MULTIHOSPITAL CAMPUSES.

(a) IN GENERAL.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended by adding at the end the following new clause:

''(vi) The Secretary shall determine payment under clause (i) for a sole-community hospital that is a part of a multi-campus hospital by making the determination under such clause for each facility of the multi-campus hospital if any facility of the hospital would have a value of 'r' greater than 0, as 'r' is defined in subparagraph (B)(ii). In making a determination for each such facility,

the Secretary shall determine the DRG-specific rate applicable to the facility based on its location in accordance with paragraph (3)(D).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1993, from multi-campus hospitals that merged facilities on or after October 1, 1987.

SEC. 618. MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.

(a) CLARIFICATION OF ADDITIONAL PAYMENT.—Section 1886(d)(5)(G)(ii)(I) (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)) is amended by striking ''the first 3 12-month cost reporting periods that begin'' and inserting ''the 36-month period beginning with the first day of the cost reporting period that begins''.

(b) SPECIAL TREATMENT EXTENDED.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 1994'' and inserting ''October 1, 1999''; and

(2) in clause (ii)(II), by striking ''October 1, 1994'' and inserting ''October 1, 1999''.

(c) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(1) in the matter preceding clause (i), by striking ''March 31, 1993'' and inserting ''September 30, 1999''; and

(2) by amending clause (iii) to read as follows:

''(iii) with respect to discharges occurring in fiscal years 1994 through 1999, the target amount for the cost reporting period beginning in the previous fiscal year increased by the applicable percentage increase under subparagraph (B)(iv).''.

SEC. 619. PROVISIONS RELATING TO RURAL HEALTH TRANSITION GRANT PROGRAM.

(a) ELIGIBILITY OF RURAL PRIMARY CARE HOSPITALS FOR GRANTS.—

(1) IN GENERAL.—Section 4005(e)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended in the matter preceding subparagraph (A) by inserting ''any rural primary care hospital as defined in section 1861(mm)(1), or'' after ''means''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after October 1, 1993.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—Section 4005(e)(9) of Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking ''1989 and'' and inserting ''1989,''; and

(2) by striking ''1992'' and inserting ''1992 and $30,000,000 for each of the fiscal years 1993 through 1999''.

(c) FREQUENCY OF REQUIRED REPORTS.—Section 4008(e)(8)(B) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ''every 6 months'' and inserting ''every 12 months''.

SEC. 620. LIMITED SERVICE HOSPITAL PROGRAM.

(a) LIMITED SERVICE HOSPITAL PROGRAM.—Section 1820 (42 U.S.C. 1395*l*–4) is amended to read as follows:

''LIMITED SERVICE HOSPITAL PROGRAM

''SEC. 1820. (a) PURPOSE.—The purpose of this section is to—

''(1) make available alternative hospital models to small rural or isolated rural communities in which facilities are relieved of the burden of selected regulatory requirements by limiting the scope of inpatient acute services required to be offered;

''(2) alter medicare reimbursement policy to support the financial viability of alternative facilities by limiting the financial risk faced by such small hospitals through the use of reasonable cost reimbursement; and

''(3) promote linkages between facilities designated by the State under this section and broader programs supporting the development of and transition to integrated provider networks.

''(b) IN GENERAL.—Any State that submits an application in accordance with subsection (c) may establish a limited hospital program described in subsection (d).

''(c) APPLICATION.—A State may establish a limited hospital program described in subsection (d) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) in the case of a State applying to establish a rural primary care hospital program (described in subsection (d)(1)(A)), provides for the creation of one or more rural health networks (as defined in subsection (e)) in the State,

''(ii) promotes regionalization of rural health services in the State, and

''(iii) improves access to hospital and other health services for rural residents of the State;

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan); and

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of designating, rural nonprofit or public hospitals or facilities located in the State as rural primary care hospitals facilities or medical assistance facilities; and

''(3) such other information and assurances as the Secretary may require.

''(d) LIMITED HOSPITAL PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (c),

may establish a limited hospital program that includes—

''(A) a rural primary care hospital program under which—

''(i) at least one facility in the State shall be designated as a rural primary care hospital in accordance with paragraph (2), and

''(ii) the State shall develop at least one rural health network (as defined in subsection (e)) in the State;

''(B) a medical assistance facility program under which at least one facility in the State shall be designated as a medical assistance facility in accordance with paragraph (2); or

''(C) both.

''(2) STATE DESIGNATION OF FACILITIES.—A State may designate one or more facilities as a rural primary care hospital or medical assistance facility in accordance with subparagraph (A) or (B).

''(A) CRITERIA FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITAL.—A State may designate a facility as a rural primary care hospital only if the facility—

''(i) is located in a rural area (as defined in section 1886(d)(2)(D)), or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas;

''(ii) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed), with a participation agreement in effect under section 1866(a);

''(iii) has in effect an agreement to participate with other hospitals and facilities in a rural health network;

''(iv) provides 24-hour emergency services to ill or injured persons prior to admission to the facility or prior to their transportation to a full-service hospital;

''(v) provides not more than 15 inpatient beds (meeting such conditions as the Secretary may establish) for providing acute inpatient care;

''(vi) provides inpatient care for a period not to exceed an average length of 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions);

''(vii) meets such staffing requirements as would apply under section 1861(e), to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to provide emergency care on a 24-hour basis under clause (v) and must have nursing services available on a 24-hour basis, but need not oth-

erwise staff the facility except when an inpatient is present,

''(II) the facility may provide any services otherwise required to be provided by a full-time, onsite dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, offsite basis under arrangements as defined in section 1861(w)(1), and

''(III) the inpatient care described in clause (vii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(viii) meets the requirements of subparagraphs (C) through (I) of paragraph (2) of section 1861(aa), and of clauses (ii) and (iv) of the second sentence of that paragraph, except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied

as if any reference to 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(B) CRITERIA FOR DESIGNATION AS MEDICAL ASSISTANCE FACILITY.—A State may designate a facility as a medical assistance facility only if the facility—

''(i) is located in a county (or equivalent unit of local government)—

''(I) with fewer than 6 residents per square mile, or

''(II) in a rural area (as defined in section 1886(d)(2)(D)) that is located more than a 35–mile or 45–minute drive from a hospital, a rural primary care hospital, or another facility described in this subsection;

''(ii) at the time such facility applies to the State for designation as a medical assistance facility—

''(I) is a hospital (or in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),

with a participation agreement in effect under section 1866(a); or

''(II) is licensed in accordance with applicable State and local laws and regulations;

''(iii) meets the requirements of clauses (iv), (vi), and (vii) of subparagraph (A); and

''(iv) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa).

''(e) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term 'rural health network' means, with respect to a State, an organization—

''(1) consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

''(B) at least 1 hospital that furnishes services that a rural primary care hospital cannot furnish, and

''(2) the members of which have entered into agreements regarding—

''(A) patient referral and transfer,

''(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data,

''(C) the provision of emergency and non-emergency transportation among the members, and

''(D) credentialing and quality assurance.

''(f) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a rural primary care hospital or medical assistance facility (as the case may be) if the facility—

''(1) is located in a State that has established a limited hospital program in accordance with subsection (d);

''(2) is designated as a rural primary care hospital or medical assistance facility by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(g) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a rural primary care hospital or medical assistance facility solely because, at the time the facility ap-

plies to the State for designation as a rural primary care hospital or medical assistance facility, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care in a rural primary care facility pursuant to subsection (d)(2)(A)(vi)). The Secretary may establish additional conditions of participation for rural primary care hospitals with a substantial number of such beds. For purposes of the first sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital or medical assistance facility.

''(h) GRANTS.—

''(1) LIMITED HOSPITAL PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (c) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) in the case of a rural primary care hospital program described in subsection (d)(1)(A), engaging in activities relating to planning and implementing rural health networks; and

''(C) designation of facilities as rural primary care hospitals or medical assistance facilities.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (c)(1) and paragraph (3) of such subsection.

''(i) STUDY ON CLINICALLY BASED ALTERNATIVE TO 96-HOUR RULE.—The Secretary shall conduct a study on the feasibility of admitting patients to rural primary care hospitals and medical assistance facilities on a limited DRG basis instead of using the 96-hour average length of stay criteria described in subsection (d)(2)(A)(vii).

''(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund—

''(1) for making grants under subsection (h)(1) to States that have established a rural primary care hospital program in the State under subsection (d)(1)(A), $15,000,000 for each of fiscal years 1993 through 1995; and

''(2) for making grants to all States under subsection (h), $25,000,000 in each of the fiscal years 1996 through 1999.''.

(b) PART A AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND MEDICAL ASSISTANCE FACILITIES.—

(1) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''MEDICAL ASSISTANCE FACILITY; MEDICAL ASSISTANCE FACILITY SERVICES

''(oo)(1) The term 'medical assistance facility' means a facility certified by the Secretary as a medical assistance facility under section 1820(f).

''(2) The term 'medical assistance facility services' means items and services, furnished to an inpatient for a medical assistance facility by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(2) COVERAGE AND PAYMENT.—(A)(i) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking ''inpatient hospital services'' the first place it appears and inserting '', inpatient hospital services and inpatient medical assistance facility services''; and

(ii) by striking ''inpatient hospital services'' the second place it appears and inserting ''such services''.

(B) Section 1814 (42 U.S.C. 1395f) is amended—

(i) in subsection (b), by striking ''inpatient rural primary care hospital services,'' and in-

serting ''inpatient rural primary care hospital services, other than a medical assistance facility providing inpatient medical assistance facility services,''; and

(ii) by amending subsection (*l*) to read as follows:

''(*l*) PAYMENT FOR INPATIENT RURAL PRIMARY CARE SERVICES AND INPATIENT MEDICAL ASSISTANCE FACILITY SERVICES.—The amount of payment under this part for inpatient rural primary care services and inpatient medical assistance facility services is the reasonable costs of the rural primary care hospital or medical assistance facility in providing such services.''.

(3) TREATMENT OF MEDICAL ASSISTANCE FACILITIES AS PROVIDERS OF SERVICES.—(A) Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting ''medical assistance facility,''after ''rural primary care hospital,''.

(B) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting ''a medical assistance facility, as defined in section 1861(oo)(1),'' after ''1861(mm)(1),''.

(C) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by

striking ''or 1861(mm)(1)'' and inserting ''1861(mm)(1), or 1861(oo)(1),''.

(4) CONFORMING AMENDMENTS.—(A) Section 1128A(b)(1) (42 U.S.C. 1320a–7a(b)(1)) is amended—

(i) by striking ''or a rural primary care hospital'' the first place it appears and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(ii) by striking ''or a rural primary care hospital'' the second place it appears and inserting '', the rural primary care hospital, or the medical assistance facility''.

(B) Section 1128B(c) (42 U.S.C. 1320a–7b(c)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(C) Section 1134 (42 U.S.C. 1320b–4) is amended by striking ''or rural primary care hospitals'' each place it appears and inserting '', rural primary care hospitals, or medical assistance facilities''.

(D) Section 1138(a)(1) (42 U.S.C. 1320b–8(a)(1)) is amended—

(i) in the matter preceding subparagraph (A), by striking ''or rural primary care hos-

pital'' and inserting '', rural primary care hospital, or medical assistance facility'', and

(ii) in the matter preceding clause (i) of subparagraph (A), by striking ''or rural primary care hospital'' and inserting '', rural primary care hospital, or medical assistance facility''.

(E) Section 1164(e) (42 U.S.C. 1320c–13(e)) is amended by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,''.

(F) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(G) Section 1833 (42 U.S.C. 1395*l*) is amended—

(i) in subsection (h)(5)(A)(iii)—

(I) by striking ''or rural primary care hospital'' and inserting ''rural primary care hospital, or medical assistance facility''; and

(II) by striking ''to the hospital'' and inserting ''to the hospital or the facility'';

(ii) in subsection (i)(1)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'';

(iii) in subsection (i)(3)(A), by striking ''or rural primary care hospital services'' and inserting ''rural primary care hospital services, or medical assistance facility services'';

(iv) in subsection (*l*)(5)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'' each place it appears; and

(v) in subsection (*l*)(5)(C), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(H) Section 1835(c) (42 U.S.C. 1395n(c)) is amended by adding at the end the following: ''A medical assistance facility shall be considered a hospital for purposes of this subsection.''.

(I) Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(J) Section 1861 (42 U.S.C. 1395x) is amended—

(i) in the last sentence of subsection (e), by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).'',

(ii) in subsection (w)(1) by inserting ''medical assistance facility,'' after ''rural primary care hospital,'', and

(iii) in subsection (w)(2), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(K) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(L) Section 1866(a)(1) (42 U.S.C 1395cc(a)(1)) is amended—

(i) in subparagraph (F)(ii), by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,'';

(ii) in subparagraph (H)—

(I) in the matter preceding clause (i), by inserting ''and in the case of medical assistance facilities which provide inpatient

medical assistance facility services'' after ''rural primary care hospital services''; and

(II) in clauses (i) and (ii), by striking ''hospital'' each place it appears and inserting ''hospital or facility'';

(iii) in subparagraph (I)—

(I) in the matter preceding clause (i), by striking ''or rural primary care hospital'' and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(II) in clause (ii), by striking ''the hospital'' and inserting ''the hospital or the facility''; and

(iv) in subparagraph (N)—

(I) in the matter preceding clause (i), by striking ''and rural primary hospitals'' and inserting '', rural primary care hospitals, and medical assistance facilities'';

(II) in clause (i), by striking ''or rural primary care hospital,'' and inserting '', rural primary care hospital, or medical assistance facility,''; and

(III) in clause (ii), by striking ''hospital'' and inserting ''hospital or facility''.

(M) Section 1866(a)(3) (42 U.S.C 1395cc(a)(3)) is amended—

(i) by striking ''rural primary care hospital,'' each place it appears in subparagraphs (A) and (B) and inserting ''rural primary care hospital, medical assistance facility,'', and

(ii) in subparagraph (C)(ii)(II), by striking ''rural primary care hospitals,'' each place it appears and inserting ''rural primary care hospitals, medical assistance facilities''.

(N) Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).''.

(c) PART B AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND MEDICAL ASSISTANCE FACILITIES.—

(1) COVERAGE.—(A) Section 1861(oo) (42 U.S.C. 1395x(oo)) as added by subsection (b)(1), is amended by adding at the end the following new paragraph:

''(3) The term 'outpatient medical assistance facility services' means medical and other health services fur-

nished by a medical assistance facility on an outpatient basis.''.

(B) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(i) in subparagraph (I), by striking ''and'' at the end;

(ii) in subparagraph (J), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(K) outpatient medical assistance facility services (as defined in section 1861(oo)(3)).''.

(2) PAYMENT.—(A) Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(i) in paragraph (2), in the matter preceding subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(ii) in paragraph (6), by striking ''and'' at the end;

(iii) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following new paragraph:

''(8) in the case of outpatient medical assistance facility services, the amounts described in section 1834(g).''.

(B) Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(i) in the subsection heading by inserting ''AND OUTPATIENT MEDICAL ASSISTANCE FACILITY SERVICES'' after ''SERVICES'';

(ii) in paragraph (1), by striking ''provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the following methods as elected by the rural primary care hospital'' and inserting ''in a rural primary care hospital or medical assistance facility under this part shall be determined by one of the following methods as elected by the rural primary care hospital or medical assistance facility'';

(iii) in paragraph (1)(A)(ii), by striking ''outpatient rural primary care hospital services'' each place it appears and inserting ''outpatient rural primary care hospital services or outpatient medical assistance facility services''; and

(iv) in paragraph (1)(B), by striking ''hospital'' and inserting ''hospital or facility''.

(d) PAYMENT CONTINUED TO DESIGNATED EACHs.—

(1) TERMINATION OF EACH DESIGNATION.—Section 1820(i)(1)(A) (42 U.S.C. 1395*l*(4)(i)(1)(A)) is amended by inserting at the end the following new flush sentence:

''The Secretary shall not designate any hospital as an essential access community hospital on or after July 1, 1994.''.

(2) PERMITTING PAYMENT TO PRIOR DESIGNATED EACHS.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as such section was in effect as of July 1, 1994'' before the period at the end; and

(B) in clause (v), by inserting ''as such section was in effect as of July 1, 1994'' after ''1820(i)(1).''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on July 1, 1994.

(e) TECHNICAL AMENDMENT RELATING TO PART A DEDUCTIBLE, COINSURANCE AND SPELL OF ILLNESS.—

(1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)), as amended by subsection (b)(2)(A), is amended—

(A) by striking ''inpatient medical assistance facility services'' and inserting ''inpatient medical assistance facility services, inpatient rural primary care hospital services, or inpatient medical assistance facility services''; and

(B) by striking ''and inpatient rural primary care hospital services''.

(2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''inpatient hospital services'' each place it appears and inserting ''inpatient hospital services, inpatient rural primary care hospital services, or inpatient medical assistance facility services,''.

(3) Section 1813(b)(3)(B) (42 U.S.C. 1395e(b)(3)(B)) is amended by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital services, inpatient medical assistance facility services,''.

(4) Section 1861(a) (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital serv-

ices, inpatient medical assistance facility services,''; and

(B) in paragraph (2), by striking ''hospital'' and inserting ''hospital, rural primary care hospital, or medical assistance facility''.

(f) REPEAL OF DEVELOPMENT OF PPS SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1814(*l*) (42 U.S.C. 1395f(*l*)) is amended by striking paragraph (2).

(2) CONFORMING AMENDMENTS.—Section 1814(*l*)(1) (42 U.S.C. 1395F(*l*)(1)) is amended—

(A) by striking ''(*l*)(1)'' and inserting ''(*l*)'';

(B) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively;

(C) in paragraph (2), as redesignated, by striking ''paragraph'' and inserting ''subsection''; and

(D) in the last sentence, by striking ''paragraph'' and inserting ''subsection''.

(g) REPEAL OF DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE PPS SYSTEM FOR OUTPATIENT RURAL PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by subsection (c)(2)(B), is amended by striking paragraph (2).

(2) CONFORMING AMENDMENTS.—Section 1834(g)(1) (42 U.S.C. 1395m(g)(1)) is amended—

(A) by striking ''(1) IN GENERAL.—''

(B) by redesignating subparagraph (A) and clauses (i) and (ii) of such subparagraph as paragraph (1) and subparagraphs (A) and (B) of such paragraph, respectively;

(C) by redesignating subparagraph (B) as paragraph (2);

(D) in paragraph (1)(A), as redesignated, by striking ''subparagraph (B)''; and

(E) in paragraph (1)(B), as so redesignated, by striking ''subparagraph'' and inserting ''paragraph''.

(h) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to services furnished on or after October 1, 1994.

SEC. 621. TERMINATION OF INDIRECT MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended in the matter preceding clause (i) by striking ''The Secretary'' and inserting ''For

discharges occurring before January 1, 1996, the Secretary''.

(b) ADJUSTMENT TO STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''excluding'' and inserting ''for discharges occurring before January 1, 1996, excluding''.

SEC. 622. SUBACUTE CARE STUDY.

(a) STUDY.—The Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary'') shall—

(1) define the level and type of care that should constitute subacute care;

(2) determine the appropriateness of furnishing subacute care in different settings by evaluating the quality of care and patient outcomes;

(3) determine the cost and effectiveness of providing subacute care under the medicare program under title XVIII of such Act to individuals who are eligible for benefits under part A of such title;

(4) determine the extent to which hospital DRG prospective payment rates under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) are appropriate for the less restrictive institutional settings that provide subacute care; and

(5) study the relationships between institutions and their payment methodologies in order to develop ways in which to maximize the continuity of care for each patient episode in which subacute care is furnished.

(b) REPORT.—Not later than October 1, 1996, the Secretary shall submit to the Congress a report on the matters studied under subsection (a).

PART III—PROVISIONS RELATING TO PART B

SEC. 631. UPDATES FOR PHYSICIANS' SERVICES.

Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after ''subparagraph (B)'' the following: ''and, in the case of 1995, specified in subparagraph (C)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

''(i) in the case of physicians' services included in the category of primary care

services (as defined for purposes of subsection (j)(1)), the conversion factor established under this subsection for 1994 reduced by 1 percent and adjusted by the update established under paragraph (3) for 1995; and

''(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 4.0 percent and adjusted by the update established under paragraph (3) for 1995.''.

SEC. 632. SUBSTITUTION OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY; REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE.

(a) USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C. 1395w–4(f)(2)(A)(iii)) is amended to read as follows:

''(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the

category of services consisting of primary care services), and''.

(b) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w–4(d)(3)(B)(ii)) is amended—

(1) in the heading, by inserting ''IN CERTAIN YEARS'' after ''ADJUSTMENT'';

(2) in the matter preceding subclause (I), by striking ''for a year'';

(3) in subclause (I), by adding ''and'' at the end;

(4) in subclause (II), by striking '', and'' and inserting a period; and

(5) by striking subclause (III).

(c) REPEAL OF PERFORMANCE STANDARD FACTOR.—

(1) IN GENERAL.—Section 1848(f)(2) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) CONFORMING AMENDMENT.—Section 1848(f)(2)(A) is amended in the matter following clause (iv) by striking ''1, multiplied by 100'' and all that follows through ''subparagraph (B))'' and inserting ''1 and multiplied by 100''.

(d) EFFECTIVE DATE.—

(1) VOLUME PERFORMANCE STANDARDS.—The amendments made by subsections (a) and (c) shall apply with respect to volume performance standards established beginning with fiscal year 1995.

(2) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1997.

SEC. 633. PAYMENT FOR PHYSICIANS' SERVICES RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII (42 U.S.C. 1831 et seq.) is amended by inserting after section 1848 the following new section:

''LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS

''SEC. 1849. (a) DEFINITIONS.—In this section, the following definitions apply:

''(1) HOSPITAL.—The term 'hospital' means a subsection (d) hospital as defined in section 1886(d)(1)(B).

''(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

''(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

''(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

''(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

''(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

''(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

''(3) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

''(4) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).

''(b) SERVICES SUBJECT TO REDUCTION.—

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

''(A) the hospital-specific per admission relative value under subsection (c)(2) for the following year; and

''(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (c)(1).

''(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (d)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an indi-

vidual who is a member of the hospital's medical staff.

''(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff of such hospital under paragraph (1).

''(c) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

''(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

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

''(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

''(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

''(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

''(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific per admission

relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

''(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)); and

''(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second calendar year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall deter-

mine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

''(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

''(d) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (b) during a year shall be reduced by 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (b)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

''(e) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

''(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission relative value shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (c)(2)(C)).

''(2) RECONCILIATION WITH REDUCTIONS TAKEN.—

''(A) REIMBURSEMENT.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the

hospital were reduced under this section for a year—

''(i) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (d), including interest at an appropriate rate determined by the Secretary; and

''(ii) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) exceeded the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a

percent of the total amount of payment otherwise determined under this part for physicians' services furnished during the year to inpatients of the hospital by the hospital's medical staff (prior to the reduction under subsection (d)), the difference between 15 percentage points and the actual number of percentage points that the medical staff exceeded the allowable average per admission relative value, including interest at any appropriate rate determined by the Secretary.

''(B) NO REIMBURSEMENT.—The Secretary shall not pay the fiduciary agent for the medical staff of a hospital any amounts by which payments for physicians' services provided by the medical staff were reduced for a year under this section if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) exceeded the allowable average per admission relative value applicable to the hospital's medical staff under subsection (c)(1) for the year by 15 percentage points or more.

''(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have 1 year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate amounts withheld made by the carrier.

''(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(A)(ii) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

''(f) CLAIMS TO BE SUBMITTED NOT LATER THAN 90 DAYS AFTER END OF YEAR.—Notwithstanding any other provision of law, no payment may be made under this part for any physician's service furnished by a mem-

ber of the medical staff of a hospital to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for the payment for such service not later than 90 days after the last day of the year.''.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting ''(subject to reduction under section 1849)'' after ''1848(a)(1)''.

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w–4(a)(1)(B)) is amended by striking ''this subsection,'' and inserting ''this subsection and section 1849,''.

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w–4(g)(4)(A)(i)) is amended by striking ''beneficiary,'' and inserting ''beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 634. CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.

(a) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting ''(1)'' after ''(m)'',

(2) by inserting ''described in paragraph (2)'' after ''physicians' services'',

(3) by striking ''10 percent'' and inserting ''the applicable percent'',

(4) by striking ''service'' the last place it appears and inserting ''services'', and

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

''(2)(A) The applicable percent referred to in paragraph (1) is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d)(2)(D).

''(B) The Secretary shall reduce payments for all services (other than primary care services) for which payment may be made under this section by such percentage as the Secretary determines necessary so that, beginning on the date of the enactment of the Health Security Act, the amendments made by section 634(a) of such Act would not result in expenditures under this section that

exceed the amount of such expenditures that would have been made if such amendment had not been made.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) are effective for services furnished on or after January 1, 1995.

SEC. 635. DEVELOPMENT AND IMPLEMENTATION OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician's service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

(2) REPORT.—The Secretary shall transmit a report by January 1, 1996, on the methodology developed under paragraph (1) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in devel-

oping the methodology and an explanation of the methodology.

(b) IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is amended—

(A) by inserting ''for the service for years before 1997'' before ''equal to'',

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding after and below subclause (II) the following:

''and for years beginning with 1997 based on the relative practice expense resources involved in furnishing the service.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)) is amended by striking ''The practice'' and inserting ''For years before 1997, the practice''.

(3) APPLICATION OF CERTAIN PROVISIONS.—In implementing the amendment made by paragraph (1)(C), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 636. DEMONSTRATION PROJECTS FOR MEDICARE STATE-BASED PERFORMANCE STANDARD RATE OF INCREASE.

Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

''(6) STATE-BASED PERFORMANCE STANDARD RATES OF INCREASE DEMONSTRATION PROJECTS.—The Secretary shall establish demonstration projects in not more than 3 States under which a State elects State-based performance standard rates of increase to substitute for the national performance standard rates of increase established for the year under paragraph (2). The Secretary shall develop criteria for the establishment of such demonstration projects which shall include the requirement of budget-neutrality for payments made under this part with respect to physicians' services furnished in a State participating in the demonstration project.''.

SEC. 637. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: ‘‘, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).’’.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ‘‘of 80 percent’’; and

(2) by striking the period at the end and inserting the following: ‘‘, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after January 1, 1995.

SEC. 638. EYE OR EYE AND EAR HOSPITALS.

Section 1833(i)(4)(A) (42 U.S.C. 1395l(i)(4)(A)) is amended in the matter following clause (iii) by striking ‘‘January 1, 1995’’ and inserting ‘‘September 30, 1997’’.

SEC. 639. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 640. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII is amended by inserting after section 1846 the following:

''COMPETITION ACQUISITION FOR ITEMS AND SERVICES

''SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1995. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall—

''(A) initially be, or be within, metropolitan statistical areas; and

''(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity meets quality standards specified by the Secretary for the furnishing of such item or service.

''(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1)

shall specify (for all of the items and services within a class)—

''(A) the quantity of items and services the entity shall provide; and

''(B) such other terms and conditions as the Secretary may require.

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

''(1) Magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of such tests and scans.

''(2) Oxygen and oxygen equipment.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; or''; and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) where such expenses are for an item or service furnished in a competitive acquisition area

(as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.''.

(c) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to the item or service under part B if the item or service had not been furnished through competitive acquisition under such section, the Secretary shall reduce the payment amount by such percentage as the Secretary determines necessary to result in such a reduction.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished

under part B of title XVIII of the Social Security Act on or after January 1, 1995.

SEC. 641. APPLICATION OF COMPETITIVE ACQUISITION PROCEDURES FOR LABORATORY SERVICES.

(a) IN GENERAL.—Section 1847(c), as added by section 640, is amended by inserting after paragraph (2) the following new paragraph:

''(3) Clinical diagnostic laboratory tests.''.

(b) REDUCTION IN FEE SCHEDULE AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAVINGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7) Notwithstanding any other provision of this subsection, if the Secretary applies the authority provided under section 1847 to establish competitive acquisition areas for the furnishing of clinical diagnostic laboratory tests in a year and the application of such authority does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to such tests under this section if the tests had not been furnished through competitive acquisition under section 1847, the Secretary shall reduce each payment amount otherwise determined under the fee schedules and negotiated rates established under this subsection by such percentage as the

Secretary determines necessary to result in such a reduction.''.

SEC. 642. EXPANDED COVERAGE FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.

(a) COVERAGE IN OUTPATIENT SETTINGS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (II); and

(B) by inserting ''or (IV) in an outpatient setting as defined by the Secretary'' following ''shortage area,''; and

(2) in clause (ii), by striking ''section 1919(a)'' and inserting ''section 1919(a) or in an outpatient setting as defined by the Secretary''.

(b) PAYMENT BASED ON PHYSICIAN FEE SCHEDULE.—

(1) Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended—

(A) by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner and clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)'';

(B) by striking ''for services furnished on or after January 1, 1992,'' and inserting ''for

services described in section 1861(s)(2)(K)(iii) furnished on or after January 1, 1992, and for services described in clauses (i), (ii), and (iv) of section 1861(s)(2)(K) furnished on or after January 1, 1997,''; and

(C) by striking ''subsection (r)(2)'' and inserting ''subsection (r)(2) or subparagraph (A) or (B) of section 1842(b)(12)''.

(2) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended—

(A) by striking ''and'' at the end of clause (i);

(B) in clause (ii) in the matter preceding subclause (I), by striking ''the prevailing'' and inserting ''for services furnished before January 1, 1997, the prevailing'';

(C) by striking the period at the end of clause (ii)(II) and inserting ''; and''; and

(D) by inserting at the end the following clause:

''(iii) in the case of services furnished on or after January 1, 1997, the fee schedule amount shall be equal to—

''(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistance at surgery,

''(II) in the case of services performed (other than as an assistant at surgery) in a hospital, 75 percent of the fee schedule amount specified under section 1848, and

''(III) in the case of other services, 85 percent of the fee schedule amount specified under section 1848.

(c) RURAL NURSE PRACTITIONERS AS ASSISTANTS AT SURGERY IN URBAN AREAS.—Section 1861(s)(2)(K)(ii) (42 U.S.C. 1395x(s)(2)(K)(ii)), as amended by subsection (a)(2), is further amended by adding ''or services as an assistant at surgery furnished by a nurse practitioner whose primary practice location (as defined by the Secretary) is in a rural area (as defined in section 1886(d)(2)(D)) to an individual who resides in a rural area when the service is furnished to such individual in an urban area by such practitioner when such practitioner refers such individual to an urban area for the

furnishing of services'' after ''as defined by the Secretary''.

(d) CONFORMING AMENDMENTS.—

(1) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''subsection (s)(2)(K)(i)'' and inserting ''subsection (s)(2)(K)''.

(2) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)), as amended by section 620(b)(4)(K), is amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(3) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)), as amended by section 620(b)(4)(L)(ii), is further amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1997.

SEC. 643. GENERAL PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''and prior to January 1999''; and

(2) in paragraph (2), by striking ''prior to January 1998''.

PART IV—PROVISIONS RELATED TO PARTS A AND B

SEC. 651. MEDICARE SECONDARY PAYER CHANGES.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking ''SUNSET'' and inserting ''EFFECTIVE DATE''; and

(2) by striking '', and before October 1, 1998''.

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking ''and on or before October 1, 1998,''.

SEC. 652. MODIFICATION TO PHYSICIAN REFERRAL EXCEPTION.

Section 1877(d) (42 U.S.C. 1395nn(d)) is amended by adding the following new paragraph:

''(4) FRONTIER PROVIDERS.—In the case of a designated health service furnished in an urban area

(as defined in section 1886(d)(2)(D)) by an entity if—

''(A) the entity is located more than 100 miles from other like entities;

''(B) no less than 50 percent of the patient-users in the entity's service area utilize the entity; or

''(C) because of the area's local topography or periods of prolonged severe weather conditions, other entities providing like services are not readily accessible for at least 30 days in 2 out of 3 years.''.

SEC. 653. EXPANSION OF CENTERS OF EXCELLENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall use a competitive process to contract with centers of excellence for cataract surgery and coronary artery by-pass surgery. Payment under title XVIII of the Social Security Act will be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(1) The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D) of the Social Security Act) for years beginning with fiscal year 1995.

(2) The amount of payment made by the Secretary to the center under title XVIII of the Social Security Act for services covered under the contract shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the contract not been in effect.

(3) The Secretary shall make payments to the center on such a basis for the following services furnished to individuals entitled to benefits under such title:

(A) Facility, professional, and related services relating to cataract surgery.

(B) Coronary artery bypass surgery and related services.

(b) REBATE OF PORTION OF SAVINGS.—In the case of any services provided under a contract conducted under subsection (a), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which—

(1) the amount of payment that would have been made by the Secretary under title XVIII of the Social Security Act to the center for such services if

the services had not been provided under the contract, exceeds

(2) the amount of payment made by the Secretary under such title to the center for such services.

SEC. 654. MEDICARE SELECT.

(a) AMENDMENTS TO PROVISIONS RELATING TO MEDICARE SELECT POLICIES.—

(1) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 is hereby repealed.

(2) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the requirements of the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those requirements if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition

and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except

in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(b) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) In the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy; except that, if such individual moves to a geographic area where such issuer, or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or

affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(ii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I); and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(d) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in

paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1995 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 9-month period specified in paragraph (1), the Secretary of Health and Human Services (hereafter in this subsection referred to as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1995 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1995 NAIC Model Regulation or the 1995 Federal Regulation, or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

ary 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 655. MEDIGAP.

(a) 30-DAY OPEN ENROLLMENT PERIOD.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''paragraph (1), (2), or (3)'',

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

''(3) Each issuer of a medicare supplemental policy shall have an open enrollment period of at least 30 days duration every year (which shall be the period specified by the Secretary under section 1876(e)(1)), during which the issuer may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of age, health status, claims experience, receipt of health care, or medical condition. The policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination

periods, and probationary periods (except as provided by paragraph (2)(B)).''.

(b) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1995 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 9-month period specified in paragraph (1), the Secretary of Health and Human Services (hereafter in this subsection re-

ferred to as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1995 Federal Regulation'').

SEC. 656. REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

(a) REDUCTION IN UPDATE TO MAINTAIN FREEZE IN 1996.—

(1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(A) in subclause (II), by striking ''or'' at the end;

(B) in subclause (III), by striking ''112 percent,'' and inserting ''and before July 1, 1996, 112 percent, or''; and

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

''(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),''.

(2) ADJUSTMENT TO LIMITS.—Section 1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) is amended by adding at the end the following new sentence: ''The effect of the amendments made by 656(a) of the Health Security Act shall not be considered by the Secretary in making adjustments pursuant to this clause.''.

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

(1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection (a), is amended in the matter following subclause (IV) by striking ''the mean'' and inserting ''the median''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 1997.

SEC. 657. TERMINATION OF GRADUATE MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

''(6) TERMINATION OF PAYMENTS ATTRIBUTABLE TO COSTS OF TRAINING PHYSICIANS.—Notwithstanding any other provision of this section or section 1861(v), no payment may be made under this title for direct graduate medical education costs attributable to an approved medical residency training program for any cost reporting period (or portion thereof) beginning on or after January 1, 1996.''.

(b) PROHIBITION AGAINST RECOGNITION OF COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 612(b), is amended by adding at the end the following new subparagraph:

''(U) Such regulations shall not include any provision for specific recognition of the costs of graduate medical education for hospitals for any cost reporting period (or portion thereof) beginning on or after January 1, 1996. Nothing in the previous sentence shall be construed to affect in any way payments to hospitals for the costs of any approved educational activities that are not described in such sentence.''.

SEC. 658. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATIONS.

Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 4207(b)(4)(B) of the Omnibus Budget Reconciliation Act of 1990 and section 13567(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) in paragraph (1), by striking ''December 31, 1997'' and inserting ''December 31, 1999''; and

(2) in paragraph (4), by striking ''March 31, 1998'' and inserting ''March 31, 2000''.

SEC. 659. STUDY ON MEDICARE SPENDING.

The Prospective Payment Assessment Commission (established under section 1886(e)(2) of the Social Security Act (42 U.S.C. 1395ww(e)(2))) and the Physician Payment Review Commission (established under section 1845 of such Act (42 U.S.C. 1395w–1)) shall each conduct a study of the rate of increase in spending under title XVIII of such Act and make recommendations to Congress on strategies to slow the rate of growth. Such studies shall include—

(1) an examination of ways to slow both the national rate of growth and the rate of growth in community-rating areas; and

(2) an assessment of whether setting local expenditure targets or local volume performance standards would be successful as part of this effort.

SEC. 660. STREAMLINED PROCESSING SYSTEMS.

(a) IN GENERAL.—The Secretary of Health and Human Services may develop a process to ensure that claims for services under title XVIII of the such Act are submitted first by the medicare program under such title, medicare supplemental policies (described in section 1886(g)(1) of such Act (42 U.S.C. 1395ww(g)(1)), and other policies that provide supplemental benefits under such title before providers can submit claims to medicare beneficiaries.

(b) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (42 U.S.C. 1395h and 1395u) (including provider nominating provisions in such section 1816 of such Act) are superseded to the extent required to carry out this section.

Subtitle B—Medical Education

SEC. 665. MEDICAL EDUCATION.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new part:

"PART D—MEDICAL EDUCATION

"Subpart I—Approved Physician and Dental Training Programs

"SEC. 1893. APPROVED PHYSICIAN AND DENTAL TRAINING PROGRAMS.

''(a) FEDERAL PAYMENTS TO QUALIFIED APPLICANTS.—

''(1) IN GENERAL.—In the case of a qualified applicant that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the applicant for the purpose specified in paragraph (3). The Secretary shall make the payments in an amount determined in accordance with subsection (b) and may administer the payments as a contract, grant, or cooperative agreement.

''(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments under such paragraph for a calendar year is in accordance with this paragraph if—

''(A) the qualified applicant submits the application not later than the date specified by the Secretary;

''(B) the application provides such assurances as the Secretary may require that the

qualified applicant will expend payments only for the purpose described in paragraph (3); and

''(C) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(3) PAYMENTS FOR OPERATION OF APPROVED MEDICAL TRAINING PROGRAMS.—The purpose of payments under paragraph (1) is to assist each approved medical training program operated by the qualified applicant with the costs of operation of such programs.

''(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.—

''(1) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in section 1896, the following amounts shall be available for a calendar year for making payments under subsection (a) from the Graduate Medical and Nursing Education Trust Fund established under section 9552(a)(2)(A) of the Internal Revenue Code of 1986:

''(A) In the case of calendar year 1996, $3,200,000,000.

''(B) In the case of calendar year 1997, $3,550,000,000.

''(C) In the case of calendar year 1998, $5,800,000,000.

''(D) In the case of each subsequent calendar year, the amount specified in this paragraph in the previous calendar year (without regard to any reduction of such amount under section 1896) updated through the midpoint of the year by the estimated percentage change in the general health care inflation factor during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected health care inflation factor.

''(2) AMOUNT OF PAYMENTS FOR QUALIFIED APPLICANTS.—

''(A) IN GENERAL.—Subject to the annual amount available under paragraph (1) for a calendar year, the amount of payments required under subsection (a) to be made to a qualified applicant that submits to the Secretary an application for such year in accordance with sub-

section (a)(2) is an amount equal to the product of—

''(i) the number of full-time equivalent training participants in the approved medical training program operated by the qualified applicant (as determined under subsection (c)); and

''(ii) the average costs of the qualified applicant in training such a participant in a calendar year for the base period, updated through the midpoint of the year by the estimated percentage change in the health care inflation factor after the base period and up to and including the calendar year involved.

For purposes of clause (ii), the term 'base period' means the most recent 2-year period for which the Secretary can determine the training costs of the qualified applicant. If the qualified applicant has not been in operation for sufficient time to have a base period, the amount determined under clause (ii) for such applicant shall be the national average costs of all qualified applicants operating the approved medical training program for the most recent 2-year pe-

riod (as determined by the Secretary), updated in accordance with clause (ii).

''(3) LIMITATION.—If the annual amount available under paragraph (1) for a calendar year is insufficient for providing each qualified applicant that submits to the Secretary an application for such year in accordance with subsection (a)(2) with the amount of payments determined under paragraph (2) for the program for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under subsection (a) for such year equals the total of such amount.

''(c) DETERMINATION OF FULL-TIME-EQUIVALENT TRAINING PARTICIPANTS.—

''(1) RULES.—The Secretary shall establish rules consistent with this subsection for the computation of the number of full-time-equivalent training participants in approved medical training programs.

''(2) ADJUSTMENT FOR PART-YEAR OR PART-TIME TRAINING PARTICIPANTS.—Such rules shall take into account individuals who serve as training participants for only a portion of a period in an ap-

proved medical training program or simultaneously with more than one such program.

''(3) WEIGHTING FACTORS FOR CERTAIN TRAINING PARTICIPANTS.—Subject to paragraph (4), such rules shall provide, in calculating the number of full-time-equivalent training participants in an approved medical training program—

''(A) for a training participant who is in the participant's initial training period, the weighting factor is 1.00, and

''(B) for a training participant who is not in the participant's initial training period, the weighting factor is .50.

''(4) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—Such rules shall provide that, in the case of an individual who is a foreign medical graduate, the individual shall not be counted as a training participant unless—

''(A) the individual has passed the FMGEMS examination, or

''(B) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

''(5) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a training participant under an approved physician training program or approved dental training program shall be counted toward the determination of full-time equivalency, without regard to the setting in which the activities are performed.

''(d) DEFINITIONS.—For purposes of this section—

''(1) APPROVED DENTAL TRAINING PROGRAM.—The term 'approved dental training program' means—

''(A) an internship, residency, or fellowship program that is accredited by the Commission on Dental Accreditation, or

''(B) a post-doctoral dental training program in oral medicine, oral radiology, dental anesthesia, or geriatric dentistry, that is determined by the Secretary to meet appropriate standards.

''(2) APPROVED MEDICAL TRAINING PROGRAM.—the term 'approved medical training program' means an approved physician training pro-

gram, an approved dental training program, or an approved podiatric training program.

''(3) APPROVED PHYSICIAN TRAINING PROGRAM.—

''(A) IN GENERAL.—The term 'approved physician training program', with respect to the medical speciality involved, means a residency or other postgraduate program that trains physicians and meets the following conditions:

''(i) Participation in the program may be counted toward certification in the medical specialty.

''(ii) The program is accredited by the Accreditation Council on Graduate Medical Education, or approved by the Council on Postgraduate Training of the American Osteopathic Association.

''(B) TRAINING IN OUTPATIENT FACILITIES.—The term 'approved physician training program' includes any postgraduate program described in subparagraph (A) that provides health services in an ambulatory setting, without regard to whether the program provides inpatient hospital services.

''(C) NONHOSPITAL TRAINING ENTITIES INCLUDED.—The term 'approved physician training program' includes any postgraduate program described in subparagraph (A), whether operated by academic health centers, teaching hospitals, multispecialty group practices, ambulatory care providers, prepaid health plans, or other entities.

''(4) APPROVED PODIATRIC TRAINING PROGRAM.—The term 'approved podiatric training program' includes a training program approved by the Council of Podiatric Medical Education of the American Podiatric Medical Association.

''(5) FOREIGN MEDICAL GRADUATE.—The term 'foreign medical graduate' means a training participant who is a graduate of a school of medicine, school of osteopathy, school of dentistry, or school of podiatry that is not—

''(A) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

''(B) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

''(C) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

''(6) FMGEMS EXAMINATION.—The term 'FMGEMS examination' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

''(7) GENERAL HEALTH CARE INFLATION FACTOR.—The term 'general health care inflation factor' means the consumer price index for medical services as determined by the Bureau of Labor Statistics.

''(8) INITIAL TRAINING PERIOD.—The term 'initial training period' means the period of board eligibility, except that—

''(A) except as provided in subparagraph (B), in no case shall the initial period of participation exceed an aggregate period of formal training of more than five years for any individual, and

''(B) a period, of not more than two years, during which an individual is in a—

''(i) joint M.D. and Ph.D. program of study or research as meets such criteria as the Secretary may establish;

''(ii) residency or fellowship program in geriatric medicine, preventive medicine, or adolescent medicine; or

''(iii) a primary care fellowship program which meets such criteria as the Secretary may establish,

shall be treated as part of the initial training participation period, but shall not be counted against any limitation on the initial training period.

The initial training period shall be determined, with respect to a training participant, as of the time the training participant enters the approved medical training program.

''(9) PERIOD OF BOARD ELIGIBILITY.—

''(A) GENERAL RULE.—Subject to subparagraphs (B) and (C), the term 'period of board eligibility' means, for a training participant, the minimum number of years of formal training necessary to satisfy the requirements

for initial board eligibility in the particular specialty for which the training participant is training.

''(B) APPLICATION OF 1985–1986 DIRECTORY.—Except as provided in subparagraph (C), the period of board eligibility shall be such period specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

''(C) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—If the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs.—

''(i) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985-1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

''(ii) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty,

below the period specified in its 1985-1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

''(10) QUALIFIED APPLICANT.—The term 'qualified applicant' means an entity that operates an approved medical training program.

''(11) TRAINING PARTICIPANT.—The term 'training participant' means an individual who is enrolled in an approved medical training program.

"SEC. 1894. GRADUATE NURSING EDUCATION PAYMENTS

''(a) FEDERAL PAYMENTS TO GRADUATE NURSE TRAINING PROGRAMS.—

''(1) IN GENERAL.—In the case of a graduate nurse training program that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the program for the purpose specified in paragraph (3). The Secretary shall make the payments in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

''(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments under such paragraph for a calendar year is in accordance with this paragraph if—

''(A) the graduate nurse training program involved submits the application not later than the date specified by the Secretary;

''(B) the application provides such assurances as the Secretary may require that the program will expend payments only for the purpose described in paragraph (3); and

''(C) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(3) PAYMENTS FOR OPERATION OF GRADUATE NURSE TRAINING PROGRAMS.—The purpose of payments under paragraph (1) is to assist a graduate nurse training program with the costs of operation.

''(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.—

''(1) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in section 1896, the following amounts shall be available for a calendar year

for making payments under subsection (a) from the Graduate Medical and Nursing Education Trust Fund established under section 9552(a)(2)(A) of the Internal Revenue Code of 1986:

''(A) In the case of calendar year 1996, $200,000,000.

''(B) In the case of each subsequent calendar year, the amount specified in this paragraph in the previous calendar year (without regard to any reduction of such amount under section 1896) updated through the midpoint of the year by the estimated percentage change in the general health care inflation factor during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected health care inflation factor.

''(2) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE PROGRAMS.—Subject to the annual amount available under paragraph (1) for a calendar year, the amount of payments required under subsection (a) to be made to a graduate nurse training program that submits to the Secretary an applica-

tion for such year in accordance with subsection (a)(2) is an amount equal to the product of—

''(A) the number of full-time equivalent training participants in the program determined in accordance with paragraph (3); and

''(B) the national average per participant cost of all graduate nurse training programs for the most recent 2-year period (as determined by the Secretary), adjusted for geography and other factors to be determined by the Secretary and updated through the midpoint of the year by the estimated percentage change in the health care inflation factor after the base period up to and including the calendar year involved.

''(3) DETERMINATION OF FULL-TIME EQUIVALENT TRAINING PARTICIPANTS.—The Secretary shall develop a method for determining full-time equivalent training participants in graduate nurse training programs for purposes of determining payments under this section.

''(4) LIMITATION.—If the annual amount available under paragraph (1) for a calendar year is insufficient for providing each graduate nurse training program that submits to the Secretary an application for such year in accordance with subsection

(a)(2) with the amount of payments determined under paragraph (2) for the program for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under subsection (a) for such year equals the total of such amount.

''(c) DEFINITIONS.—For purposes of this section—

''(1) GRADUATE NURSE TRAINING PROGRAM.—The term 'graduate nurse training program' means a program for advanced nurse education, a program for education as a nurse practitioner, a program for education as a nurse midwife, a program for education as a nurse anesthetist, and such other programs for training in clinical nurse specialties as are determined by the Secretary to require advanced education.

''(2) PROGRAM FOR ADVANCED NURSE EDUCATION.—The term 'program for advanced nurse education' means a program meeting the conditions to be a program for which awards of grants and contracts may be made under section 821 of the Public Health Service Act.

''(3) PROGRAM FOR EDUCATION AS NURSE PRACTITIONER.—The term 'program for education

as a nurse practitioner' means a program meeting the conditions to be a program for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as a nurse practitioners.

''(4) PROGRAM FOR EDUCATION AS NURSE MIDWIFE.—The term 'program for education as a nurse midwife'' means a program meeting the conditions to be a program for which awards of grants and contracts may be made under section 822 of the Public Health Service Act for education as nurse midwives.

''(5) PROGRAM FOR EDUCATION AS NURSE ANESTHETIST.—The term 'program for education as a nurse anesthetist' means a program meeting the conditions to be a program for which awards of grants may be made under section 831 of the Public Health Service Act for education as nurse anesthetists.

''(6) GENERAL HEALTH CARE INFLATION FACTOR.—The term 'general health care inflation factor', has the meaning given such term in section 1893(d)(7) for such year.

"SEC. 1895. MEDICAL SCHOOL PAYMENTS.

''(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS.—

''(1) IN GENERAL.—In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the program for the purpose specified in paragraph (3). The Secretary shall make the payments in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

''(2) APPLICATION FOR PAYMENTS.—For purposes of paragraph (1), an application for payments under such paragraph for a calendar year is in accordance with this paragraph if—

''(A) the medical school involved submits the application not later than the date specified by the Secretary; and

''(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(3) PURPOSE OF PAYMENTS.—The purpose of payments under paragraph (1) is to assist a medical school with the costs associated with the transition

to managed competition and expanded ambulatory teaching services.

''(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.—

''(1) AVAILABILITY OF TRUST FUND FOR PAYMENTS.—Except as provided in section 1896, the following amounts shall be available for a calendar year for making payments under subsection (a) from the Graduate Medical and Nursing Education Trust Fund established under section 9552(a)(2)(A) of the Internal Revenue Code of 1986:

''(A) In the case of calendar year 1996, $200,000,000.

''(B) In the case of calendar year 1997, $300,000,000.

''(C) In the case of calendar year 1998, $400,000,000.

''(D) In the case of calendar year 1999, $500,000,000.

''(E) In the case of calendar year 2000, $600,000,000.

''(F) In the case of each subsequent calendar year, the amount specified in this paragraph in the previous calendar year (without regard to any reduction of such amount under

section 1896) updated through the midpoint of the year by the estimated percentage change in the general health care inflation factor (as defined in section 1893(d)(7)) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected health care inflation factor.

''(2) AMOUNT OF PAYMENTS FOR MEDICAL SCHOOLS.—

''(A) IN GENERAL.—Subject to the annual amount available under paragraph (1) for a calendar year, the amount of payments required under subsection (a) to be made to a medical school that submits to the Secretary an application for such year in accordance with subsection (a)(2) is an amount equal to an amount determined by the Secretary in accordance with subparagraph (B).

''(B) DEVELOPMENT OF FORMULA.—The Secretary shall develop a formula for allocation of funds to medical schools under this section consistent with the purpose described in subsection (a)(3).

''(c) LIMITATION.—If the annual amount available under subsection (b) for a calendar year is insufficient for providing each medical school that submits to the Secretary an application for such year in accordance with subsection (a)(2) with the amount of payments determined under subsection (b)(2) for the program for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under subsection (a) for such year equals the total of such amount.

''(d) MEDICAL SCHOOL DEFINED.—For purposes of this section, the term 'medical school' means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

"**SEC. 1896. AMOUNTS IN TRUST FUND INSUFFICIENT.**

''If the sum of the amounts specified in sections 1893(b)(1), 1894(b)(1), and 1895(b)(1) for a calendar year exceeds the amounts available for such calendar year in the Graduate Medical Education and Nursing Trust Fund established under section 9552(a)(2)(A) of the Internal Revenue Code of 1986, then each such amount shall be reduced to an amount which bears the same ratio to such amount as the amounts available bear to the sum of such amounts.

"Subpart II—Academic Health Centers and Other Eligible Institutions

"SEC. 1897. ACADEMIC HEALTH CENTERS AND OTHER ELIGIBLE INSTITUTIONS.

''(a) FEDERAL PAYMENTS TO ACADEMIC HEALTH CENTERS AND OTHER ELIGIBLE INSTITUTIONS.—

''(1) IN GENERAL.—In the case of an eligible institution, that in accordance with paragraph (2) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year, the Secretary shall make payments for such year to the institution for the purposes specified in paragraph (3). The Secretary shall make the payments in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

''(2) APPLICATION.—For purposes of paragraph (1), an application for payments under such paragraph for a calendar year is in accordance with this paragraph if—

''(A) the eligible institution involved submits the application at such time, in such manner, and accompanied by such agreements, and information as the Secretary may determine necessary to carry out this section; and

''(B) such application is accompanied by—

''(i) an assurance that, in exchange for receiving payments under paragraph (1), the eligible institution shall agree to maintain its status as an eligible institution; and

''(ii) such additional assurances as the Secretary may reasonably require consistent with the purposes of this section.

''(3) PAYMENT FOR COSTS INCURRED BY ELIGIBLE INSTITUTIONS.—

''(A) NON-COMPARABLE COSTS OF ACADEMIC HEALTH CENTERS AND OTHER TEACHING HOSPITALS.—With respect to an eligible institution that is a qualified academic health center or a qualified teaching hospital, the purpose of payments under paragraph (1) is to assist such institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred by such institutions in providing health services. Such costs include—

''(i) with respect to productivity in the provision of health services, costs resulting from the reduced rate of productivity of faculty due to teaching responsibilities;

''(ii) the uncompensated costs of clinical research;

''(iii) exceptional costs associated with the treatment of health conditions with respect to which an eligible institution has specialized expertise (including treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care); and

''(iv) the costs of treating a substantial number of severely ill patients.

''(B) OTHER COSTS.—With respect to—

''(i) an eligible institution that is a school of dentistry, the purpose of payments under paragraph (1) is to assist such school with the costs of training dentists, including unreimbursed oral health care costs; and

''(ii) an eligible institution that is a high intensity nonteaching rural hospital, the purpose of payments under paragraph (1) is to assist the institution with the costs described under subparagraph (A)(iv).

''(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.—

''(1) AVAILABILITY OF FUNDS FROM TRUST FUND.—Except as provided in subsection (e), the following amounts shall be available for a calendar year for making payments under subsection (a) from the Academic Health Center Trust Fund established under section 9552(a)(2)(B) of the Internal Revenue Code of 1986:

''(A) In the case of calendar year 1996, $6,280,000,000.

''(B) In the case of calendar year 1997, $7,250,000,000.

''(C) In the case of calendar year 1998, $8,220,000,000.

''(D) In the case of calendar year 1999, $9,400,000,000.

''(E) In the case of calendar year 2000, $10,640,000,000.

''(F) In the case of each subsequent calendar year, the amount specified in this paragraph in the previous calendar year (without regard to any reduction of such amount under subsection (e)) updated through the midpoint of the year by the estimated percentage change in

the general health care inflation factor (as defined in section 1893(d)(7)) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected health care inflation factor.

''(2) SPECIAL ALLOTMENTS.—Of the amounts available for a calendar year for making payments under subsection (a) pursuant to paragraph (1)—

''(A) such amounts as are necessary shall be reserved to make payments to eligible institutions that are high intensity nonteaching rural hospitals; and

''(B) after reserving the amounts described in subparagraph (A), the following amounts shall be reserved to make payments to eligible institutions that are schools of dentistry:

''(i) In the case of calendar year 1996, $50,000,000.

''(ii) In the case of each subsequent calendar year, the amount specified in this subparagraph for the previous calendar year updated through the midpoint of the year by the estimated percentage change in

the general health care inflation factor during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected health care inflation factor.

''(3) AMOUNT OF PAYMENTS FOR ELIGIBLE INSTITUTIONS.—

''(A) QUALIFIED ACADEMIC HEALTH CENTER OR QUALIFIED TEACHING HOSPITAL.—Subject to the annual amount available under paragraphs (1) and (2) for a calendar year, the amount of payments required under subsection (a) to be made to a qualified academic health center or qualified teaching hospital is an amount equal to—

''(i) the inpatient costs of the qualified academic health center or qualified teaching hospital for furnishing patient care for all patients for the calendar year, multiplied by

''(ii) (e raised to the power (.405 x r)–1), where 'r' is the ratio of the qualified academic health center's or the qualified teaching hospital's full-time equivalent

training participants (as determined under section 1893(c)) to beds for such center or institution for the calendar year and 'e' is the natural log of one.

''(B) SCHOOL OF DENTISTRY.—Subject to the annual amount available under paragraphs (1) and (2) for a calendar year, the amount required under subsection (a) to be made to a school of dentistry is an amount equal to the sum of—

''(i) 75 percent of the amount available pursuant to paragraph (2)(B) multiplied by the ratio of the number of full-time equivalent training participants in the school of dentistry (determined in accordance with a method to be developed by the Secretary) to the national number of full-time equivalent training participants in all schools of dentistry (as determined by the Secretary); and

''(ii) 25 percent of the amount available pursuant to paragraph (2)(B) multiplied by the ratio of the unreimbursed oral health care costs of the school of dentistry to the national unreimbursed oral health

care costs of all schools of dentistry (as determined by the Secretary).

''(C) HIGH INTENSITY NONTEACHING RURAL HOSPITAL.—Subject to the annual amount available under paragraphs (1) and (2) for a calendar year, the amount required under subsection (a) to be made to a high intensity nonteaching rural hospital is an amount equal to 5 percent of the inpatient costs of patient care for all patients of the hospital.

''(4) LIMITATION.—If the annual amount available under paragraph (1) for a calendar year is insufficient for providing each eligible institution that submits to the Secretary an application for such year in accordance with subsection (a)(2) with the amount of payments determined under paragraph (3) for the institution for such year or is in excess of the amount required for making such payments for such year, the Secretary shall make such pro rata reductions or increases in the amounts so determined as may be necessary to ensure that the total of payments made under subsection (a) for such year equals the total of such amount.

''(c) REPORT ON MODIFICATIONS IN FORMULA.—Not later than July 1, 1996, the Secretary shall submit

to the Congress a report containing any recommendations of the Secretary regarding policies for allocating amounts under subsection (b)(3) among eligible institutions. In making such recommendations, the Secretary shall consider the costs described in subsection (a)(3) (including outpatient costs) that are incurred by such institutions.

''(d) DEFINITIONS.—For purposes of this section:

''(1) QUALIFIED ACADEMIC HEALTH CENTER.—The term 'qualified academic health center' means an entity that—

Subtitle C—Home and Community-Based Services

SEC. 667. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 301, is amended by adding at the end the following new part:

"PART C—STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

"SEC. 1971. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

''(a) IN GENERAL.—Each State that has a plan for home and community-based services for individuals with disabilities submitted to and approved by the Secretary under section 1972(b) is entitled to payment in accordance with section 1978.

''(b) ENTITLEMENT TO SERVICES.—Nothing in this part shall be construed to create a right to services for individuals or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled under this part.

''(c) DESIGNATION OF AGENCY.—Not later than 6 months after the date of enactment of this part, the Secretary shall designate an agency responsible for program administration under this part.

"SEC. 1972. STATE PLANS.

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

''(1) ELIGIBILITY.—

''(A) IN GENERAL.—Within the amounts provided by the State and under section 1978 for such plan, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 1973(a)) in the State.

''(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of an individual who has some reasonable probability of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to apply. The initial screening and the determination of disability (as defined under section 1973(b)(1)) shall be conducted by a public agency.

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

''(i) income,

''(ii) age,

''(iii) geography,

''(iv) nature or category of disability,

''(v) residential setting (other than an institutional setting), or

''(vi) other grounds specified by the Secretary;

except that the Secretary may permit a State to limit eligibility based on level of disability.

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

''(2) SERVICES.—

''(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities in a format required by the Secretary. The needs assessment shall

include demographic data concerning the number of individuals within each category of disability described in this part, and the services available to meet the needs of such individuals.

''(B) SPECIFICATION.—Consistent with section 1974, the plan shall specify—

''(i) the services made available under the plan,

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

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

''(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care.

''(D) ALLOCATION.—The State plan—

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

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

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

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

''(v) shall ensure that—

''(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than,

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

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

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

''(3) COST SHARING.—The plan shall impose cost sharing with respect to covered services in accordance with section 1975.

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

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

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

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

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

''(5) PROVIDER REIMBURSEMENT.—

''(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment to consumer-directed providers of personal assistance services, including payment through the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

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

''(i) agency administered services furnished under the plan; and

''(ii) consumer-directed personal assistance services furnished under the plan, including cash payments or vouchers to individuals with disabilities, except that such payments shall be adequate to cover amounts required under applicable employment tax and health care coverage provisions.

''(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted or provided for under section 1975 as payment in full for services furnished under the plan.

''(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 1976.

''(8) ADVISORY GROUP.—The State plan shall—

''(A) assure the establishment and maintenance of an advisory group under section 1977(b), and

''(B) include the documentation prepared by the group under section 1977(b)(4).

''(9) ADMINISTRATION AND ACCESS.—

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

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

''(i) coordinate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this part with the State medicaid plan, titles V and XX, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or

assistance targeted to individuals with disabilities, and

''(ii) coordinate with health plans.

''(C) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2003, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

''(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

''(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this part, including the processing of claims under the plan, and

''(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

''(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this part according to specified performance standards. States that fail to comply with such requirements may be subject to the withholding of Federal funds for services or administration until such time as compliance is achieved.

''(d) TECHNICAL ASSISTANCE.—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include

serving as a clearinghouse for information regarding successful practices in providing long-term care services.

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

"SEC. 1973. INDIVIDUALS WITH DISABILITIES DEFINED.

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

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

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

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

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

''(A) whose score, on a standard mental status protocol (or protocols) appropriate for measuring the individual's particular condition

specified by the Secretary, indicates either severe cognitive impairment or severe mental impairment, or both;

''(B) who—

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

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

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

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

Not later than 2 years after the date of enactment of this part, the Secretary shall make recommenda-

tions regarding the most appropriate duration of disability under this paragraph.

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

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

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

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

''(b) DETERMINATION.—

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

an individual is an individual with disabilities shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this part and by using a uniform protocol consisting of an initial screening and a determination of disability specified by the Secretary. A State may not impose cost sharing with respect to a determination of disability. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 1974(b) or for other purposes.

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

''(c) ELIGIBILITY CRITERIA.—The Secretary shall reassess the validity of the eligibility criteria described in

subsection (a) as new knowledge regarding the assessments of functional disabilities becomes available. The Secretary shall report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on its findings under the preceding sentence as determined appropriate by the Secretary.

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

"SEC. 1974. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

''(a) SPECIFICATION.—

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

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

''(B) any limits with respect to such services.

''(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(2), such services

may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

''(b) REQUIREMENT FOR CARE MANAGEMENT.—

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

''(A) a comprehensive assessment of the individual's need for home and community-based services (regardless of whether all needed services are available under the plan),

''(B) an individualized plan of care based on such assessment,

''(C) arrangements for the provision of such services, and

''(D) monitoring of the delivery of services.

''(2) CARE MANAGEMENT SERVICES.—

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

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

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

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

''(3) COMPREHENSIVE ASSESSMENTS.—The Secretary shall develop a uniform comprehensive assessment tool that shall be used by the States under paragraph (1)(A). Alternative comprehensive assessment tools may be used by the States only with the approval of the Secretary. The Secretary shall provide guidance to the States with regard to the appropriate qualifications for individuals who conduct comprehensive assessments.

''(4) INDIVIDUALIZED PLAN OF CARE.—

''(A) IN GENERAL.—The plan of care under paragraph (1)(B) shall—

''(i) specify which services included under the individual plan will be provided under the State plan under this part,

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

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

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

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

''(B) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under paragraph (1)(B) for an individual with disabilities shall—

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

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

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

''(c) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (g)).

''(d) ADDITIONAL SERVICES.—

''(1) TYPES OF SERVICES.—Subject to subsection (e), services available under a State plan under this part may include any (or all) of the following:

''(A) Homemaker and chore assistance.

''(B) Home modifications.

''(C) Respite services.

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

''(E) Adult day services.

''(F) Habilitation and rehabilitation.

''(G) Supported employment.

''(H) Home health services.

''(I) Transportation.

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

''(2) CRITERIA FOR SELECTION OF SERVICES.—The State electing services under paragraph (1) shall specify in the State plan—

''(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to each category of individuals with disabilities, and

''(B) how the types, and the amount, duration, and scope, of services specified, within the limits of available funding, provide substantial assistance in living independently to individuals

within each of the categories of individuals with disabilities.

''(e) EXCLUSIONS AND LIMITATIONS.—

''(1) IN GENERAL.—A State plan may not provide for coverage of—

''(A) room and board,

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

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

''(D) the services described in paragraph (2) with respect to an individual who is eligible for medical assistance consisting of such services under the State plan under part A.

''(2) MEDICAID SERVICES DESCRIBED.—The services described in this paragraph are the following:

''(A) Personal care services (as described in section 1905(a)(24)).

''(B) Private duty nursing services (as referred to in section 1905(a)(8)).

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

''(D) Home and community care furnished to functionally disabled elderly individuals under section 1929.

''(E) Community supported living arrangements services under section 1930.

''(F) Case-management services (as described in section 1915(g)(2)).

''(G) Home health care services (as referred to in section 1905(a)(7)).

''(H) Clinic services and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in subparagraph (F).

''(3) STATE MAINTENANCE OF EFFORT REGARDING MEDICAID ELIGIBILITY AND COVERED SERVICES.—

''(A) IN GENERAL.—A State plan under this part shall provide that the State will, during the time that the State is furnishing home and community-based services under this part, continue to make available under the State plan

under part A to the classes or categories of individuals described in subparagraph (B) any of the services described in paragraph (2) that were available to such classes or categories of individuals during the fiscal year immediately preceding the fiscal year in which the State first submits a State plan for approval under this part.

''(B) CLASSES OR CATEGORIES OF INDIVIDUALS.—The classes or categories of individuals described in this subparagraph are any classes or categories of individuals who were eligible for medical assistance consisting of any of the services described in paragraph (2) during the fiscal year immediately preceding the fiscal year in which the State first submits a State plan for approval under this part.

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

''(1) vouchers,

''(2) cash payments directly to individuals with disabilities,

''(3) capitation payments to health plans, and

''(4) payment to providers.

''(g) PERSONAL ASSISTANCE SERVICES.—

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

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

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

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

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

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

''(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

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

''SEC. 1975. COST SHARING.

''(a) NO COST SHARING FOR POOREST.—

''(1) IN GENERAL.—The State plan may not impose any cost sharing for individuals with income

(as determined under subsection (d)) less than 125 percent of the official poverty level (referred to in paragraph (2)) applicable to a family of the size involved.

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

''(b) SLIDING SCALE FOR REMAINDER.—

''(1) REQUIRED COINSURANCE.—The State plan shall impose cost sharing in the form of coinsurance (based on the amount paid under the State plan for a service)—

''(A) at a rate of 10 percent for individuals with disabilities with income not less than 125 percent, and less than 175 percent, of such official poverty line (as so applied);

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

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

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

''(E) at a rate of 35 percent for such individuals with income equal to at least 325 percent of such official poverty line (as so applied).

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

''(A) of $100 for individuals with disabilities with income not less than 125 percent, and less than 175 percent, of such official poverty line (as so applied);

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

''(C) of $300 for such individuals with income not less than 225 percent, and less than

275 percent, of such official poverty line (as so applied);

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

''(E) of $500 for such individuals with income equal to at least 325 percent of such official poverty line (as so applied).

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

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

"SEC. 1976. QUALITY ASSURANCE AND SAFEGUARDS.

''(a) QUALITY ASSURANCE.—

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

''(A) safeguarding the health and safety of individuals with disabilities,

''(B) setting the minimum standards for agency providers and how such standards will be enforced,

''(C) setting the minimum competency requirements for agency provider employees who provide direct services under this part and how the competency of such employees will be enforced,

''(D) setting minimum competency requirements for consumer directed providers of personal assistance services and how such competency requirements will be demonstrated,

''(E) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services,

''(F) establishing a process to receive, investigate, and resolve allegations of neglect and/or abuse,

''(G) establishing optional training programs for individuals with disabilities in the use and direction of consumer directed providers of personal assistance services,

''(H) establishing an appeals procedure for eligibility denials and a grievance procedure for disagreements with the terms of an individualized plan of care;

''(I) providing for participation in quality assurance activities, and

''(J) specifying the role of the long-term care ombudsman (under the Older Americans Act of 1965) and the Protection and Advocacy Agency (under the Developmental Disabilities Assistance and Bill of Rights Act) in assuring quality of services and protecting the rights of individuals with disabilities.

''(2) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this part, the Secretary shall issue regulations implementing the quality provisions of this subsection.

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

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

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

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

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

''(5) Surveys of client satisfaction.

''(6) State optional training programs for informal caregivers.

''(c) SAFEGUARDS.—

''(1) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

''(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emo-

tional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

''(d) SPECIFIED RIGHTS.—The State plan shall provide that in furnishing home and community-based services under the plan the following individual rights are protected:

''(1) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

''(2) The right to—

''(A) voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances,

''(B) be told how to complain to State and local authorities, and

''(C) prompt resolution of any grievances or complaints.

''(3) The right to confidentiality of personal and clinical records and the right to have access to such records.

''(4) The right to privacy and to have one's property treated with respect.

''(5) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

''(6) The right to education or training for oneself and for members of one's family or household on the management of care.

''(7) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's plan of care.

''(8) The right to be fully informed orally and in writing of the individual's rights.

''(9) The right to a free choice of providers.

''(10) The right to direct provider activities when an individual is competent and willing to direct such activities.

"SEC. 1977. ADVISORY GROUPS.

''(a) FEDERAL ADVISORY GROUP.—

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

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

''(b) STATE ADVISORY GROUPS.—

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

''(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from the those nominated as described in paragraph (3).

''(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

''(4) PARTICULAR CONCERNS.—Each advisory group shall—

''(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan,

''(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan,

''(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable,

''(D) report to the Governor and make available to the public any differences between the group's recommendations and the plan,

''(E) report to the Governor and make available to the public specifically the degree to which the plan is consumer-directed, and

''(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

"SEC. 1978. PAYMENTS TO STATES.

''(a) IN GENERAL.—Subject to section 1972(a)(9)(C) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with a plan approved under this part, for each quarter (beginning on or after January 1, 1998), from its allotment under section 1979(b), an amount equal to—

''(1) the Federal home and community-based services matching percentage (as defined in subsection (b)) of amount demonstrated by State claims to have been expended during the quarter for home and community-based services under the plan for individuals with disabilities; plus

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

''(3) an amount equal to 90 percent of amount expended during the quarter under the plan for activities (including preliminary screening) relating to

determination of eligibility and performance of needs assessment; plus

''(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2003, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

''(5) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

''(b) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—In subsection (a), the term 'Federal home and community-based services matching percentage' means, with respect to a State, the State's Federal medical assistance percentage (as defined in section 1905(b)) increased by 15 percentage points, except that the Federal home and community-based services matching percentage shall in no case be less than 65 percent or more than 90 percent.

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

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

''(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

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

''(e) FAILURE TO COMPLY WITH STATE PLAN.—If a State furnishing home and community-based services under this part fails to comply with the State plan approved under this part, the Secretary may withhold an

amount of funds determined appropriate by the Secretary from any payment to the State under this section.

"SEC. 1979. TOTAL FEDERAL BUDGET; ALLOTMENTS TO STATES.

''(a) TOTAL FEDERAL BUDGET.—The total Federal budget for State plans under this part for any fiscal year beginning on or after October 1, 1997, is an amount equal to the sum of—

''(1) the amount of funds deposited in the Long-Term Care Account of the Health Security Trust Fund established under section 9551 of the Internal Revenue Code of 1986 for such fiscal year; and

''(2) any funds in such account that were not expended in any preceding fiscal year.

''(b) ALLOTMENTS TO STATES.—

''(1) IN GENERAL.—The Secretary shall allot to each State for each fiscal year an amount that bears the same ratio to the total Federal budget for the fiscal year (specified under subsection (a)) as the State allotment factor (under paragraph (2) for the State for the fiscal year) bears to the sum of such factors for all States for that fiscal year.

''(2) STATE ALLOTMENT FACTOR.—

''(A) IN GENERAL.—For each State for each fiscal year, the Secretary shall compute a State allotment factor equal to the sum of—

''(i) the base allotment factor (specified in subparagraph (B)), and

''(ii) the low income allotment factor (specified in subparagraph (C)).

''(B) BASE ALLOTMENT FACTOR.—The base allotment factor, specified in this subparagraph, for a State for a fiscal year is equal to the product of the following:

''(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

''(ii) 80 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—80 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

''(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

''(iv) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—The Federal home and community-based services matching percentage (determined under section 1978(b)) for the fiscal year.

''(C) LOW INCOME ALLOTMENT FACTOR.—The low income allotment factor, specified in this subparagraph, for a State for a fiscal year is equal to the product of the following:

''(i) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in the State (determined under paragraph (3)) for the fiscal year.

''(ii) 10 PERCENT OF THE NATIONAL PER CAPITA BUDGET.—10 percent of the national average per capita budget amount (determined under paragraph (4)) for the fiscal year.

''(iii) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor (determined under paragraph (5)) for the State for the fiscal year.

''(iv) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PER-

CENTAGE.—The Federal home and community-based services matching percentage (determined under section 1978(b)) for the fiscal year.

''(v) LOW INCOME INDEX.—The low income index (determined under paragraph (6)) for the State for the preceding fiscal year.

''(3) NUMBER OF INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in a State for a fiscal year shall be determined as follows:

''(A) BASE.—The Secretary shall determine the number of individuals in the State by age, sex, and income category, based on the 1990 decennial census, adjusted (as appropriate) by the March 1996 current population survey.

''(B) DISABILITY PREVALENCE LEVEL BY POPULATION CATEGORY.—The Secretary shall determine, for each such age, sex, and income category, the national average proportion of the population of such category that represents individuals with disabilities. The Secretary may

conduct periodic surveys in order to determine such proportions.

''(C) BASE DISABLED POPULATION IN A STATE.—The number of individuals with disabilities in a State in 1996 is equal to the sum of the products, for such each age, sex, and income category, of—

''(i) the population of individuals in the State in the category (determined under subparagraph (A)), and

''(ii) the national average proportion for such category (determined under subparagraph (B)).

''(D) UPDATE.—The Secretary shall determine the number of individuals with disabilities in a State in a fiscal year equal to the number determined under subparagraph (C) for the State increased (or decreased) by the percentage increase (or decrease) in the disabled population of the State as determined under the current population survey from 1996 to the year before the fiscal year involved.

''(4) NATIONAL PER CAPITA BUDGET AMOUNT.—The national average per capita budget amount, for a fiscal year, is—

''(A) the total Federal budget specified under subsection (a) for the fiscal year; divided by

''(B) the sum, for the fiscal year, of the numbers of individuals with disabilities (determined under paragraph (3)) for all the States for the fiscal year.

''(5) WAGE ADJUSTMENT FACTOR.—The wage adjustment factor, for a State for a fiscal year, is equal to the ratio of—

''(A) the average hourly wages for service workers (other than household or protective services) in the State, to

''(B) the national average hourly wages for service workers (other than household or protective services).

The hourly wages shall be determined under this paragraph based on data from the most recent decennial census for which such data are available.

''(6) LOW INCOME INDEX.—The low income index for each State for a fiscal year is the ratio, determined for the preceding fiscal year, of—

''(A) the percentage of the State's population that has income below 150 percent of the poverty level, to

''(B) the percentage of the population of the United States that has income below 150 percent of the poverty level.

Such percentages shall be based on data from the most recent decennial census for which such data are available, adjusted by data from the most recent current population survey as determined appropriate by the Secretary.

''(7) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services provided to an individual to the extent that the State received payment for such services under section 1903(a).

''(c) CARRY-OVER.—With respect to fiscal years 1998 through 2005, a State shall be permitted to carry-over not more than 25 percent of the allotment of such State for expenditures in the subsequent year.

''(d) STATE ENTITLEMENT.—This part constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

''SEC. 1980. FEDERAL EVALUATIONS.

''Not later than December 31, 2003, December 31, 2006, and each December 31 thereafter, the Secretary

shall provide to Congress analytical reports that evaluate—

''(1) the extent to which individuals with low incomes and disabilities are equitably served;

''(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

''(3) the comparability of program participation across States, described by level and type of disability; and

''(4) the ability of service providers to sufficiently meet the demand for services.''.

(b) CONFORMING AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 301, is amended by striking the title inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS, STATE PROGRAMS FOR PREMIUM AND COST-SHARING ASSISTANCE, AND STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES".

Subtitle D—Medicaid Program

PART I—INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM

SEC. 671. LIMITING COVERAGE UNDER MEDICAID OF ITEMS AND SERVICES COVERED UNDER STANDARD BENEFITS PACKAGE.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''TREATMENT OF ITEMS AND SERVICES IN THE STANDARD BENEFITS PACKAGE

''SEC. 1931. (a) ITEMS AND SERVICES COVERED UNDER STANDARD BENEFITS PACKAGE.—Except as provided in subsection (c), a State plan under this part shall not provide medical assistance consisting of payment for

items and services in the standard benefits package described in section 21201(a).

''(b) MEDICAL ASSISTANCE NOT AFFECTED.—Subsection (a) shall not be construed as—

''(1) affecting the eligibility of any individual for medical assistance consisting of payment for items and services not covered under the standard benefits package;

''(2) affecting the amount, duration, and scope of any medical assistance consisting of payment for the items and services described in paragraph (1); or

''(3) prohibiting payment of medical assistance for items and services covered under the standard benefits package to the extent that the items and services under this part exceed the items and services covered under such package with respect to amount, duration, and scope.

''(c) EXCEPTIONS.—

''(1) IN GENERAL.—Subsection (a) shall not affect the provision of medical assistance consisting of payment for items and services in the standard benefits package—

''(A) which are provided to—

''(i) except as provided in paragraph (2), an individual eligible for medical as-

sistance under the State plan who is not a premium subsidy eligible individual (as defined in section 1952(a)(2));

''(ii) an individual with respect to whom supplemental security income benefits are being paid under title XVI; and

''(iii) an individual who is eligible for benefits under part A of title XVIII; or

''(B) which consist of emergency services to certain aliens under section 1903(v)(2).

''(2) SPECIAL RULE.—With respect to the first year in which the eligibility percentage for premium assistance under section 1952(a)(2)(B) equals 200 percent and any succeeding year, subsection (a) shall apply to an individual who is not a premium subsidy eligible individual because the individual's family income determined under section 1958(2) exceeds 200 percent of the poverty line (as defined in section 1958(5)).

''(d) STATE MAINTENANCE OF EFFORT.—

''(1) IN GENERAL.—

''(A) REDUCTION IN QUARTERLY PAYMENTS.—For any calendar quarter in an applicable year (as defined in subparagraph (B)), the amount otherwise payable to a State under

section 1903 for the quarter shall be reduced by the State maintenance of effort amount for the quarter determined under paragraph (2).

''(B) APPLICABLE YEAR.—For purposes of this paragraph, the term 'applicable year' means 1996 and any succeeding year.

''(2) MAINTENANCE OF EFFORT AMOUNT.—

''(A) IN GENERAL.—The maintenance of effort amount for a State for a calendar quarter in an applicable year shall be equal to 25 percent of the State's base payment amount (determined under subparagraph (B)), multiplied by the inflation index (described in subparagraph (C)(i)) and the State population index (described in subparagraph (C)(ii)).

''(B) STATE BASE PAYMENT AMOUNT.—The base payment amount for a State for an applicable year shall be an amount, as determined by the Secretary, equal to the total expenditures from State funds made under the State plan during fiscal year 1994 with respect to medical assistance consisting of items and services of the type included in the standard benefits package for individuals who would not have received such medical assistance if the

provisions of this section and part B (as in effect in the applicable year) had been in effect in fiscal year 1994.

''(C) INDEXES.—

''(i) INFLATION INDEX.—

''(I) IN GENERAL.—For purposes of this paragraph, the Secretary shall establish a cumulative inflation index for the applicable year which equals 1 plus the product of—

''(aa) the percentage change in the national per capita health expenditures plus the applicable percentage points (determined under subclause (II)); multiplied by

''(bb) the cumulative level of the index for the preceding year.

''(II) APPLICABLE PERCENTAGE POINTS.—For purposes of subclause (I), the applicable percentage points are—

''(aa) for each of years 1995 through 1997, 1;

''(bb) for 1998, .8;

''(cc) for 1999, .6;

''(dd) for 2000, .4;

''(ee) for 2001, .2; and

''(ff) for succeeding years, 0.

''(III) BASE YEAR.—The base year for the inflation index under this clause is 1994.

''(ii) STATE POPULATION INDEX.—For purposes of this paragraph, the Secretary shall establish a State population index where the level of the index is equal to 1 plus the cumulative percentage change in the number of individuals residing in a State from 1994 through December 31 of the year preceding the applicable year.''.

(b) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following new paragraph:

''(16) with respect to items and services covered under the standard benefits package described in

section 21201(a) for individuals to whom section 1931(a) applies.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1996.

PART II—COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES

SEC. 672. COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES.

(a) STATE EXPENDITURES LIMITED TO CERTIFIED HEALTH PLANS.—Section 1903(m) (42 U.S.C. 1396b) is amended by adding at the end the following new paragraph:

''(7) No payment shall be made under this part to a State with respect to expenditures incurred by the State for payment for services provided by an entity with a contract under this subsection unless such entity is a certified standard health plan (as defined in section 21011(a)(2)).''.

(b) MODIFICATION TO 75/25 RULE.—Section 1903(m)(2)(A)(ii) (42 U.S.C. 1396b(m)(2)(A)(ii)) is amended by striking ''75 percent'' and inserting ''50 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to pay-

ments for calendar quarters beginning on or after January 1, 1996.

PART III—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

SEC. 673. REPLACEMENT OF DSH PAYMENT PROVISIONS WITH PROVISIONS RELATING TO PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

(a) AMENDMENTS TO PROVISIONS REQUIRING STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—

(1) ADJUSTMENTS TO NATIONAL DSH PAYMENT LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r–4(f)(1)(B)) is amended to read as follows:

''(B) NATIONAL DSH PAYMENT LIMIT.—

''(i) IN GENERAL.—Except as provided in clause (ii), the national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under the State plans under this part for medical assistance during the fiscal year.

''(ii) REDUCTION IN LIMIT.—For fiscal years during which the eligibility percentage for premium assistance under section 1952(a)(2)(B)—

''(I) equals or exceeds 125 percent but is less than 150 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

''(II) equals or exceeds 150 percent but is less than 175 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

''(III) equals or exceeds 175 percent but is less than 200 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

''(IV) equals 200 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

(2) ADJUSTMENTS TO STATE ALLOTMENT LIMITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r–4(f)(2)(B)) is amended to read as follows:

''(B) EXCEPTIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), a State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State

plan for medical assistance during the fiscal year.

''(ii) REDUCTION IN LIMIT.—For fiscal years during which the eligibility percentage for premium assistance under section 1952(a)(2)(B)—

''(I) equals or exceeds 125 percent but is less than 150 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

''(II) equals or exceeds 150 percent but is less than 175 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

''(III) equals or exceeds 175 percent but is less than 200 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

''(IV) equals 200 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

(3) ELIMINATION OF HIGH DSH STATES AND STATE SUPPLEMENTAL AMOUNTS.—

(A) IN GENERAL.—Section 1923(f)(2)(A) (42 U.S.C. 1396r–4(f)(2)(A)) is amended to read as follows:

''(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year increased by the State growth factor (as defined in paragraph (3)(B)) for the fiscal year.''.

(B) CONFORMING AMENDMENTS.—(i) Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(ii) Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)), as redesignated by clause (i), is amended by striking subparagraphs (A) and (C) and redesignating subparagraphs (B), (D), and (E) as subparagraphs (A), (B), and (C).

(iii) Section 1923(f)(3)(B) (42 U.S.C. 1396r–4(f)(3)(B)), as redesignated by clauses (i) and (ii), is amended to read as follows:

''(B) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the product of the State

growth factor and the State DSH payment limit for the previous fiscal year.''.

(iv) Section 1923(f)(1)(A) (42 U.S.C. 1396r–4(f)(1)(A) is amended by striking ''(as defined in paragraph (4)(B))'' and inserting ''(as defined in paragraph (3)(A))''.

(3) TERMINATION OF REQUIREMENT ON STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(h) TERMINATION OF REQUIREMENT TO MAKE PAYMENT ADJUSTMENTS.—

''(1) IN GENERAL.—Any requirement imposed by this section on a State to increase the rate or amount of payment for inpatient hospital services provided by a hospital which serves a disproportionate number of low income patients with special needs shall terminate in the year described in paragraph (2).

''(2) YEAR DESCRIBED.—The year described in this paragraph is the first year beginning after the year in which the eligibility percentage for premium assistance under section 1952(a)(2)(B) equals 200 percent.''.

(4) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by section 671(b), is amended—

(1) by striking ''or'' at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) during or after the year described in section 1923(h)(2) with respect to any payment made by a State to a hospital which serves a disproportionate number of low income patients with special needs that is in excess of the payment otherwise required under this part.''.

(5) EFFECTIVE DATE.—The amendments made by this section shall be effective for calendar quarters beginning on or after October 1, 1997.

(b) PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.—Title XIX, as amended by sections 301 and 667, is amended by adding at the end the following new part:

''PART D—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

''SEC. 1991. PAYMENTS TO HOSPITALS.

''(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 1992. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

''(b) AMOUNT OF ENTITLEMENT.—For purposes of subsection (a), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $2,500,000,000 for the first applicable fiscal year (as defined in section 1994) and for each subsequent fiscal year.

''(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a year shall be made on a quarterly basis during the year.

''SEC. 1992. IDENTIFICATION OF ELIGIBLE HOSPITALS.

''(a) HOSPITALS IN PARTICIPATING STATES.—In order to be an eligible hospital under this part, a hospital must be located in a State that is a participating State under title XXI.

''(b) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (c) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria and provide the Secretary with a list of such hospitals.

''(c) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this subsection if the hospital's low-income utilization rate for the base year under section 1923(b)(3) (as such section is in effect on the day before the date of the enactment of this part) is not less than 25 percent.

"SEC. 1993. AMOUNT OF PAYMENTS.

''(a) IN GENERAL.—The total amount available for payments under this part in a year shall be allocated to hospitals for low-income assistance in accordance with this subsection.

''(b) DETERMINATION OF HOSPITAL PAYMENT AMOUNT.—The amount of payment to an eligible hospital during a year shall be the equal to the hospital's low-income percentage (as defined in subsection (c)) of the total amount available for payments under this part for the year.

''(c) LOW-INCOME PERCENTAGE DEFINED.—

''(1) IN GENERAL.—For purposes of this section, an eligible hospital's 'low-income percentage'

for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

''(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

''(A) the total number of inpatient days for the hospital for the year (as reported to the Secretary by the State in which the hospital is located, in accordance with a reporting schedule and procedures established by the Secretary); and

''(B) the hospital's low-income utilization rate for the base year under section 1923(b)(3) (as such section is in effect on the day before the date of the enactment of this part).

"SEC. 1994. DEFINITIONS.

''For purposes of this part:

''(1) BASE YEAR.—The term 'base year' means 1995.

''(2) FIRST APPLICABLE FISCAL YEAR—The term 'first applicable fiscal year' means first fiscal year that begins after the fiscal year in which the

eligibility percentage for premium assistance under section 1952(a)(2)(B) equals 200 percent.''

(c) CONFORMING AMENDMENT.—Title XIX (42 U.S.C. 1396 et seq.), as amended by sections 301 and 667, is amended by striking the title inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS, PROGRAMS FOR PREMIUM AND COST-SHARING ASSISTANCE, PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES, AND PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS".

PART IV—MEDICAID LONG-TERM CARE PROVISIONS

SEC. 674. PAYMENTS FOR HOME OR COMMUNITY-BASED CARE, PERSONAL CARE SERVICES, AND FRAIL ELDERLY SERVICES.

(a) IN GENERAL.—

(1) PAYMENT.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(A) by striking the period at the end of paragraph (7) and inserting ''; plus''; and

(B) by adding at the end the following new paragraph:

''(8) an amount equal to the Federal home or community-based care matching percentage (as defined in section 1905(t)) of the total amount expended during such quarter for home or community-based services furnished under a waiver under subsection (c) or (d) of section 1915, personal care services described in section 1905(a)(24), and home and community care for functionally disabled elderly individuals under section 1929.''.

(2) FEDERAL HOME OR COMMUNITY-BASED CARE MATCHING PERCENTAGE.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(t) The term 'Federal home or community-based care matching percentage' means, with respect to a State, the State's Federal medical assistance percentage (as defined in subsection (b)) increased by 10 percentage points.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for medical assistance for calendar quarters beginning on or after January 1, 1995.

SEC. 675. INCREASED RESOURCE DISREGARD FOR INDIVIDUALS RECEIVING CERTAIN SERVICES.

(a) IN GENERAL.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by adding ''and'' at the end of subparagraph (F); and

(3) by adding at the end the following new subparagraph:

''(G) provide that, in determining the eligibility of any unmarried individual who has applied for or is receiving medical assistance consisting of community-based services furnished under a waiver under subsection (c) or (d) of section 1915, personal care services described in section 1905(a)(24), or home and community care for functionally disabled elderly individuals under section 1929, the first $4,000 of resources may, at the option of the State, be disregarded.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for medical assistance for calendar quarters beginning on or after January 1, 1995.

SEC. 676. FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.

(a) EXPANSION OF NUMBER OF WAIVERS.—Section 9412(b)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking ''15'' and inserting ''40''.

(b) DEVELOPMENT OF PROTOCOLS AND MODEL CERTIFICATION GUIDELINES.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 is amended by adding at the end the following new paragraphs:

''(5) The Secretary, in consultation with the States and organizations operating projects in accordance with waivers under this subsection shall develop and publish a waiver protocol that will establish minimum standard requirements that an organization must meet to be eligible for a waiver under this subsection. In developing the protocol under the preceding sentence, the Secretary shall incorporate standards for organizations to deliver integrated acute and long-term care services for the elderly, children, and young adults.

''(6) The Secretary shall develop model guidelines that shall be available to States that choose to establish a comprehensive procedure for the licensure and certification of an organization operating a demonstration project under a waiver granted pursuant to this subsection. Such guidelines shall encom-

pass the range of services provided by such an organization.

(c) EVALUATIONS AND REPORTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by subsection (b), is amended by adding at the end the following new paragraph:

''(7)(A) The Secretary shall develop standard evaluation protocols to assess the cost-effectiveness and quality of service provided under—

''(i) demonstration projects operating on the date of the enactment of this paragraph under waivers granted pursuant to this subsection; and

''(ii) demonstration projects granted waivers after the date of the enactment of this paragraph.

''(B) The Secretary shall conduct evaluations of the demonstration projects in accordance with the protocols developed under subparagraph (A) and based on the results of such evaluations, report to the Committee on Finance of the Senate, the Committee on Ways and Means of the House of Representatives, and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the House of Representatives by—

''(i) not later than January 1, 1998, with respect to demonstration projects described in subparagraph (A)(i); and

''(ii) not later than January 1, 2003, with respect to demonstration projects described in subparagraph (A)(ii);

on the desirability of granting permanent status under titles XVIII and XIX of the Social Security Act to such demonstration projects that the Secretary has determined to be successful.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 677. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended in the matter preceding subparagraph (A) by striking '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1995.

SEC. 678. ELIMINATION OF RULE REGARDING AVAILABILITY OF BEDS IN CERTAIN INSTITUTIONS.

(a) IN GENERAL.—The first sentence of section 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by inserting the following before the end period: ''(at the option of the State, such determination may be made without regard to the availability of beds in such a hospital, nursing facility, or intermediate care facility for the mentally retarded located in the State)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to waivers granted or renewed on or after January 1, 1995.

PART V—MISCELLANEOUS

SEC. 679. MEDICAID COVERAGE OF ALL CERTIFIED NURSE PRACTITIONER AND CLINICAL NURSE SPECIALIST SERVICES.

(a) IN GENERAL.—Paragraph (21) of section 1905(a) (42 U.S.C. 1396d(a)) is amended to read as follows:

''(21) services furnished by all certified nurse practitioners (as defined by the Secretary) or clinical nurse specialists (as defined in subsection (u)) which

the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;''.

(b) CLINICAL NURSE SPECIALIST DEFINED.—Section 1905 (42 U.S.C. 1396), as amended by section 674, is amended by adding at the end the following new subsection:

''(u) The term 'clinical nurse specialist' means an individual who—

''(1) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(2) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to payments for calendar quarters beginning on or after January 1, 1995.

TITLE VII—REVENUE PROVISIONS

SEC. 700. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Financing Provisions

PART I—INCREASE IN TAX ON TOBACCO PRODUCTS

SEC. 701. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended—

(1) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$62 per thousand'', and

(2) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$130.20 per thousand''.

(b) CIGARS.—Subsection (a) of section 5701 is amended—

(1) by striking ''$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)'' in paragraph (1) and inserting ''$51.13 per thousand'', and

(2) by striking ''equal to'' and all that follows in paragraph (2) and inserting ''equal to 66 percent of the price for which sold but not more than $155 per thousand.''

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended by striking ''0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)'' and inserting ''3.88 cents''.

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended by striking ''1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)'' and inserting ''7.76 cents''.

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 is amended—

(1) by striking ''36 cents (30 cents on snuff removed during 1991 or 1992)'' in paragraph (1) and inserting ''$13.69'', and

(2) by striking ''12 cents (10 cents on chewing tobacco removed during 1991 or 1992)'' in paragraph (2) and inserting ''$5.45''.

(f) PIPE TOBACCO.—Subsection (f) of section 5701 is amended by striking ''67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)'' and inserting ''$17.35''.

(g) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

''(h) APPLICATION TO TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

''(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

''(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

''(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Health Security Act.

''(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of this subsection shall be taken into account in determining the amount of any exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

''(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Health Security Act.

''(4) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection.''

(h) FUNDING OF SUBSIDIES FOR CHILDREN AND PREGNANT WOMEN.—Section 5701 is amended by adding at the end the following new subsection:

''(i) FUNDING OF SUBSIDIES FOR CHILDREN AND PREGNANT WOMEN.—In the case of articles removed after June 30, 1996, and before January 1, 2002—

''(1) each of the following rates of tax shall be increased by the amount determined in accordance with the following table:

"For the tax under subsection:	The increase is:
(a)(1)	$15.00
(a)(2)	37.40
(b)(1)	15.00
(b)(2)	31.50
(e)(1)	4.00
(e)(2)	1.60
(f)	5.00
(g)	5.00,

''(2) the rate of tax under subsection (c) shall be increased by 0.93 cent,

''(3) the rate of tax under subsection (d) shall be increased by 1.86 cents, and

''(4) subsection (a)(2) shall be applied by substituting '81.81 percent' for '66 percent'.''

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1994.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on each tax-increase date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on any tax-increase date, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date which is 3 months after the tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or his delegate.

(C) TAX-INCREASE DATE.—The term ''tax-increase date'' means January 1, 1995, and July 1, 1996.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same

extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 702. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: ''Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.''

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

''(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

''(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

''(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.''

(3) Subsection (a) of section 5761 is amended by striking ''subsection (b)'' and inserting ''subsection (b) or (c)''.

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking ''The penalty imposed by subsection (b)'' and insert-

ing ''The penalties imposed by subsections (b) and (c)''.

(5)(A) Subpart F of chapter 52 is amended by adding at the end the following new section:

''SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

''(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

''(b) CROSS REFERENCE.—

''For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).''

(B) The table of sections for subpart F of chapter 52 is amended by adding at the end the following new item:

''Sec. 5754. Restriction on importation of previously exported tobacco products.''

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting ''or importer'' after ''manufacturer''.

(2) The heading of subsection (b) of section 5763 is amended by inserting ''QUALIFIED IMPORTERS,'' after ''MANUFACTURERS,''.

(3) The heading for subchapter B of chapter 52 is amended by inserting ''**and Importers**'' after ''**Manufacturers**''.

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting ''and importers'' after ''manufacturers''.

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking ''EMPLOYEE USE OR'' in the heading, and

(B) by striking ''for use or consumption by employees or'' in the text.

(2) Subsection (e) of section 5723 is amended by striking ''for use or consumption by their employees, or for experimental purposes'' and inserting ''for experimental purposes''.

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking ''and manufacturers may similarly remove such articles for use of the United States;''.

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking ''On each book or set of cigarette papers containing more than 25 papers,'' and inserting ''On cigarette papers,''.

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting ''under section 5704'' after ''internal revenue bond''.

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking ''or'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

''(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or''.

(h) SPECIAL RULES RELATING TO PUERTO RICO AND THE VIRGIN ISLANDS.—Section 7652 is amended by adding at the end the following new subsection:

''(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the

Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Health Security Act.''

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1994.

SEC. 703. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 701, is amended by redesignating subsections (g) and (h) as subsections (h) and (i) and by inserting after subsection (f) the following new subsection:

''(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of $17.35 per pound (and a proportionate tax at the like rate on all fractional parts of a pound).''

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

''(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of

its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.''

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking ''and pipe tobacco'' and inserting ''pipe tobacco, and roll-your-own tobacco''.

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking ''or pipe tobacco'' and inserting ''pipe tobacco, or roll-your-own tobacco'', and

(B) by striking paragraph (1) and inserting the following new paragraph:

''(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for the person's own personal consumption or use, and''.

(3) The chapter heading for chapter 52 is amended to read as follows:

''CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES''.

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

''CHAPTER 52. Tobacco products and cigarette papers and tubes.''

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1994.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before January 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

PART II—HEALTH RELATED ASSESSMENTS

SEC. 705. ASSESSMENTS ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE.—Subtitle D (relating to miscellaneous excise taxes) is amended by adding after chapter 36 the following new chapter:

"CHAPTER 37—HEALTH RELATED ASSESSMENTS

"Subchapter A—Insured and Self-Insured Health Plans

"SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

''(a) IMPOSITION OF TAX.—There is hereby imposed—

''(1) on each taxable health insurance policy, a tax equal to 1.75 percent of the premiums received under such policy, and

''(2) on each amount received for health-related administrative services, a tax equal to 1.75 percent of the amount so received.

''(b) LIABILITY FOR TAX.—

''(1) HEALTH INSURANCE.—The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

''(2) HEALTH-RELATED ADMINISTRATIVE SERVICES.—The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

''(c) TAXABLE HEALTH INSURANCE POLICY.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

''(2) EXEMPTION OF CERTAIN POLICIES.—The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

''(A) liabilities incurred under workers' compensation laws,

''(B) tort liabilities,

''(C) liabilities relating to ownership or use of property,

''(D) credit insurance, or

''(E) such other similar liabilities as the Secretary may specify by regulations.

''(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE.—In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or health coverage if—

''(A) the charge for such nonaccident or health coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

''(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium paid under such a policy shall be subject to tax under subsection (a)(1).

''(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a taxable health insurance policy,

''(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

''(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement—

''(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

''(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

''(d) HEALTH-RELATED ADMINISTRATIVE SERVICES.—For purposes of this section, the term 'health-related administrative services' means—

''(1) the processing of claims or performance of other administrative services in connection with accident or health coverage under a taxable health insurance policy if the charge for such services is not included in the premiums under such policy, and

''(2) processing claims, arranging for provision of accident or health coverage, or performing other administrative services in connection with an applicable self-insured health plan (as defined in section 4502(c)) established or maintained by a person other than the person performing the services.

For purposes of paragraph (1), rules similar to the rules of subsection (c)(3) shall apply.

"SEC. 4502. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF TAX.—In the case of any applicable self-insured health plan, there is hereby imposed a tax for each month equal to 1.75 percent of the sum of—

''(1) the accident or health coverage expenditures for such month under such plan, and

''(2) the direct administrative expenditures for such month under such plan.

''(b) LIABILITY FOR TAX.—

''(1) IN GENERAL.—The tax imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1), the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization, or

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a voluntary employees' beneficiary association under section 501(c)(9), or

''(iii) a plan described in subsection (c)(2)(E),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9), or

''(E) in the case of a plan not described in the preceding subparagraphs, by a qualified association (as defined in section 21433(c) of the Social Security Act).

''(d) ACCIDENT OR HEALTH COVERAGE EXPENDITURES.—For purposes of this section—

''(1) IN GENERAL.—The accident or health coverage expenditures of any applicable self-insured health plan for any month are the aggregate expenditures paid in such month for accident or health coverage provided under such plan to the extent such

expenditures are not subject to tax under section 4501.

''(2) TREATMENT OF REIMBURSEMENTS.—In determining accident or health coverage expenditures during any month of any applicable self-insured health plan, reimbursements (by insurance or otherwise) received during such month shall be taken into account as a reduction in accident or health coverage expenditures.

''(3) CERTAIN EXPENDITURES DISREGARDED.—Paragraph (1) shall not apply to any expenditure for the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident or health coverage which is subject to the allowance under section 167, except that, for purposes of paragraph (1), allowances under section 167 shall be considered as expenditures.

''(e) DIRECT ADMINISTRATIVE EXPENDITURES.—For purposes of this section, the term 'direct administrative expenditures' means the administrative expenditures under the plan to the extent such expenditures are not subject to tax under section 4501. In determining the amount of such expenditures, rules similar to the rules of subsection (d)(3) shall apply.

"SEC. 4503. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT OR HEALTH COVERAGE.—The term 'accident or health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a taxable health insurance policy (as defined in section 4501(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) PREMIUM.—The term 'premium' means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating. Amounts returned where the amount is not fixed in the contract but depends on the experience of the insurer or the discretion of management shall not be included in return premiums.

''(4) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the taxes imposed by this subchapter except as provided in paragraph (2).

''(2) EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program—

''(A) no tax shall be imposed under section 4501 on any premium received pursuant to such program or on any amount received for health-related administrative services pursuant to such program, and

''(B) no tax shall be imposed under section 4502 on any expenditures pursuant to such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) the insurance programs established by parts A and B of title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D is amended by inserting after the item relating to chapter 36 the following new item:

''CHAPTER 37. Health related assessments.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to premiums received,

and expenses incurred, with respect to coverage for periods after December 31, 1995.

SEC. 706. TAX ON HIGH COST HEALTH PLANS.

(a) IN GENERAL.—Subchapter A of chapter 37 (relating to assessments on insured and self-insured health benefits), as added by section 705, is amended by adding at the end the following new part:

''PART II—HIGH COST HEALTH PLANS

''SEC. 4511. TAX ON HIGH COST HEALTH PLANS.

''(a) IMPOSITION OF TAX.—If an applicable health plan is a high cost plan for any taxable period, there is hereby imposed a tax equal to 25 percent of the taxable amount with respect to the high cost plan for the period.

''(b) LIABILITY FOR TAX.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the tax imposed by subsection (a) shall be paid by the issuer of the high cost plan.

''(2) SELF-INSURED PLANS.—In the case of a high cost plan which is a self-insured plan, the tax shall be paid by the plan sponsor.

''(c) HIGH COST PLAN.—For purposes of this section—

''(1) IN GENERAL.—An applicable health plan is a high cost plan for any taxable period if—

''(A) the premiums received under the plan during the taxable period, exceed

''(B) the sum of the target amounts determined with respect to each class of enrollment under the plan.

''(2) TARGET AMOUNT.—

''(A) IN GENERAL.—The target amount for any class of enrollment under a plan for any taxable period is an amount equal to the product of—

''(i) the target premium for such class, and

''(ii) the number of primary insureds in such class during the period.

''(B) PROPORTIONATE REDUCTION OF TARGET PREMIUM.—The target premium under subparagraph (A)(i) applicable to an individual who was a primary insured for only a portion of the taxable period shall be proportionately reduced to reflect the period the individual was not a primary insured.

''(3) CERTAIN SUPPLEMENTAL PREMIUMS INCLUDED.—The amount determined under paragraph (1)(A) shall include applicable supplemental premiums.

''(4) CERTAIN ACTUARIAL ADJUSTMENTS DISREGARDED.—The amount determined under paragraph (1)(A) (after application of paragraph (3)) shall be adjusted, in accordance with regulations, as follows:

''(A) AGE ADJUSTMENTS UNDER COMMUNITY-RATED PLANS.—In the case of a community-rated plan, to reflect the premiums which would have been received if any age adjustment factor were disregarded.

''(B) RISK ADJUSTMENTS UNDER OTHER PLANS.—In the case of any plan which is not a community-rated plan, by adjusting such amount so that it does not reflect the relative risks among the participants in the plan.

''(5) CERTAIN PLANS NOT TREATED AS HIGH COST PLANS.—

''(A) IN GENERAL.—An applicable health plan shall not be treated as a high cost plan for any taxable period beginning in a calendar year if its adjusted average premium is determined, in such manner as the Secretary may prescribe, to be in the bottom quartile of the adjusted average premiums of all certified standard health

plans in the United States for the calendar year.

''(B) ADJUSTED AVERAGE PREMIUM.—For purposes of subparagraph (A), the adjusted average premium for any plan shall be determined in such manner as the Secretary shall prescribe and shall be equal to the weighted average premium for all classes of enrollment under the plan—

''(i) adjusted to reflect—

''(I) differences in cost-of-living among community-rated areas,

''(II) other differences among community-rated areas which affect premium costs,

''(III) in the case of a community-rated plan, age adjustment factors, and

''(IV) in the case of plans which are not community-rated plans, relative risks described in paragraph (4)(B), and

''(ii) determined by taking into account applicable supplemental premiums under the plan.

''(d) TAXABLE AMOUNT.—For purposes of this section, the term 'taxable amount' means the excess (if any) which is determined under subsection (c)(1), except that in applying subsection (c) for purposes of this subsection, the reference premium shall be substituted for the target premium.

''(e) TARGET AND REFERENCE PREMIUMS.—For purposes of this section—

''(1) IN GENERAL.—As soon as practicable after the annual open enrollment period established under section 21024 of the Social Security Act for a community rating area, the Secretary shall establish—

''(A) separate target and reference premiums for each class of enrollment under community-rated plans in such area, and

''(B) separate target and reference premiums for each class of enrollment under plans which are not community-rated plans in such area.

''(2) BASIS FOR ESTABLISHING PREMIUMS.—

''(A) TARGET PREMIUMS.—The Secretary shall establish target premiums under paragraph (1) for each community rating area at the levels which the Secretary estimates will re-

sult in the following plans being treated as high cost plans (determined without regard to subsection (c)(5)):

''(i) Community-rated certified standard health plans in the area which cover 40 percent of the total primary insureds covered by all such plans in the area.

''(ii) Certified standard health plans in the area which are not community-rated which cover 40 percent of the total primary insureds covered by all such plans in the area.

''(B) REFERENCE PREMIUMS.—The Secretary shall establish reference premiums under paragraph (1) for each community rating area which shall be equal to the average premium per primary insured for all certified standard health plans offered in the area for the class of enrollment for which the premium is being established.

''SEC. 4512. DEFINITIONS AND SPECIAL RULES.

''(a) APPLICABLE PLANS.—For purposes of this part—

''(1) APPLICABLE HEALTH PLAN.—The term 'applicable health plan' means a certified standard health plan or a certified nonstandard health plan.

''(2) APPLICABLE SUPPLEMENTAL PREMIUM.—The term 'applicable supplemental premium' means, with respect to any issuer or plan sponsor of a certified standard health plan, any premium received by the issuer or plan sponsor under a certified supplemental health plan covering an individual who is covered under the certified standard health plan.

''(b) CERTIFIED HEALTH PLANS.—For purposes of this part—

''(1) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' has the meaning given such term by section 21011(a)(2) of the Social Security Act, except that such term does not include a plan offering the alternative standard benefit package described in subtitle C of such Act.

''(2) CERTIFIED NONSTANDARD HEALTH PLAN.—The term 'certified nonstandard health plan' has the meaning given such term by section 21011(a)(3) of such Act.

''(3) CERTIFIED SUPPLEMENTAL HEALTH PLAN.—The term 'certified supplemental health

plan' has the meaning given such term by section 21011(a)(4) of such Act.

''(c) COMMUNITY RATING AREAS AND PLANS.—For purposes of this part—

''(1) COMMUNITY RATING AREA.—The term 'community rating area' means an area established under section 21021 of the Social Security Act.

''(2) COMMUNITY-RATED PLAN.—The term 'community-rated plan' means a plan which is community-rated under section 21113 of such Act.

''(d) PREMIUMS.—For purposes of this part—

''(1) IN GENERAL.—The term 'premium' has the meaning given such term by section 4503(a)(3).

''(2) ADMINISTRATIVE COSTS.—Amounts received for health-related administrative services (as defined in section 4501(d)) provided in connection with any applicable health plan or any certified supplemental health plan taken into account under section 4511(c)(3) shall be treated as premiums.

''(3) SELF-INSURED PLANS.—In the case of a self-insured plan, premiums shall include—

''(A) a reasonable estimate (actuarially determined in such manner as the Secretary may prescribe) of the expenditures described in sub-

sections (d) and (e) of section 4502 with respect to coverage under the plan, and

''(B) in the case of any coverage provided through an insurance policy, premiums paid for such coverage.

''(e) INSURANCE POLICY, SELF-INSURED PLANS, AND PLAN SPONSOR.—For purposes of this part—

''(1) INSURANCE POLICY.—The term 'insurance policy' has the meaning given such term by section 4503(a)(2).

''(2) SELF-INSURED PLAN.—The term 'self-insured plan' means any certified standard health plan any portion of the coverage of which is provided other than through an insurance policy (including an arrangement described in section 4501(c)(4)(B)).

''(3) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term by section 4502(b)(2), except that in the case of a plan not described in such section, such term means the person or persons who establish or maintain the plan.

''(f) TAXABLE PERIOD.—For purposes of this part—

''(1) IN GENERAL.—The term 'taxable period' means, with respect to any applicable health plan in a community rating area for any year, the 12-month period following the close of the annual open enroll-

ment period for such area under section 21024 of the Social Security Act for which an individual enrolling during such enrollment period receives coverage under the plan.

''(2) SPECIAL RULE FOR MULTISTATE SELF-INSURED PLANS.—If an applicable health plan in a community rating area has a different annual open enrollment period than the one described in paragraph (1), its taxable period for any year shall be determined under paragraph (1) by reference to its first coverage period beginning on or after the first day of the coverage period for the enrollment period described in paragraph (1).

''(g) SPECIAL RULES.—For purposes of this part—

''(1) DEPOSITS.—The Secretary may require deposits of any taxes imposed by section 4511 at such times as the Secretary determines appropriate.

''(2) GOVERNMENTAL ENTITIES SUBJECT TO TAX.—The rules of section 4503(b) shall apply for purposes of this part.

''(3) PLANS COVERING MORE THAN 1 AREA.—If an applicable health plan covers individuals residing in more than 1 community rating area, the individuals in each such area shall be treated as covered by a separate plan.

''(4) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this part shall be covered over to any possession of the United States.

''(h) FUNDING OF SUBSIDIES FOR CHILDREN AND PREGNANT WOMEN.—In the case of taxable periods beginning after December 31, 1996, and before January 1, 2002, the rate of tax under section 4511(a) shall be increased by 4 percent.

''(i) REGULATIONS.—The Secretary shall issue such regulations as are necessary to carry out the provisions of this part, including regulations—

''(1) requiring the maintenance of such records, and the reporting of such information as the Secretary determines necessary, and

''(2) which provide that 2 or more plans of a person or any related persons must be aggregated, or a plan must be treated as 2 or more separate plans.''

(b) TAX NOT DEDUCTIBLE.—Section 275(a) (relating to disallowance of deductions for certain taxes) is amended by adding at the end the following new paragraph:

''(7) Taxes imposed by section 4511 (relating to taxes on high cost health plans).''

(c) CONFORMING AMENDMENTS.—

(1) Subchapter A of chapter 37, as added by section 705, is amended by inserting after the subchapter heading the following:

''Part I. Premium and related assessments.
''Part II. High cost health plans.

''PART I—PREMIUM AND RELATED ASSESSMENTS''.

(2) Section 4503, as so added, is amended by striking ''subchapter'' each place it appears and inserting ''part''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

PART III—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES

SEC. 711. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 is amended by adding at the end the following new part:

''PART VIII—CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

''Sec. 59B. Recapture of certain health care subsidies.

"SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES.

''(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the aggregate of the Medicare part B recapture amounts (if any) for months during such year that a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part.

''(b) MEDICARE PART B PREMIUM RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the Medicare part B premium recapture amount for any month is the amount equal to the excess of—

''(1) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(2) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(c) PHASE-IN OF RECAPTURE AMOUNT.—

''(1) IN GENERAL.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $15,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but for this subsection) be imposed by this section for such taxable year as such excess bears to $15,000.

''(2) JOINT RETURNS.—If a recapture amount is determined separately for each spouse filing a joint return, paragraph (1) shall be applied by substituting '$30,000' for '$15,000' each place it appears.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $90,000,

''(B) $115,000 in the case of a joint return, and

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

''(i) is married (as determined under section 7703) but does not file a joint return for such year, and

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

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

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

''(3) JOINT RETURNS.—In the case of a joint return—

''(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

''(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

''(4) COORDINATION WITH OTHER PROVISIONS.—

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

''(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(i) the amount of any credit allowable under this chapter, or

''(ii) the amount of the minimum tax under section 55.

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

''(5) TAXES IMPOSED BY POSSESSIONS.—The tax imposed by this section shall not apply to a bona fide resident of a possession with respect to which the requirements of section 21026 of the Social Security Act are met.''

(b) TRANSFERS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—There are hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund amounts equivalent to the aggregate increase in liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the application of section 59B(a) of such Code, as added by this section.

(2) TRANSFERS.—The amounts appropriated by paragraph (1) to the Federal Supplementary Medical Insurance Trust Fund shall be transferred from time to time (but not less frequently than quarterly) from the general fund of the Treasury on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in paragraph (1). Any quarterly payment shall be made on the first day of such quarter and shall take into account the recapture amounts referred to in such section 59B(a) for such quarter. Proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(c) REPORTING REQUIREMENTS.—

(1) Paragraph (1) of section 6050F(a) (relating to returns relating to social security benefits) is amended by striking ''and'' at the end of subpara-

graph (B) and by inserting after subparagraph (C) the following new subparagraph:

''(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and''.

(2) Paragraph (2) of section 6050F(b) is amended to read as follows:

''(2) the information required to be shown on such return with respect to such individual.''

(3) Subparagraph (A) of section 6050F(c)(1) is amended by inserting before the comma ''and in the case of the information specified in subsection (a)(1)(D)''.

(4) The heading for section 6050F is amended by inserting ''**AND MEDICARE PART B COVERAGE**'' before the period.

(5) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting ''and Medicare part B coverage'' before the period.

(d) WAIVER OF CERTAIN ESTIMATED TAX PENALTIES.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating

to failure to pay estimated income tax) for any period before April 16, 1997, with respect to any underpayment to the extent that such underpayment resulted from section 59B(a) of the Internal Revenue Code of 1986, as added by this section.

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

''Part VIII. Certain health care subsidies received by high-income individuals.''

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

PART IV—OTHER PROVISIONS

SEC. 715. INCREASE IN TAX ON CERTAIN HOLLOW POINT AND LARGE CALIBER HANDGUN AMMUNITION.

(a) INCREASE IN MANUFACTURERS TAX.—

(1) IN GENERAL.—Section 4181 (relating to imposition of tax on firearms) is amended—

(A) by striking ''Shells, and cartridges'' and inserting ''Shells and cartridges not taxable at 10,000 percent'', and

(B) by adding at the end the following:

''ARTICLES TAXABLE AT 10,000 PERCENT.—

''Any jacketed, hollow point projectile which may be used in a handgun and the jacket of which is designed to produce, upon impact, sharp-tipped, barb-like projections that extend beyond the diameter of the unfired projectile.

''Any cartridge with a projectile measuring .500 inch or greater in diameter which may be used in a handgun.''

(2) ADDITIONAL TAXES ADDED TO THE GENERAL FUND.—Section 3(a) of the Act of September 2, 1937 (16 U.S.C. 669b(a)), commonly referred to as the ''Pittman-Robertson Wildlife Restoration Act'', is amended by adding at the end the following new sentence: ''There shall not be covered into the fund the portion of the tax imposed by such section 4181 that is attributable to any increase in amounts received in the Treasury under such section by reason of the amendments made by section 715(a)(1) of the Health Security Act, as estimated by the Secretary.''

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to sales after December 31, 1994.

(2) FLOOR STOCKS TAX.—

(A) IN GENERAL.—In the case of any article held on January 1, 1995, which is taxable under section 4181 of the Internal Revenue Code of 1986 on and after such date at a tax rate of 10,000 percent, there is hereby imposed a tax equal to the excess of—

(i) the tax which would be imposed under section 4181 of such Code if the article were sold on such date, over

(ii) the prior tax (if any) imposed under such section on such article.

(B) CREDIT.—Each person shall be allowed as a credit against the taxes imposed by subparagraph (A) an amount equal to the taxes imposed on articles which such person destroys (in such manner as the Secretary may prescribe) after December 31, 1994, and before April 1, 1995.

(C) PAYMENT.—The taxes imposed by subparagraph (A) on any article shall be paid by the person holding the article on January 1, 1995. Such taxes shall be paid before April 1, 1995, in such manner as the Secretary of the Treasury may prescribe.

(D) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 1995, shall be subject to the tax imposed by subparagraph (A) if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(ii) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(E) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this paragraph.

(F) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 4181 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed

by subparagraph (A), to the same extent as if such taxes were imposed by such section 4181. The Secretary may treat any person who bore the ultimate burden of the tax imposed by subparagraph (A) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 716. MODIFICATION TO SELF-EMPLOYMENT TAX TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS AND PARTNERS.

(a) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

(1) AMENDMENT TO INTERNAL REVENUE CODE.—Section 1402 (relating to definitions) is amended by adding at the end the following new subsection:

''(k) TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS.—

''(1) IN GENERAL.—In the case of any individual—

''(A) who is a 2-percent shareholder (as defined in section 1372(b)) of an S corporation for any taxable year of such corporation, and

''(B) who provides significant services to or on behalf of such S corporation during such taxable year,

such shareholder's net earnings from self-employment shall include 80 percent of such shareholder's pro rata share (as determined under section 1366(a)) of the taxable income or loss of such corporation for such taxable year from service-related businesses carried on by such corporation, and to the extent provided in regulations, for any other taxable year to the extent attributable to such services.

''(2) CERTAIN EXCEPTIONS TO APPLY.—In determining the amount to be taken into account under paragraph (1), the exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), rules similar to the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.

''(3) SERVICE-RELATED BUSINESS.—For purposes of this subsection, the term 'service-related business' means—

''(A) any trade or business involving the performance of services in the fields of health (other than with respect to inpatient personal care facilities), law, engineering, architecture,

accounting, actuarial services, performing arts, consulting, athletics, or financial services (other than lending or brokerage services), or

''(B) any other trade or business with respect to which the Secretary determines that capital is an insignificant income-producing factor.

''(4) APPLICATION OF DEFERRED COMPENSATION RULES.—For purposes of subchapter D of chapter 1 (and any other provision of this title relating thereto), in the case of an individual who is treated as having net earnings from self-employment by reason of paragraph (1)—

''(A) such individual shall not be treated as a self-employed individual (within the meaning of section 401(c)(1)) with respect to services performed for the S corporation, and

''(B) such net earnings shall be treated as compensation received by the individual as an employee of the S corporation.''

(2) AMENDMENT TO SOCIAL SECURITY ACT.—Section 211 of the Social Security Act is amended by adding at the end the following new subsection:

''Treatment of Certain S Corporation Shareholders

''(k)(1) In the case of any individual—

''(A) who is a 2-percent shareholder (as defined in section 1372(b) of the Internal Revenue Code of 1986) of an S corporation for any taxable year of such corporation, and

''(B) who provides significant services to or on behalf of such S corporation during such taxable year,

such shareholder's net earnings from self-employment shall include 80 percent of such shareholder's pro rata share (as determined under section 1366(a) of such Code) of the taxable income or loss of such corporation for such taxable year from service-related businesses (as defined in section 1402(k)(3) of such Code) carried on by such corporation, and to the extent provided in regulations, for any other taxable year to the extent attributable to such services.

''(2) In determining the amount to be taken into account under paragraph (1), the exceptions provided in subsection (a) shall apply, except that, in the case of the exceptions provided in subsection (a)(5), rules similar to the rules of subparagraph (B) thereof shall apply to shareholders in S corporations.''

(b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

(1) AMENDMENT OF THE INTERNAL REVENUE CODE.—Paragraph (13) of section 1402(a) is amended to read as follows:

''(13) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than—

''(A) guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services, or

''(B) in the case of a limited partner who provides significant services to or on behalf of the partnership for any taxable year of the partnership, 80 percent of the limited partner's distributive share (determined without regard to payments described in subparagraph (A)) of the taxable income or loss of such partnership—

''(i) for such taxable year from service-related businesses (as defined in subsection (k)(3)) of such partnership, and

''(ii) to the extent provided in regulations, for any other taxable year to the extent attributable to such services;''.

(2) AMENDMENT OF THE SOCIAL SECURITY ACT.—Paragraph (12) of section 211(a) of the Social Security Act is amended to read as follows:

''(12) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than—

''(A) guaranteed payments described in section 707(c) of the Internal Revenue Code of 1986 to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services, or

''(B) in the case of a limited partner who provides significant services to or on behalf of the partnership for any taxable year of the partnership, 80 percent of the limited partner's distributive share (determined without regard to payments described in subparagraph (A)) of the taxable income or loss of such partnership—

''(i) for such taxable year from service-related businesses (as defined in section 1402(k)(3) of such Code) of such partnership, and

''(ii) to the extent provided in regulations prescribed by the Secretary of the Treasury, for any other taxable year to the extent attributable to such services;''.

(c) INVENTORY INCOME.—Section 1402 (relating to definitions), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(l) INVENTORY INCOME.—

''(1) IN GENERAL.—The net earnings from self-employment of any taxpayer for any taxable year under subsection (a) (determined without regard to this subsection) shall be reduced by 40 percent of the lesser of—

''(A) the taxpayer's allocable share of net inventory income, or

''(B) the amount of such net earnings in excess of the applicable amount for the taxable year.

''(2) NET INVENTORY INCOME.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'net inventory income' means net income from the sale of property described in section 1221(1).

''(B) DEALERS IN SECURITIES.—For purposes of subparagraph (A)—

''(i) any security described in section 475(c)(2) (without regard to the last sentence thereof) which is held by a person as a dealer in securities (as defined in section 475(c)(1)) shall be treated as property described in section 1221(1), and

''(ii) net income from any such security shall be taken into account to the extent otherwise taken into account in computing net earnings from self-employment.

''(3) APPLICABLE AMOUNT.—For purposes of paragraph (1), the term 'applicable amount' means the excess of—

''(A) $135,000, adjusted, in the case of any taxable year beginning in any calendar year after 1996, in the same manner as is used in adjusting the contribution and benefit base for the calendar year under section 230(b) of the Social Security Act, over

''(B) the amount of wages paid to the individual during the taxable year.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of individuals beginning after December 31, 1995, and to taxable years

of S corporations and partnerships ending with or within such taxable years of individuals.

SEC. 717. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after September 30, 1995.

(b) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning October 1, 1995,

the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendment made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before October 1, 1995, shall be considered to be ''employment'' (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with October 1995.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term ''medicare qualified State or local government employment'' means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to

time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting ''(1)'' after ''(g)'', and

(C) by adding at the end the following new paragraph:

''(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are fully informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking ''subparagraphs (B) and (C),'' and inserting ''subparagraph (B),''.

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking ''paragraphs (2) and (3).'' and inserting ''paragraph (2).''

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after September 30, 1995.

Subtitle B—Tax Treatment of Employer-Provided Health Care

SEC. 721. TAX TREATMENT OF VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS.

(a) IN GENERAL.—Chapter 37 (relating to health-related taxes), as added by section 705, is amended by adding at the end the following new subchapter:

"Subchapter B—Voluntary Employer-Provided Health Benefits

"SEC. 4521. TAXABLE EMPLOYER-PROVIDED HEALTH BENEFITS.

''(a) IMPOSITION OF TAX.—There is hereby imposed a tax equal to the product of—

''(1) the sum of—

''(A) the taxable employer contributions for any taxable year, plus

''(B) the aggregate employer contributions for permitted coverage described in subparagraph (A) or (B) of subsection (b)(2) during

any portion of the taxable year during which there is discriminatory permitted coverage, and

''(2) the highest rate of tax imposed under section 11(b) for the taxable year.

''(b) TAXABLE EMPLOYER CONTRIBUTION.—For purposes of this section—

''(1) IN GENERAL.—The term 'taxable employer contribution' means any employer contribution under an accident or health plan for coverage of an employee other than permitted coverage.

''(2) PERMITTED COVERAGE.—For purposes of this subsection, the term 'permitted coverage' means—

''(A) coverage under a certified standard health plan (as defined in section 21011(a)(2) of the Social Security Act),

''(B) coverage under a certified supplemental health benefit plan (as defined in section 21011(a)(4) of the Social Security Act), except that this subparagraph shall not apply to coverage of any employee who is covered under such a certified standard health plan which provides the alternative standard benefits package described in subtitle C of such Act,

''(C) coverage under a qualified long-term care insurance policy (as defined in section 7702B(b)),

''(D) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury,

''(E) coverage only for accidental death or dismemberment,

''(F) coverage under a medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act),

''(G) worker's compensation or similar insurance, and

''(H) coverage under an equivalent health care program (as defined in section 21100(6) of the Social Security Act).

''(c) DISCRIMINATORY PERMITTED COVERAGE.—For purposes of this section, the term 'discriminatory permitted coverage' means, with respect to any period, coverage—

''(1) which is permitted coverage described in subparagraph (A) or (B) of subsection (b)(2), and

''(2) with respect to which the requirements of subsection (a) or (b) of section 4522 are not met during such period.

"SEC. 4522. DISCRIMINATORY EMPLOYER PRACTICES.

''(a) HEALTH STATUS REQUIREMENTS.—For purposes of section 4521(c), an employer meets the requirements of this subsection if, with respect to coverage described in such section—

''(1) there is no waiting period or denial of coverage with respect to an employee, and

''(2) the amount of the employer contribution on behalf of an employee is not conditioned, and does not vary,

by reason of the employee's health status, claims experience, medical history, receipt of health care, or lack of evidence of insurability.

''(b) UNIFORM CONTRIBUTION REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of section 4521(c), an employer meets the requirements of this subsection if the employer contribution on behalf of an employee for coverage described in such section is equivalent to each employer contribution on behalf of all other employees who elect such coverage under plans offered by the employer.

''(2) EQUIVALENT CONTRIBUTION.—For purposes of paragraph (1), a contribution is equivalent to any other contribution if—

''(A) it is the same dollar amount as the other contribution,

''(B) it represents the same percentage of cost under the plan to which it is made as does the other contribution, or

''(C) it represents the same percentage of the weighted average premium for the class of enrollment (as defined in section 1952 of the Social Security Act) for the community rating area in which the employee works as does the other contribution.

For purposes of applying subparagraph (B) or (C), any dollar limitation applicable to all employer contributions (whether expressed as a dollar amount or a percentage described in subparagraph (C)) shall be disregarded.

''(3) EXCLUDED EMPLOYEES.—

''(A) IN GENERAL.—The following employees of an employer shall be excluded from consideration under this subsection:

''(i) Any employee before the employee has completed 6 months of service with the employer.

''(ii) Any employee who normally works less than 24 hours per week.

''(iii) Any employee who normally works during not more than 6 months of any year.

''(iv) Any employee who has not attained age 18.

''(v) Any employee who is included in a unit of employees covered by an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and 1 or more employers if there is evidence that employer-provided benefits for standard health benefits coverage was the subject of good faith bargaining between the employee representatives and employer or employers.

''(vi) Any employee who is a nonresident alien and who receives no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the

United States (within the meaning of section 861(a)(3)).

''(vii) Any former employee.

''(B) COVERAGE OF PART-TIME EMPLOYEES.—

''(i) IN GENERAL.—If an employer makes an employer contribution for any period for coverage described in section 4521(c) for any employee who normally works at least 10 hours but less than 24 hours per week, subparagraph (A)(ii) shall be applied by substituting '10 hours' for '24 hours'.

''(ii) REQUIREMENTS MAY BE MET SEPARATELY.—If an employer elects the application of this clause—

''(I) the requirements of this subsection shall be applied separately to employees to whom this subsection applies by reason of clause (i), and

''(II) such employees shall be excluded in determining whether such requirements are met with respect to any other employees.

''(iii) PRO RATA CONTRIBUTIONS PERMISSIBLE.—For purposes of this subsection, contributions on behalf of any employee to which this subsection applies by reason of clause (i) shall not fail to be treated as equivalent solely because they are proportionate to the number of hours the employee works.

''(4) AGGREGATION RULES.—For purposes of this subsection—

''(A) IN GENERAL.—All employers treated as a single employer under subsection (b) or (c) of section 414 shall be treated as a single employer.

''(B) AFFILIATED SERVICE GROUPS.—All employees of members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

''(5) SEPARATE LINES OF BUSINESS.—If, under section 414(r), an employer is treated as operating separate lines of business for a year, the employer may apply this subsection separately to employees in each separate line of business.

"SEC. 4523. EXCEPTIONS.

''(a) EXCEPTION FOR REASONABLE DILIGENCE.—No tax shall be imposed by this subchapter during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that the employer had taken any action subject to tax under this subchapter.

''(b) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by this subchapter with respect to any action subject to tax under this subchapter if—

''(1) such action was due to reasonable cause and not to willful neglect, and

''(2) such action is corrected during the 30-day period beginning on the 1st date the employer knew, or exercising reasonable diligence would have known, that such action was subject to such tax.

''(c) WAIVER BY SECRETARY.—In the case of any action subject to tax under this subchapter which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of any tax imposed by this subchapter to the extent that the payment of such tax would be excessive relative to the failure involved.

"SEC. 4524. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) EMPLOYER.—

''(A) IN GENERAL.—The term 'employer' means any person or governmental entity for whom an individual performs services, of whatever nature, as an employee (as defined in section 3401(c)).

''(B) SPECIAL RULES.—

''(i) A partnership shall be treated as the employer of each partner who is an employee within the meaning of section 401(c)(1).

''(ii) An S corporation shall be treated as the employer of each shareholder who is an employee within the meaning of section 401(c)(1).

''(2) EMPLOYER CONTRIBUTIONS.—

''(A) IN GENERAL.—The term 'employer contribution' means, with respect to coverage under a health plan, a reasonable estimate of the portion of the cost of the coverage which is to be provided by the employer.

''(B) SPECIAL RULE FOR CAFETERIA PLANS.—The cost of any coverage provided through a cafeteria plan shall be determined on the basis of the coverage available through the plan.

''(b) LIABILITY FOR TAX.—Any tax imposed by this subchapter shall be paid by the employer.

''(c) TAXES TO APPLY TO GOVERNMENTAL AND OTHER TAX-EXEMPT ENTITIES.—Notwithstanding any other provision of law or rule of law, none of the following shall be exempt from the taxes imposed by this subchapter:

''(1) The United States, any State or political subdivision thereof, the District of Columbia, and any agency or instrumentality of any of the foregoing.

''(2) Any other entity otherwise exempt from tax under chapter 1.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as are necessary to carry out the provisions of this subchapter, including regulations providing for the determination of the amount of any employer contribution, the aggregation of governmental and tax-exempt entities, and the prevention of the avoidance of any tax imposed by this subchapter through the use of any arrangement described in section 414(o).''

(b) EMPLOYEE LEASING.—Paragraph (3) of section 414(n) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by adding at the end the following new subparagraph:

''(D) subchapter B of chapter 37.''

(c) TAX NOT DEDUCTIBLE.—Paragraph (7) of section 275(a), as added by section 706(b), is amended by inserting ''or 4521 (relating to taxable employer-provided health benefits'' after ''plans)''.

(d) CONFORMING AMENDMENT.—The table of subchapters for chapter 37 is amended by adding at the end the following new item:

''SUBCHAPTER B. Voluntary employer-provided health benefits.''

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 722. ELIMINATION OF EXCLUSION OF HEALTH BENEFITS PROVIDED THROUGH A FLEXIBLE SPENDING ARRANGEMENT.

(a) IN GENERAL.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) EXCEPTION FOR COVERAGE THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Subsection (a) shall not apply to coverage provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''

(b) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (21) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (21) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the end thereof the following new sentence: ''Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (16) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end thereof the following new sentence:

''Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on January 1, 1996.

(2) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a flexible spending arrangement maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in paragraph (1) shall not apply to benefits pursuant to any such agreement before the later of—

(A) January 1, 1996, or

(B) the earlier of—

(i) the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994), or

(ii) January 1, 1998.

SEC. 723. 2-YEAR EXTENSION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (6) of section 162(l) (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''1993'' and inserting ''1995''.

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

SEC. 724. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) GENERAL RULE.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(10) LIMITATION ON PREPAYMENTS.—If the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), to the extent such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made, such premium shall be treated as paid ratably over the period during which such insurance coverage or care is

to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994.

Subtitle C—Deduction for Individuals Purchasing Own Health Insurance

SEC. 731. DEDUCTION FOR HEALTH INSURANCE COSTS OF INDIVIDUALS.

(a) IN GENERAL.—Section 213 (relating to deduction for medical, dental, etc. expenses) is amended by adding at the end the following new subsection:

''(f) STANDARD HEALTH INSURANCE COSTS OF INDIVIDUALS.—

''(1) IN GENERAL.—The adjusted gross income limitation under subsection (a) shall not apply to 100 percent of the amounts paid by an eligible individual during the taxable year for qualified health care costs (and such amounts shall not be taken into account in determining whether such limitation applies to other amounts).

''(2) QUALIFIED HEALTH CARE COSTS.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified health care costs' means expenses for coverage of the taxpayer, the taxpayer's spouse, or any dependent under a certified standard health plan.

''(B) LIMITATIONS.—For purposes of subparagraph (A)—

''(i) NO DEDUCTION FOR EMPLOYER-SUBSIDIZED HEALTH COSTS.—Qualified health care costs shall not include any amount paid for coverage of an individual under a certified standard health plan for any month if the individual is eligible to participate for such month in an employer-subsidized certified standard health plan maintained by any employer of the taxpayer, the taxpayer's spouse, or any dependent.

''(ii) CERTAIN PREPAYMENTS.—If any amount paid during a taxable year is allocable to coverage to be provided more than 12 months after the month of payment, such amount shall be treated as paid ratably over the period of the coverage.

''(3) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' has the meaning given such term by section 21011(a)(2) of the Social Security Act.

''(B) EMPLOYER.—The term 'employer' has the meaning given such term by section 4524(a)(1).

''(C) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this subsection shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.

''(4) REDUCTION IN PERCENTAGE.—For requirement that the President reduce the percentage under paragraph (1) to offset deficits in Federal health care spending, see section 801 of the Health Security Act.''

(b) DEDUCTION ALLOWED AGAINST GROSS INCOME.—Section 62(a) (defining adjusted gross income) is amended by inserting after paragraph (15) the following new paragraph:

''(16) DEDUCTION FOR QUALIFIED HEALTH CARE COSTS.—The deduction allowed under section 213(a) for amounts described in section 213(f).''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle D—Exempt Organizations

PART I—HEALTH CARE ORGANIZATIONS

SEC. 741. QUALIFICATION AND DISCLOSURE REQUIREMENTS FOR NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

''(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS.—

''(1) IN GENERAL.—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—

''(A) such organization, with the participation of community representatives, annually—

''(i) assesses its community's needs for health care services and qualified outreach services, and

''(ii) prepares a written plan to meet those needs,

''(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

''(C) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan, and

''(D) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay.

''(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization shall not be treated as described in subsection (c)(3) unless substantially all of its primary care health services are provided as described in subsection (m)(6)(A).

''(3) DEFINITIONS AND SPECIAL RULE.—For purposes of this subsection—

''(A) QUALIFIED OUTREACH SERVICES.—The term 'qualified outreach services' means health care services (or preventive care, educational, or social services programs related thereto) which are provided—

''(i) in 1 or more medically underserved areas,

''(ii) at below cost to individuals who are otherwise unable to afford such services, or

''(iii) at emergency care facilities which provide specialty services and which normally operate at a loss.

Such term shall not include insurance described in subparagraph (B)(iii) unless such insurance is provided on a subsidized basis.

''(B) HEALTH CARE SERVICES.—The term 'health care services' means—

''(i) any activity which consists of providing medical care (as defined in section 213(d)(1)(A)) to individuals,

''(ii) in the case of an organization described in subsection (c)(3), any activity

which is treated as accomplishing an exempt purpose of the organization solely because it is carried on as part of an activity described in clause (i), and

''(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

''(C) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means, with respect to a health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

''(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

''(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

''(4) EXCEPTIONS.—This subsection shall not apply to any organization which—

''(A) demonstrates, in a manner not inconsistent with regulations prescribed by the Secretary, that one of its principal purposes is academic training or medical research, or

''(B) provides health care services exclusively on an uncompensated basis, regardless of ability to pay.

''(5) DISALLOWANCE OF CHARITABLE DEDUCTIONS.—No gift or bequest to an organization which is not exempt from tax by reason of this subsection shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

''(6) REQUIREMENTS SUPPLEMENT OTHER REQUIREMENTS.—The requirements of this subsection are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in paragraph (3) or (4) of subsection (c).''

(b) REPORTING AND DISCLOSURE OF NEEDS ASSESSMENT AND PLAN.—

(1) REPORTING.—

(A) ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3).—Subsection (b) of section 6033 (relating to certain organizations described in section 501(c)(3)) is amended by striking

''and'' at the end of paragraph (9), by redesignating paragraph (10) as paragraph (12), and by inserting after paragraph (9) the following new paragraphs:

''(10) in the case of an organization which prepares a plan described in section 501(n)(1)(A) (relating to community needs)—

''(A) a copy of such plan for the year, and

''(B) information on the implementation of such plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan),

''(11) such information as the Secretary may require with respect to any taxable inurement (as defined in section 4958(d)), and''.

(B) ORGANIZATIONS DESCRIBED IN SECTION 501(C)(4).—Section 6033 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

''(f) CERTAIN ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Every organization described in section 501(c)(4) which is subject to the requirements of subsection (a) and which prepares a plan described in section

501(n)(1)(A) (relating to community needs) for the year—

''(1) shall include a copy of such plan with the return required under subsection (a) for the year, and

''(2) shall include on such return the information referred to in paragraphs (10)(B) and (11) of subsection (b) with respect to such organization.''

(2) DISCLOSURE.—

(A) IN GENERAL.—Subsection (e) of section 6104 (relating to public inspection of certain annual returns and applications for exemption) is amended by adding at the end the following new paragraph:

''(3) COMMUNITY HEALTH CARE NEEDS ASSESSMENT AND PLAN.—

''(A) IN GENERAL.—Every organization which is required to prepare a plan described in section 501(n)(1)(A) (relating to community needs)—

''(i) shall make a copy of such plan (and the assessment on which such plan is based) available for inspection during regular business hours by any individual at the principal office of such organization and, if

such organization regularly maintains 1 or more regional or district offices having 3 or more employees, at each such regional or district office, and

''(ii) upon request of an individual made at such principal office or such a regional or district office, shall provide—

''(I) a copy of such plan (and assessment), and

''(II) a copy of the annual return filed under section 6033,

to such individual without charge other than a reasonable fee for any reproduction and mailing costs.

If the request under clause (ii) is made in person, such copies shall be provided immediately and, if made other than in person, shall be provided within 30 days.

''(B) PERIOD OF AVAILABILITY.—Subparagraph (A) shall apply—

''(i) with respect to any plan (and assessment) during the 3-year period after the close of the year for which such plan is prepared, and

''(ii) with respect to any return, during the 3-year period beginning on the filing date (as defined in paragraph (1)(D)).

''(C) LIMITATION.—Subparagraph (A)(ii) shall not apply to any request if the Secretary determines, upon application by an organization, that such request is part of a harassment campaign and that compliance with such request is not in the public interest.''

(B) TECHNICAL AMENDMENT.—The heading for subsection (e) of section 6104 is amended by striking ''AND APPLICATIONS FOR EXEMPTION'' and inserting '', APPLICATIONS FOR EXEMPTION, AND COMMUNITY NEEDS ASSESSMENT AND PLAN FOR HEALTH AND OUTREACH SERVICES''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 1995.

(2) HMO SERVICE REQUIREMENT.—So much of the amendments made by this section as relates to section 501(n)(2) of the Internal Revenue Code of 1986, as added by this section, shall take effect on the date of the enactment of this Act.

SEC. 742. EXCISE TAXES FOR PRIVATE INUREMENT BY TAX-EXEMPT HEALTH CARE ORGANIZATIONS.

(a) IN GENERAL.—Chapter 42 (relating to private foundations and certain other tax-exempt organizations) is amended by redesignating subchapter D as subchapter E and by inserting after subchapter C the following new subchapter:

"Subchapter D—Private Inurement by Tax-Exempt Health Care Organizations

"SEC. 4958. TAXES ON PRIVATE INUREMENT.

''(a) INITIAL TAXES.—

''(1) ON THE BENEFICIARY.—There is hereby imposed on any taxable inurement a tax equal to 25 percent of the amount thereof. The tax imposed by this paragraph shall be paid by any beneficiary of such inurement.

''(2) ON THE MANAGEMENT.—In any case in which there is a tax imposed by paragraph (1), there is hereby imposed on the participation of any organization manager of an organization in any taxable inurement which occurs with respect to such organization, knowing that it is taxable inurement, a tax equal to 2½ percent of the amount thereof, unless such participation is not willful and is due to reason-

able cause. The tax imposed by this paragraph shall be paid by any organization manager who participated in the taxable inurement.

''(b) ADDITIONAL TAXES.—

''(1) ON THE BENEFICIARY.—In any case in which an initial tax is imposed by subsection (a)(1) on any taxable inurement and such inurement is not corrected within the taxable period, there is hereby imposed a tax equal to 200 percent of the amount of the taxable inurement. The tax imposed by this paragraph shall be paid by any beneficiary of such inurement.

''(2) ON THE MANAGEMENT.—In any case in which an additional tax is imposed by paragraph (1), if an organization manager refused to agree to part or all of the correction, there is hereby imposed a tax equal to 50 percent of the amount of the taxable inurement. The tax imposed by this paragraph shall be paid by any organization manager who refused to agree to part or all of the correction.

''(c) SPECIAL RULES RELATING TO LIABILITY FOR TAX.—For purposes of this section—

''(1) JOINT AND SEVERAL LIABILITY.—If more than one person is liable under any paragraph of subsection (a) or (b) with respect to any one taxable

inurement, all such persons shall be jointly and severally liable under such paragraph with respect to such inurement.

''(2) LIMIT FOR MANAGEMENT.—With respect to any 1 taxable inurement, the maximum amount of the tax imposed by subsection (a)(2) shall not exceed $10,000, and the maximum amount of the tax imposed by subsection (b)(2) shall not exceed $10,000.

''(d) TAXABLE INUREMENT.—For purposes of this section, the term 'taxable inurement' means any inurement not permitted under paragraph (3) or (4) of section 501(c), as the case may be, in a transaction involving an applicable tax-exempt health care organization in which—

''(1) the value of any economic benefit provided to or for the use of a disqualified person exceeds the value of the consideration (including the performance of services) received by the organization for providing such benefit, or

''(2) the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the gross or net revenues of 1 or more activities of the organization.

The amount of any taxable inurement with respect to any such transaction shall be the excess described in paragraph (1) or the amount described in paragraph (2). For purposes of paragraph (1), an economic benefit shall not be treated as provided as consideration for the performance of services unless the organization clearly indicated its intent to so treat such benefit.

''(e) OTHER DEFINITIONS.—For purposes of this section—

''(1) DISQUALIFIED PERSON.—The term 'disqualified person' means, with respect to any transaction—

''(A) any person who was, at any time during the 5-year period ending on the date of such transaction—

''(i) an organization manager, or

''(ii) an individual (other than an organization manager)—

''(I) in a position to exercise substantial influence over the affairs of the organization, or

''(II) performing substantial medical services as a physician pursuant to an employment or other con-

tractual relationship with the organization or a related organization,

''(B) a member of the family of an individual described in subparagraph (A), and

''(C) a 35-percent controlled entity.

''(2) ORGANIZATION MANAGER.—The term 'organization manager' means, with respect to any applicable tax-exempt health care organization, any officer, director, or trustee of such organization (or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization).

''(3) 35-PERCENT CONTROLLED ENTITY.—

''(A) IN GENERAL.—The term '35-percent controlled entity' means—

''(i) a corporation in which persons described in subparagraph (A) or (B) of paragraph (1) own more than 35 percent of the total combined voting power,

''(ii) a partnership in which such persons own more than 35 percent of the profits interest, and

''(iii) a trust or estate in which such persons own more than 35 percent of the beneficial interest.

''(B) CONSTRUCTIVE OWNERSHIP RULES.—Rules similar to the rules of paragraphs (3) and (4) of section 4946(a) shall apply for purposes of this subsection.

''(4) FAMILY MEMBERS.—The members of an individual's family shall be determined under section 4946(d); except that such members also shall include the brothers and sisters (whether by the whole or halfblood) of the individual and their spouses.

''(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANIZATIONS.—

''(1) IN GENERAL.—For purposes of this section, the status of any organization as an applicable tax-exempt health care organization shall be terminated only if—

''(A)(i) such organization notifies the Secretary (at such time and in such manner as the Secretary may by regulations prescribe) of its intent to accomplish such termination, or

''(ii) there is a final determination by the Secretary that such status has terminated, and

''(B)(i) such organization pays the tax imposed by paragraph (2) (or any portion not abated pursuant to paragraph (3)), or

''(ii) the entire amount of such tax is abated pursuant to paragraph (3).

''(2) IMPOSITION OF TAX.—There is hereby imposed on each organization referred to in paragraph (1) a tax equal to the lesser of—

''(A) the amount which the organization substantiates by adequate records or other corroborating evidence as the aggregate tax benefit resulting from its exemption from tax under section 501(a), or

''(B) the value of the net assets of such organization.

''(3) ABATEMENT OF TAX.—The Secretary may abate the unpaid portion of the assessment of any tax imposed by paragraph (2), or any liability in respect thereof, if the applicable tax-exempt health care organization distributes all of its net assets to 1 or more organizations each of which has been in existence, and described in section 501(c)(3), for a continuous period of at least 60 calendar months. If the distributing organization is described in section 501(c)(4), the preceding sentence shall be applied by treating the reference to section 501(c)(3) as including a reference to section 501(c)(4).

''(4) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (d), (e), and (f) of section 507 shall apply for purposes of this subsection.

"SEC. 4959. OTHER DEFINITIONS.

''(a) APPLICABLE TAX-EXEMPT HEALTH CARE ORGANIZATION.—For purposes of this subchapter, the term 'applicable tax-exempt health care organization' means any organization—

''(1) the predominant activity of which is the provision of health care services (as defined in section 501(n)(3)), and

''(2) which (without regard to any taxable inurement) would be described in paragraph (3) or (4) of section 501(c) and exempt from tax under section 501(a).

Such term does not include a private foundation (as defined in section 509(a)).

''(b) TAXABLE PERIOD; CORRECTION.—For purposes of this subchapter—

''(1) TAXABLE PERIOD.—The term 'taxable period' means, with respect to any taxable inurement, the period beginning with the date on which the inurement occurs and ending on the earliest of—

''(A) the date of mailing a notice of deficiency under section 6212 with respect to the tax imposed by subsection (a)(1) of section 4958, or

''(B) the date on which the tax imposed by such subsection (a)(1) is assessed.

''(2) CORRECTION.—The terms 'correction' and 'correct' mean, with respect to any taxable inurement, undoing the inurement to the extent possible, establishing safeguards to prevent future such inurement, and where fully undoing the inurement is not possible, such additional corrective action as is prescribed by the Secretary by regulations.''

(b) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Paragraph (4) of section 501(c) is amended by inserting ''(A)'' after ''(4)'' and by adding at the end the following:

''(B) Subparagraph (A) shall not apply to an entity the predominant activity of which is the provision of health care services (as defined in subsection (n)(3)) unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual.''

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4955 is amended—

(A) by striking ''SECTION 4945'' in the heading and inserting ''SECTIONS 4945 and 4958'', and

(B) by inserting before the period ''or a taxable inurement for purposes of section 4958''.

(2) Subsections (a), (b), and (c) of section 4963 are each amended by inserting ''4958,'' after ''4955,''.

(3) Subsection (e) of section 6213 is amended by inserting ''4958 (relating to private inurement),'' before ''4971''.

(4) Paragraphs (2) and (3) of section 7422(g) are each amended by inserting ''4958,'' after ''4955,''.

(5) Subsection (b) of section 7454 is amended by inserting ''or whether an organization manager (as defined in section 4958(f)) has 'knowingly' participated in taxable inurement (as defined in section 4958(d)),'' after ''section 4912(b),''.

(6) The table of subchapters for chapter 42 is amended by striking the last item and inserting the following:

''SUBCHAPTER D. Private inurement by tax-exempt health care organizations.
''SUBCHAPTER E. Abatement of first and second tier taxes in certain cases.''

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to inurement occurring on or after June 30, 1994.

(2) APPLICATION OF BINDING CONTRACT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(C)(4).—The amendments made by this section shall not apply to any inurement involving an organization described in section 501(c)(4) of the Internal Revenue Code of 1986 occurring before July 1, 1996, pursuant to a written contract which was binding on June 29, 1994, and at all times thereafter before such inurement occurred.

SEC. 743. TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS, PARENT ORGANIZATIONS, AND HEALTH INSURANCE PURCHASING COOPERATIVES.

(a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—

(1) IN GENERAL.—Section 501(m) (relating to certain organizations providing commercial-type in-

surance not exempt from tax) is amended by adding at the end the following new paragraph:

''(6) CERTAIN ACTIVITIES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS NOT TREATED AS COMMERCIAL-TYPE INSURANCE.—For purposes of this subsection, the provision of (or the arranging for the provision of) medical care on a prepaid basis by a health maintenance organization shall not be treated as providing commercial-type insurance if (and only if) such care is—

''(A) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

''(B) care provided by a health care professional to a member of such organization on a basis under which substantially all of the risks of the rates of utilization is assumed by the provider of such care,

''(C) care (other than primary care) provided to a member of such organization pursuant to a referral by such organization, or

''(D) emergency care provided to a member of such organization at a location outside such member's area of residence.''

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (3) of section 501(m) is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(B) Paragraph (5) of section 501(m) is amended by striking ''paragraph (3)(E)'' and inserting ''paragraph (3)(D)''.

(b) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking ''and'' at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

''(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii), and''.

(c) PURCHASING COOPERATIVES EXEMPT FROM TAX.—

(1) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end the following new paragraph:

''(26)(A) Any health insurance purchasing cooperative described in part III of subtitle D of title XXI of the Social Security Act.

''(B) Such a cooperative shall not be exempt from tax pursuant to any provision other than this paragraph.

''(C) Such a cooperative shall not be exempt from tax unless—

''(i) no part of the net earnings of such cooperative inures to the benefit of any private shareholder or individual,

''(ii) no substantial part of the activities of such cooperative is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and

''(iii) such cooperative does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''

(2) CERTAIN PROVISIONS APPLICABLE TO ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE APPLICABLE TO PURCHASING COOPERATIVES.—Section 501 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) CERTAIN PROVISIONS MADE APPLICABLE TO HEALTH INSURANCE PURCHASING COOPERATIVES.—A health insurance purchasing cooperative described in subsection (c)(26) shall be treated—

''(1) as described in subsection (c)(3) for purposes of applying subsection (h) (relating to expenditures by public charities to influence legislation), section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and section 4958 (relating to private inurement), and

''(2) as described in subsection (h)(4).''

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 744. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 831 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.—

''(1) GENERAL RULE.—Any organization to which this subsection applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

''(2) ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any organization—

''(A) which is not exempt from taxation under this subtitle,

''(B) which is not taxable as a life insurance company under part I of this subchapter,

''(C) which is not an organization to which section 833 applies, and

''(D) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

''(i) Issuing accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts.

''(ii) Operating as a health maintenance organization.

''(iii) Entering into arrangements under which—

''(I) fixed payments or premiums are received as consideration for the organization's agreement to provide or arrange for the provision of health care services, regardless of how the health care services are provided or arranged to be provided, and

''(II) substantially all of the risks of the rates of utilization of such services is assumed by such organization or the provider of such services.

In the case of an organization which has as a material business activity the issuing of accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts, the administering of accident and health insurance contracts by such organization shall

be treated as part of such business activity for purposes of subparagraph (D)(i).''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

(2) TRANSITIONAL RULES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 831(c) of the Internal Revenue Code of 1986 (as added by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1994; except that this paragraph shall not apply if such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1995.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—Except as provided in regulations prescribed by the Secretary of the Treasury or

his delegate, in the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986 shall be taken into account for such company's first taxable year beginning after December 31, 1994.

(C) TREATMENT OF CURRENTLY TAX-EXEMPT COMPANIES.—Except as provided in regulations prescribed by the Secretary of the Treasury or his delegates, in the case of any organization to which this paragraph applies and which was exempt from tax under chapter 1 of the Internal Revenue Code of 1986 for such organization's last taxable year beginning before January 1, 1995—

(i) no adjustment shall be made under section 481 (or any other provision) of such Code on account of a change in its method of accounting required by this sec-

tion for its first taxable year beginning after December 31, 1994, and

(ii) for purposes of determining gain or loss, the adjusted basis of any asset held by such organization on the first day of such taxable year shall be treated as equal to its fair market value as of such day.

SEC. 745. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

''(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

''(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

''(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

''(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit

health insurance or health service type organizations, and

''(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1986.

SEC. 746. TAX EXEMPTION FOR HIGH-RISK INSURANCE POOLS.

Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(27)(A) In the case of taxable years beginning after December 31, 1989, and before January 1, 1997, a qualified high risk health insurance pool.

''(B) For purposes of subparagraph (A), the term 'qualified high risk health insurance pool' means an entity—

''(i) which was established by a State or political subdivision thereof to provide health insurance on a nonprofit basis to persons unable to obtain health insurance because of health conditions,

''(ii) with respect to which the State or political subdivision—

''(I) participates in the ongoing governance of the entity, and

''(II) subsidizes the operation of the entity, and

''(iii) no part of the net earnings of which inure to the benefit of any private shareholder, member, or individual.''

PART II—TAX TREATMENT OF SECTION 501(c)(3) BONDS

SEC. 748. TAX TREATMENT OF 501(c)(3) BONDS SIMILAR TO GOVERNMENTAL BONDS.

(a) IN GENERAL.—Subsection (a) of section 150 (relating to definitions and special rules) is amended by striking paragraphs (2) and (4), by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively, and by inserting after paragraph (1) the following new paragraph:

''(2) EXEMPT PERSON.—

''(A) IN GENERAL.—The term 'exempt person' means—

''(i) a governmental unit, or

''(ii) a 501(c)(3) organization, but only with respect to its activities which do not constitute unrelated trades or busi-

nesses as determined by applying section 513(a).

''(B) GOVERNMENTAL UNIT NOT TO INCLUDE FEDERAL GOVERNMENT.—The term 'governmental unit' does not include the United States or any agency or instrumentality thereof.

''(C) 501(c)(3) ORGANIZATION.—The term '501(c)(3) organization' means any organization described in section 501(c)(3) and exempt from tax under section 501(a).''

(b) REPEAL OF QUALIFIED 501(c)(3) BOND DESIGNATION.—Section 145 (relating to qualified 501(c)(3) bonds) is repealed.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (3) of section 141(b) is amended—

(A) by striking ''government use'' in subparagraph (A)(ii)(I) and subparagraph (B)(ii) and inserting ''exempt person use'',

(B) by striking ''a government use'' in subparagraph (B) and inserting ''an exempt person use'',

(C) by striking ''related business use'' in subparagraph (A)(ii)(II) and subparagraph (B) and inserting ''related private business use'',

(D) by striking ''RELATED BUSINESS USE'' in the heading of subparagraph (B) and inserting ''RELATED PRIVATE BUSINESS USE'', and

(E) by striking ''GOVERNMENT USE'' in the heading thereof and inserting ''EXEMPT PERSON USE''.

(2) Subparagraph (A) of section 141(b)(6) is amended by striking ''a governmental unit'' and inserting ''an exempt person''.

(3) Paragraph (7) of section 141(b) is amended—

(A) by striking ''government use'' and inserting ''exempt person use'', and

(B) by striking ''GOVERNMENT USE'' in the heading thereof and inserting ''EXEMPT PERSON USE''.

(4) Section 141(b) is amended by striking paragraph (9).

(5) Paragraph (1) of section 141(c) is amended by striking ''governmental units'' and inserting ''exempt persons''.

(6) Section 141 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) CERTAIN ISSUES USED TO PROVIDE RESIDENTIAL RENTAL HOUSING FOR FAMILY UNITS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of this title, the term 'private activity bond' includes any bond issued as part of an issue if any portion of the net proceeds of the issue are to be used (directly or indirectly) by an exempt person described in section 150(a)(2)(A)(ii) to provide residential rental property for family units. This paragraph shall not apply if the bond would not be a private activity bond if the section 501(c)(3) organization were not an exempt person.

''(2) EXCEPTION FOR BONDS USED TO PROVIDE QUALIFIED RESIDENTIAL RENTAL PROJECTS.—Paragraph (1) shall not apply to any bond issued as part of an issue if the portion of such issue which is to be used as described in paragraph (1) is to be used to provide—

''(A) a residential rental property for family units if the first use of such property is pursuant to such issue,

''(B) qualified residential rental projects (as defined in section 142(d)), or

''(C) property which is to be substantially rehabilitated in a rehabilitation beginning with-

in the 2-year period ending 1 year after the date of the acquisition of such property.

''(3) SUBSTANTIAL REHABILITATION.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), rules similar to the rules of section 47(c)(1)(C) shall apply in determining for purposes of paragraph (2)(C) whether property is substantially rehabilitated.

''(B) EXCEPTION.—For purposes of subparagraph (A), clause (ii) of section 47(c)(1)(C) shall not apply, but the Secretary may extend the 24-month period in section 47(c)(1)(C)(i) where appropriate due to circumstances not within the control of the owner.

''(4) CERTAIN PROPERTY TREATED AS NEW PROPERTY.—Solely for purposes of determining under paragraph (2)(A) whether the 1st use of property is pursuant to tax-exempt financing—

''(A) IN GENERAL.—If—

''(i) the 1st use of property is pursuant to taxable financing,

''(ii) there was a reasonable expectation (at the time such taxable financing was provided) that such financing would be replaced by tax-exempt financing, and

''(iii) the taxable financing is in fact so replaced within a reasonable period after the taxable financing was provided,

then the 1st use of such property shall be treated as being pursuant to the tax-exempt financing.

''(B) SPECIAL RULE WHERE NO OPERATING STATE OR LOCAL PROGRAM FOR TAX-EXEMPT FINANCING.—If, at the time of the 1st use of property, there was no operating State or local program for tax-exempt financing of the property, the 1st use of the property shall be treated as pursuant to the 1st tax-exempt financing of the property.

''(C) DEFINITIONS.—For purposes of this paragraph—

''(i) TAX-EXEMPT FINANCING.—The term 'tax-exempt financing' means financing provided by tax-exempt bonds.

''(ii) TAXABLE FINANCING.—The term 'taxable financing' means financing which is not tax-exempt financing.''

(7) Section 141(f), as redesignated by paragraph (6), is amended—

(A) by adding ''or'' at the end of subparagraph (E),

(B) by striking '', or'' at the end of subparagraph (F), and inserting in lieu thereof a period, and

(C) by striking subparagraph (G).

(8) The last sentence of section 144(b)(1) is amended by striking ''(determined'' and all that follows to the period.

(9) Clause (ii) of section 144(c)(2)(C) is amended by striking ''a governmental unit'' and inserting ''an exempt person''.

(10) Section 146(g) is amended—

(A) by striking paragraph (2), and

(B) by redesignating the remaining paragraphs after paragraph (1) as paragraphs (2) and (3), respectively.

(11) The heading of section 146(k)(3) is amended by striking ''GOVERNMENTAL'' and inserting ''EXEMPT PERSON''.

(12) The heading of section 146(m) is amended by striking ''GOVERNMENT'' and inserting ''EXEMPT PERSON''.

(13) Subsection (h) of section 147 is amended to read as follows:

''(h) CERTAIN RULES NOT TO APPLY TO MORTGAGE REVENUE BONDS AND QUALIFIED STUDENT LOAN BONDS.—Subsections (a), (b), (c), and (d) shall not apply to any qualified mortgage bond, qualified veterans' mortgage bond, or qualified student loan bond.''

(14) Section 147 is amended by striking paragraph (4) of subsection (b) and redesignating paragraph (5) of such subsection as paragraph (4).

(15) Subparagraph (F) of section 148(d)(3) is amended—

(A) by striking ''or which is a qualified 501(c)(3) bond'', and

(B) by striking ''GOVERNMENTAL USE BONDS AND QUALIFIED 501(C)(3)'' in the heading thereof and inserting ''EXEMPT PERSON''.

(16) Subclause (II) of section 148(f)(4)(B)(ii) is amended by striking ''(other than a qualified 501(c)(3) bond)''.

(17) Clause (iv) of section 148(f)(4)(C) is amended—

(A) by striking ''a governmental unit or a 501(c)(3) organization'' each place it appears and inserting ''an exempt person'',

(B) by striking ''qualified 501(c)(3) bonds,'', and

(C) by striking the comma after ''private activity bonds'' the first place it appears.

(18) Subparagraph (A) of section 148(f)(7) is amended by striking ''(other than a qualified 501(c)(3) bond)''.

(19) Paragraph (2) of section 149(d) is amended—

(A) by striking ''(other than a qualified 501(c)(3) bond)'', and

(B) by striking ''CERTAIN PRIVATE'' in the heading thereof and inserting ''PRIVATE''.

(20) Section 149(e)(2) is amended—

(A) by striking ''which is not a private activity bond'' in the second sentence and inserting ''which is a bond issued for an exempt person described in section 150(a)(2)(A)(i)'', and

(B) by adding at the end the following new sentence: ''Subparagraph (D) shall not apply to any bond which is not a private activity bond but which would be such a bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person.''

(21) The heading of subsection (b) of section 150 is amended by striking ''TAX-EXEMPT PRIVATE

ACTIVITY BONDS'' and inserting ''CERTAIN TAX-EXEMPT BONDS''.

(22) Paragraph (3) of section 150(b) is amended—

(A) by inserting ''owned by a 501(c)(3) organization'' after ''any facility'' in subparagraph (A),

(B) by striking ''any private activity bond which, when issued, purported to be a tax-exempt qualified 501(c)(3) bond'' in subparagraph (A) and inserting ''any bond which, when issued, purported to be a tax-exempt bond, and which would be a private activity bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person'', and

(C) by striking the heading thereof and inserting ''BONDS FOR EXEMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—''.

(23) Paragraph (5) of section 150(b) is amended—

(A) by striking ''private activity'' in subparagraph (A),

(B) by inserting ''and which would be a private activity bond if the 501(c)(3) organization using the proceeds thereof were not an ex-

empt person'' after ''tax-exempt bond'' in subparagraph (A),

(C) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) such facility is required to be owned by an exempt person, and'', and

(D) by striking ''GOVERNMENTAL UNITS OR 501(C)(3) ORGANIZATIONS'' in the heading thereof and inserting ''EXEMPT PERSONS''.

(24) Section 150 is amended by adding at the end the following new subsection:

''(f) CERTAIN RULES TO APPLY TO BONDS FOR EXEMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—

''(1) IN GENERAL.—Nothing in section 103(a) or any other provision of law shall be construed to provide an exemption from Federal income tax for interest on any bond which would be a private activity bond if the 501(c)(3) organization using the proceeds thereof were not an exempt person unless such bond satisfies the requirements of subsections (b) and (f) of section 147.

''(2) SPECIAL RULE FOR POOLED FINANCING OF 501(C)(3) ORGANIZATION.—

''(A) IN GENERAL.—At the election of the issuer, a bond described in paragraph (1) shall

be treated as meeting the requirements of section 147(b) if such bond meets the requirements of subparagraph (B).

''(B) REQUIREMENTS.—A bond meets the requirements of this subparagraph if—

''(i) 95 percent or more of the net proceeds of the issue of which such bond is a part are to be used to make or finance loans to 2 or more 501(c)(3) organizations or governmental units for acquisition of property to be used by such organizations,

''(ii) each loan described in clause (i) satisfies the requirements of section 147(b) (determined by treating each loan as a separate issue),

''(iii) before such bond is issued, a demand survey was conducted which shows a demand for financing greater than an amount equal to 120 percent of the lendable proceeds of such issue, and

''(iv) 95 percent or more of the net proceeds of such issue are to be loaned to 501(c)(3) organizations or governmental units within 1 year of issuance and, to the extent there are any unspent proceeds

after such 1-year period, bonds issued as part of such issue are to be redeemed as soon as possible thereafter (and in no event later than 18 months after issuance). A bond shall not meet the requirements of this subparagraph if the maturity date of any bond issued as part of such issue is more than 30 years after the date on which the bond was issued (or, in the case of a refunding or series of refundings, the date on which the original bond was issued).''

(25) Section 1302 of the Tax Reform Act of 1986 is repealed.

(26) Subparagraph (C) of section 57(a)(5) is amended by striking clause (ii) and redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(27) Paragraph (3) of section 103(b) is amended by inserting ''and section 150(f)'' after ''section 149''.

(28) Paragraph (3) of section 265(b) is amended—

(A) by striking clause (ii) of subparagraph (B) and inserting the following:

''(ii) CERTAIN BONDS NOT TREATED AS PRIVATE ACTIVITY BONDS.—For purposes of clause (i)(II), there shall not be treated as a private activity bond any obligation issued to refund (or which is part of a series of obligations issued to refund) an obligation issued before August 8, 1986, which was not an industrial development bond (as defined in section 103(b)(2) as in effect on the day before the date of the enactment of the Tax Reform Act of 1986) or a private loan bond (as defined in section 103(o)(2)(A), as so in effect, but without regard to any exemption from such definition other than section 103(o)(2)(A)).''; and

(B) by striking ''(other than a qualified 501(c)(3) bond, as defined in section 145)'' in subparagraph (C)(ii)(I).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds (including refunding bonds) issued after December 31, 1994.

Subtitle E—Tax Treatment of Long-Term Care Insurance and Services

SEC. 751. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in subsection (g)), or''.

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, curing, mitigating, treating, preventive, therapeutic, and rehabilitative services, and maintenance and personal care services (whether performed in a residential or nonresidential setting) which—

''(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

''(B) have as their primary purpose—

''(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

''(ii) protection from threats to health and safety due to severe cognitive impairment, and

''(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

''(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who—

''(A) is unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), at least 2 activities of daily living as defined in paragraph (3), or

''(B) has severe cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless a licensed professional within the preceding 12-month period has certified that such individual meets such requirements.

''(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(4) LICENSED PROFESSIONAL.—The term 'licensed professional' means—

''(A) a physician or registered professional nurse, or

''(B) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

''(A) by a relative (directly or through a partnership, corporation, or other entity) unless

the relative is a licensed professional with respect to such services, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

''(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in—

''(i) subparagraphs (A) and (B), or

''(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7702B(b)) and the amount paid for such insurance is not disallowed under section 7702B(d)(4).''

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraph (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 752. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident or health insurance contract,

''(2) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy shall be treated as amounts received for per-

sonal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) except to the extent provided in section 106(c), any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident or health plan with respect to such coverage,

''(4) except as provided in subsection (d)(4), amounts paid for a qualified long-term care insurance policy providing the benefits described in subsection (b)(6)(B) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any certified long-term care policy (as defined in section 21011(b)(2) of the Social Security Act) that—

''(A) limits benefits under such policy to individuals who are certified by a licensed pro-

fessional (as defined in section 213(g)(4)) within the preceding 12-month period—

''(i) as being unable to perform, without substantial assistance from another individual (including assistance involving cueing or substantial supervision), 2 or more activities of daily living (as defined in section 213(g)(3)), or

''(ii) having a severe cognitive impairment (as defined in section 213(g)(2)(B)), and

''(B) satisfies the requirements of paragraphs (2), (3), (4), (5), and (6).

''(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect to a policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an individual certified in accordance with paragraph (1)(A).

''(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met if the policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

''(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a policy if such policy provides that—

''(A) policyholder dividends are required to be applied as a reduction in future premiums or, to the extent permitted under paragraph (6), to increase benefits described in subsection (a)(2),

''(B) refunds of premiums upon a partial surrender or a partial cancellation are required to be applied as a reduction in future premiums, and

''(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the contract.

Any refund on a complete surrender or cancellation of the policy shall be includible in gross income to

the extent that any deduction or exclusion was allowable with respect to the premiums.

''(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a policy if such policy does not pay, or provide reimbursement for, expenses incurred to the extent that such expenses are also paid or reimbursed under title XVIII of the Social Security Act or are paid or reimbursed under a certified standard health plan (as defined in section 21011(a)(2) of the Social Security Act).

''(6) MAXIMUM BENEFIT.—

''(A) IN GENERAL.—The requirements of this paragraph are met if the benefits payable under the policy for any period (whether on a periodic basis or otherwise) may not exceed the dollar amount in effect for such period.

''(B) NONREIMBURSEMENT PAYMENTS PERMITTED.—Benefits shall include all payments described in subsection (a)(2) to or on behalf of an insured individual without regard to the expenses incurred during the period to which the payments relate. For purposes of section 213(a), such payments shall be treated as

compensation for expenses paid for medical care.

''(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis).

''(D) ADJUSTMENTS FOR INCREASED COSTS.—

''(i) IN GENERAL.—In the case of any calendar year after 1996, the dollar amount in effect under subparagraph (C) for any period or portion thereof occurring during such calendar year shall be equal to the sum of—

''(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

''(II) the product of the amount referred to in subclause (I) multiplied by the cost-of-living adjustment for the calendar year.

''(ii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the cost-of-liv-

ing adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iii) for the preceding calendar year exceeds such index for the second preceding calendar year.

''(iii) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

''(iv) SPECIAL RULE FOR CALENDAR YEAR 1997.—Notwithstanding clause (ii), for purposes of clause (i), the cost-of-living adjustment for calendar year 1997 is the sum of 1.5 percent plus the percentage by which the CPI for calendar year 1996 (as defined in section 1(f)(4)) exceeds the CPI for calendar year 1995 (as so defined).

''(E) PERIOD.—For purposes of this paragraph, a period begins on the date that an individual has a condition which would qualify for

certification under subsection (b)(1)(A) and ends on the earlier of the date upon which—

''(i) such individual has not been so certified within the preceding 12-months, or

''(ii) the individual's condition ceases to be such as to qualify for certification under subsection (b)(1)(A).

''(F) AGGREGATION RULE.—For purposes of this paragraph, all policies issued with respect to the same insured shall be treated as one policy.

''(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for personal injuries or sickness or provided under an accident or health plan and shall not be treated as excludible from gross income under any provision of this title.

''(d) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether

or not qualified) provided by rider on a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract or policy.

''(2) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for coverage under a long-term care insurance policy and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage shall be treated as premiums for purposes of subsection (b)(2).

''(3) APPLICATION OF SECTION 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

''(5) AMOUNT OF DISTRIBUTION UNDER RIDER.—This subsection shall not apply to any rider on a life insurance contract unless the percentage reduction in the cash surrender value of the contract by reason of any payment under the rider does not exceed the percentage reduction in the death benefit payable under the contract by reason of the payment.

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a long-term care insurance policy, except that the coverage under a rider described in this subsection shall not fail to be treated as such an addition by reason of a reduction in the contract's death benefit or cash surrender value resulting from any payment under the rider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.''

(b) EMPLOYER CONTRIBUTIONS TO LONG-TERM CARE COVERAGE NOT EXCLUDED.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 7202, is amended by adding at the end the following new subsection:

''(c) EXCEPTION FOR LONG-TERM CARE INSURANCE.—Subsection (a) shall not apply to employer-provided coverage under any qualified long-term care insurance policy.''

(2) EMPLOYMENT TAX TREATMENT.—Each of the following provisions, as amended by section 7202(b), is amended by striking ''section 106(b)'' and inserting ''subsection (b) or (c) of section 106'':

(A) The last sentence of section 3121(a).

(B) The last sentence of section 209(a) of the Social Security Act.

(C) The last sentence of section 3231(e)(1).

(D) The last sentence of section 3306(b).

(E) The last sentence of section 3401(a).

(c) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance.''

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to policies issued after December 31, 1995, except that a policy issued before January 1, 1996, which, on January 1, 1996, satisfies the requirements of a qualified long-term care insurance policy as set forth in section 7702B(b) of the Internal Revenue Code of 1986 shall be treated as having been issued on January 1, 1996.

(2) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a policy providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance policy (as defined in section 7702B(b) of such code), no gain or loss shall be recognized on the exchange, except that gain (if any) shall be recognized to the extent of the sum of the money and the fair market value of the other prop-

erty received. For purposes of this paragraph, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying section 101(f), 7702, or 7702A of such Code to any contract, the issuance of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

SEC. 753. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount received unless—

''(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

''(ii) the percentage reduction in the cash surrender value of the contract by reason of the distribution does not exceed the percentage reduction in the death benefit payable under the contract by reason of such distribution.

''(B) PRESENT VALUE.—The present value of the reduction in the death benefit shall be determined by—

''(i) using a discount rate which is based on an interest rate which does not exceed the highest interest rate set forth in subparagraph (C), and

''(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after

the date of the certification referred to in paragraph (3).

''(C) RATES.—The interest rates set forth in this subparagraph are the following:

''(i) the 90-day Treasury bill yield,

''(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

''(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

''(D) SPECIAL RULES RELATING TO LIENS.—If a lien is imposed against a life insurance contract with respect to any amount referred to in paragraph (1)—

''(i) for purposes of subparagraph (A), the amount of such lien shall be treated as a reduction (at the time of receipt) in the death benefit or cash surrender value to the extent that such benefit or value, as

the case may be, is (or may become) subject to the lien, and

''(ii) paragraph (1) shall not apply to the amount received unless any rate of interest with respect to any amount in connection with which such lien is imposed does not exceed the highest rate set forth in subparagraph (C).

''(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured having a financial interest in any trade or business carried on by the taxpayer.''

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section shall apply to amounts received after the date of the enactment of this Act.

(2) DELAY IN APPLICATION OF DISCOUNT RULES.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 shall not apply to any amount received before January 1, 1995.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying section 101(f), 7702, or 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 754. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).''

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle F—Health Care Trust Funds

SEC. 761. ESTABLISHMENT OF HEALTH CARE TRUST FUNDS.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to establishment of trust funds) is amended by adding at the end the following new part:

''PART II—HEALTH CARE TRUST FUNDS

''SEC. 9551. HEALTH SECURITY TRUST FUND.

''(a) CREATION OF TRUST FUND.—

''(1) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Security Trust Fund', consisting of such amounts as may be appropriated or credited to it under this section or section 9602(b).

''(2) ACCOUNTS IN THE TRUST FUND.—The Health Security Trust Fund shall consist of—

''(A) the Health Insurance Account,

''(B) the Infrastructure Development Account,

''(C) the State Health Quality and Consumer Protection Account,

''(D) the Long-Term Care Account, and

''(E) the Federal Outlay Program Fraud and Abuse Control Account.

Each such account shall consist of such amounts as may be allocated to it under this section.

''(b) TRANSFERS TO THE TRUST FUND.—

''(1) IN GENERAL.—There are hereby appropriated to the Health Security Trust Fund—

''(A) amounts equivalent to the taxes received in the Treasury under section 5701 (re-

lating to taxes imposed on tobacco products) to the extent such amounts are attributable to the rates of tax in excess of such rates of tax in effect on the day before the date of the enactment of the Health Security Act,

''(B) amounts equivalent to the taxes received in the Treasury under section 4511 (relating to taxes on high cost health plans),

''(C) the amount determined by the Secretary, after consultation with the Secretary of Health and Human Services, to be equal to the sum of—

''(i) the decrease in Federal expenditures under title XIX of the Social Security Act by reason of the provisions of, and the amendments made by, the Health Security Act, and

''(ii) any reduction in payments to States under such title by reason of the State maintenance-of-effort requirement under section 1931(d) of the Social Security Act,

''(D) amounts determined by the Secretary, after consultation with the Secretary of Health and Human Services, to be equal to the

decrease in Federal expenditures (other than any decrease described in paragraph (2)) attributable to the provisions of subtitle G of title XXI of the Social Security Act (relating to automobile insurance coordination), and

''(E) amounts equivalent to the following amounts received in the Treasury:

''(i) Criminal fines imposed and collected, and amounts resulting from the forfeiture of property, in cases involving a Federal health care offense (as defined in section 1128D of the Social Security Act).

''(ii) Penalties and damages imposed and collected under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

''(iii) Administrative penalties and assessments imposed and collected under section 1128A of the Social Security Act (except as otherwise provided by law).

''(2) TRANSFERS FROM OTHER TRUST FUNDS.—The Secretary of Health and Human Services shall transfer each fiscal year to the Health Se-

curity Trust Fund from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund the amount which the Secretary estimates is equal to the decrease in expenditures in each such trust fund attributable to the provisions of subtitle G of title XXI of the Social Security Act (relating to automobile insurance coordination).

''(3) TRANSFERS FROM CERTAIN RECOVERED AMOUNTS AND GIFTS.—The Secretary of Health and Human Services shall transfer each fiscal year to the Health Security Trust Fund—

''(A) the portion of amounts recovered under section 1128A(a) of the Social Security Act with respect to a certified health plan or certified long-term care policy which is not repaid to the plan or policy, or

''(B) any money gifts or bequests made to or on behalf of the United States for allocation to the account described in subsection (a)(2)(E).

''(c) HEALTH INSURANCE ACCOUNT.—

''(1) TRANSFERS TO THE ACCOUNT.—There shall be allocated to the Health Insurance Account all amounts received in the Health Security Trust

Fund which are not allocated to any other account under this section.

''(2) EXPENDITURES FROM ACCOUNT.—Amounts in the Health Insurance Account are appropriated to the Secretary of Health and Human Services to carry out the health insurance premium assistance program and the cost-sharing grant program established under part B of title XIX of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(d) INFRASTRUCTURE DEVELOPMENT ACCOUNT.—

''(1) TRANSFERS TO THE ACCOUNT.—

''(A) IN GENERAL.—There shall be allocated to the Infrastructure Development Account from amounts received in the Health Security Trust Fund each fiscal year, $1,300,000,000.

''(B) ADJUSTMENT.—In the case of any fiscal year beginning after fiscal year 1999, the dollar amount under subparagraph (A) in effect for the preceding fiscal year (after application of this subparagraph) shall be increased by an amount equal to the product of—

''(i) such dollar amount, and

''(ii) the estimated percent change in the Consumer Price Index for all urban consumers (United States city average) during the 12-month period ending at the midpoint of the fiscal year, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected percentage change in such index.

''(2) EXPENDITURES FROM ACCOUNT.—Amounts in the Infrastructure Development Account are appropriated to carry out the programs established under parts I and II of subtitle F of title XXI of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(e) STATE HEALTH QUALITY AND CONSUMER PROTECTION ACCOUNT.—

''(1) TRANSFERS TO ACCOUNT.—There is allocated to the State Health Quality and Consumer Protection Account from amounts received in the Health Security Trust Fund each fiscal year the amounts determined as follows:

''(A) For fiscal year 1995, $200,000,000.

''(B) For fiscal years 1996, 1997, and 1998, $500,000,000.

''(C) For fiscal years 1999 through 2004, $450,000,000.

''(2) EXPENDITURES FROM ACCOUNT.—Amounts in the State Health Quality and Consumer Protection Account are appropriated to carry out the programs established by sections 21003(c)(3), 21503, and 21816 of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(f) LONG-TERM CARE ACCOUNT.—

''(1) TRANSFERS TO ACCOUNT.—There is allocated to the Long-Term Care Account each fiscal year amounts described in subsections (b)(1)(D) and (2).

''(2) EXPENDITURES FROM ACCOUNT.—Amounts in the Long-Term Care Account are appropriated to carry out the program established under part C of title XIX of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(g) FEDERAL OUTLAY PROGRAM FRAUD AND ABUSE ACCOUNT.—

''(1) TRANSFERS TO ACCOUNT.—There is allocated to the Federal Outlay Program Fraud and Abuse Account each fiscal year an amount equal to the sum of $75,000,000, plus 50 percent of the amounts transferred to the Trust Fund under subsection (b)(1)(E), plus the amounts transferred to the Trust Fund under subsection (b)(3)(B).

''(2) EXPENDITURES FROM ACCOUNT.—

''(A) IN GENERAL.—Amounts in the Federal Outlay Program Fraud and Abuse Account are appropriated to carry out the program described in section 1128C of the Social Security Act.

''(B) MAINTENANCE OF EFFORT.—No amounts in the Federal Outlay Program Fraud and Abuse Account which are made available to any Federal agency shall replace or reduce the amount of appropriations otherwise made available under appropriation Acts for such agency.

''(h) ALLOCATION OF INTEREST.—Amounts credited to the Health Security Trust Fund under section 9602(b) for any fiscal year shall be allocated to each account rat-

ably on the basis of the amounts allocated to the account for the fiscal year (without regard to this subsection).

"SEC. 9552. GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS TRUST FUND.

''(a) CREATION OF TRUST FUND.—

''(1) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Graduate Medical Education and Academic Health Centers Trust Fund', consisting of such amounts as may be appropriated or credited to the Academic Health Centers Trust Fund as provided in this section or section 9602(b).

''(2) ACCOUNTS IN THE TRUST FUND.—The Graduate Medical Education and Academic Health Centers Trust Fund shall consist of the following 2 accounts:

''(A) The Graduate Medical and Nursing Education Trust Fund.

''(B) The Academic Health Centers Trust Fund.

Each such account shall consist of such amounts as are allocated to it under this section.

''(b) TRANSFERS TO THE TRUST FUND.—

''(1) TAXES.—There are hereby appropriated to the Graduate Medical Education and Academic

Health Centers Trust Fund amounts received in the Treasury under sections 4501 and 4502 (relating to assessments on insured and self-insured health plans), other than any portion of such amounts transferred to the Biomedical and Behavioral Research Trust Fund under section 9553(b).

''(2) TRANSFERS FROM OTHER TRUST FUNDS.—The Secretary of Health and Human Services shall transfer each fiscal year to the Graduate Medical Education and Academic Health Centers Trust Fund from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under the Social Security Act the sum of—

''(A) the amount that would have been paid from the Federal Hospital Insurance Trust Fund in such fiscal year under section 1886(d)(5)(B) of such Act (as in effect before the date of the enactment of the Health Security Act), plus

''(B) the amount that would have been paid from such trust funds in such fiscal year under section 1886(h) of such Act (as so in effect).

''(c) GRADUATE MEDICAL AND NURSING EDUCATION TRUST FUND.—

''(1) TRANSFERS.—There is allocated to the Graduate Medical and Nursing Education Trust Fund each fiscal year an amount equal to the sum of—

''(A) amounts described in subsection (b)(2)(B), plus

''(B) the excess of—

''(i) the amounts made available under subpart I of part D of title XVIII of the Social Security Act, over

''(ii) the amount described in subparagraph (A).

''(2) EXPENDITURES.—Amounts in the Graduate Medical and Nursing Education Trust Fund are appropriated to carry out the programs established under subpart I of part D of title XVIII of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(d) ACADEMIC HEALTH CENTERS TRUST FUND.—

''(1) TRANSFERS.—There is allocated to the Academic Health Centers Trust Fund each fiscal year an amount equal to the sum of—

''(A) amounts described in subsection (b)(2)(A), plus

''(B) the excess of—

''(i) the amounts made available under subpart II of part D of title XVIII of the Social Security Act, over

''(ii) the amount described in subparagraph (A).

''(2) EXPENDITURES.—Amounts in the Academic Health Centers Trust Fund are appropriated to carry out the programs established under subpart II of part D of title XVIII of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(e) RULES RELATING TO ACCOUNTS.—

''(1) INSUFFICIENT FUNDS.—If, for any fiscal year, the sum of the amounts required to be allocated under subsections (c) and (d) exceeds the amounts received in the Graduate Medical Education and Academic Health Centers Trust Fund,

then each of such amounts required to be so allocated shall be reduced to an amount which bears the same ratio to such amount as the amounts received in the trust fund bear to the amounts required to be so allocated (without regard to this paragraph).

''(2) ALLOCATION OF EXCESS FUNDS AND INTEREST.—Amounts received in the Graduate Medical Education and Academic Health Centers Trust Fund in excess of the amounts required to be allocated under subsections (c) and (d), and amounts credited to such trust fund under section 9602(b), for any fiscal year shall be allocated to each account ratably on the basis of the amounts allocated to the account for the fiscal year (without regard to this paragraph).

"SEC. 9553. BIOMEDICAL AND BEHAVIORAL RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Biomedical and Behavioral Research Trust Fund', consisting of such amounts as may be appropriated or credited to the Biomedical and Behavioral Research Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO THE TRUST FUND.—There are hereby appropriated to the Biomedical and Behavioral Research Trust Fund amounts equivalent to 14.3 percent of amounts received in the Treasury under sections 4501 and 4502 (relating to assessments on insured and self-insured health plans).

''(c) EXPENDITURES FROM THE TRUST FUND.—

''(1) IN GENERAL.—The Secretary shall pay annually, within 30 days after the President signs an appropriations Act for the Departments of Labor, Health and Human Services, and Education and related agencies, or by the end of the first quarter, to the Secretary of Health and Human Services, an amount equal to the amount in the Biomedical and Behavioral Research Trust Fund at the time of such payment.

''(2) DISTRIBUTION OF AMOUNTS.—The Secretary of Health and Human Services shall distribute—

''(A) 3 percent of the amounts received under paragraph (1) during any fiscal year to the Office of the Director of the National Institutes of Health and for construction of intramural and extramural buildings and facilities

under section 1502 of the National Institutes of Health Revitalization Act of 1993,

''(B) 20 percent of the amounts received under paragraph (1) during any fiscal year to the Agency for Health Care Policy and Research for health care services research under section 21502 of the Social Security Act, and

''(C) the remainder of the amounts received under paragraph (1) during any fiscal year to member institutes of the National Institutes of Health in the same proportion to the total amount received under such paragraph, as the amount of annual appropriations under appropriations Acts for each member institute for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes of the National Institutes of Health for the fiscal year.

''(3) MAINTENANCE OF EFFORT.—No amounts in the Biomedical and Behavioral Research Trust Fund shall replace or reduce the amount of appropriations for the National Institutes of Health under appropriations Acts.''

(b) CONFORMING AMENDMENT.—Subchapter A of chapter 98 is amended by inserting after the subchapter heading the following new items:

''Part I. General trust funds.
''Part II. Health care trust funds.

''PART I—GENERAL TRUST FUNDS''.

Subtitle G—Other Revenue Provisions

PART I—EMPLOYMENT STATUS PROVISIONS

SEC. 771. EMPLOYMENT STATUS PROPOSAL REQUIRED FROM DEPARTMENT OF THE TREASURY.

Not later than January 1, 1996, the Secretary of the Treasury shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a legislative proposal providing statutory standards for the classification of workers as employees or independent contractors.

SEC. 772. INCREASE IN SERVICES REPORTING PENALTIES.

(a) INCREASE IN PENALTY.—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

''(3) INCREASED PENALTY FOR RETURNS INVOLVING PAYMENTS FOR SERVICES.—

''(A) IN GENERAL.—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure

with respect to any applicable return shall be equal to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

''(B) EXCEPTION WHERE SUBSTANTIAL COMPLIANCE.—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

''(C) APPLICABLE RETURN.—For purposes of this paragraph, the term 'applicable return' means any information return required to be filed under—

''(i) section 6041(a) but only if such return relates to payments to any person for services performed by such person (other than as an employee), or

''(ii) section 6041A(a).''

(b) CONFORMING AMENDMENT.—Section 6721(a)(1) is amended by striking ''In'' and inserting ''Except as provided in paragraph (3), in''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to returns the due date for which (without regard to extensions) is more than 30 days after the date of the enactment of this Act.

PART II—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

SEC. 775. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 22 the following new section:

"**SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

''(1) the number of months during such taxable year—

''(A) during which the taxpayer is a qualified primary health services provider, and

''(B) which are within the taxpayer's eligible service period, and

''(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

''(A) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is providing primary health services,

''(B) is providing primary health services full time in the health professional shortage area identified in such certification, and

''(C) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

''(2) SPECIAL RULES RELATING TO SHORTAGE AREAS.—

''(A) AREAS CEASING TO BE SHORTAGE AREAS.—For purposes of paragraph (1)(B) and

subsection (e)(2), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area on the first day of the provider's eligible service period.

''(B) AREAS WITHIN METROPOLITAN AREAS.—A qualified practitioner who is providing services within a metropolitan statistical area (as defined in section 143(k)(2)) shall not be treated as meeting the requirements of paragraph (1)(B) unless such services are provided for, or on behalf of, a governmental or nonprofit entity.

''(3) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

''(c) ELIGIBLE SERVICE PERIOD.—For purposes of this section, the term 'eligible service period' means the period of 36 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider (as specified in the certification under subsection (b)(1)(A)). A taxpayer shall not have more than 1 eligible service period.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

''(2) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

''(3) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

''(4) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

''(5) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

''(6) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

''(7) PRACTITIONER CURRENTLY PRACTICING IN SHORTAGE AREAS.—In the case of a qualified practitioner who, on December 31, 1994, was providing primary health services in any health professional shortage area—

''(A) the practitioner's eligible service period shall begin on January 1, 1995, and

''(B) if such practitioner is a physician, subsection (a)(2) shall be applied by substituting '$500' for '$1,000'.

''(e) RECAPTURE OF CREDIT.—

''(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

''(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

''(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the aggregate credits allowed to such taxpayer under this section for all prior taxable years.

''(2) RECAPTURE EVENT DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified pri-

mary health services provider during any of the first 24 months during the taxpayer's eligible service period.

''(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

''(3) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55.''

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

''Sec. 23. Primary health services providers.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 776. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) (relating to dollar limitation on expensing of certain depreciable business assets) is amended to read as follows:

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

''(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

''(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

''(ii) $15,000.''

(b) DEFINITION.—Section 179(d) (relating to definitions) is amended by adding at the end the following new paragraph:

''(11) HEALTH CARE PROPERTY.—

''(A) IN GENERAL.—For purposes of this section, the term 'health care property' means section 179 property—

''(i) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

''(ii) which is owned (directly or indirectly) and used by 1 or more physicians (as defined in section 1861(r) of the Social Security Act) in the active conduct of the full-time trade or business of all such physicians of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

''(iii) substantially all the use of which is in such area.

''(B) SPECIAL RULE FOR METROPOLITAN STATISTICAL AREAS.—A physician who is providing services within a metropolitan statistical area (as defined in section 143(k)(2)) shall not be treated as meeting the requirements of subparagraph (A)(ii) unless such services are provided for, or on behalf of, a governmental or nonprofit entity.''

(c) RECAPTURE.—Paragraph (10) of section 179(d) is amended by inserting ''and with respect to any health care property which ceases (other than by an area failing

to be treated as a health professional shortage area) to be health care property at any time'' before the period.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service in taxable years beginning after December 31, 1994.

PART III—MISCELLANEOUS PROVISIONS

SEC. 781. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) MINIMUM PERIOD FOR WORKING LIVES.—Section 419A(c)(2) (relating to additional reserves for post-retirement medical and life insurance benefits) is amended by inserting ''(but not less than 10 years)'' after ''working lives of the covered employees''.

(b) SEPARATE ACCOUNTING.—

(1) REQUIREMENT.—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:

''Such reserve shall be maintained as a separate account.''

(2) USE OF RESERVE FOR OTHER PURPOSES.—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by adding after subparagraph (C) the following new subparagraph:

''(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit.''

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) SEPARATE ACCOUNTING.—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 782. COORDINATION WITH HEALTH CARE CONTINUATION PROVISIONS.

(a) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) IN GENERAL.—Clause (i) of section 4980B(f)(2)(B) (defining period of coverage) is amended to read as follows:

''(i) MAXIMUM PERIOD.—The later of—

''(I) the date which is 6 months after the date of the qualifying event, or

''(II) the last day of the calendar year in which the qualifying event occurs.''

(2) CONFORMING AMENDMENTS.—Section 4980B(f)(2) is amended—

(A) by striking clause (v) of subparagraph (B),

(B) by striking the last sentence of subparagraph (C), and

(C) by striking subparagraph (E).

(b) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) is amended to read as follows:

''(A) MAXIMUM REQUIRED PERIOD.—The later of—

''(i) the date which is 6 months after the date of the qualifying event, or

''(ii) the last day of the calendar year in which the qualifying event occurs.''

(2) CONFORMING AMENDMENTS.—Section 602 of such Act (29 U.S.C. 1162) is amended—

(A) by striking subparagraph (E) of paragraph (2),

(B) by striking the last sentence of paragraph (3), and

(C) by striking paragraph (5).

(c) AMENDMENTS TO PHSA.—

(1) IN GENERAL.—Section 2202(2)(A) of the Public Health Service Act (42 U.S.C. 300bb–2(2)(A)) is amended to read as follows:

''(A) MAXIMUM REQUIRED PERIOD.—The later of—

''(i) the date which is 6 months after the date of the qualifying event, or

''(ii) the last day of the calendar year in which the qualifying event occurs.''

(2) CONFORMING AMENDMENTS.—Section 2202 of such Act (42 U.S.C. 300bb–2) is amended—

(A) by striking subparagraph (E) of paragraph (2),

(B) by striking the last sentence of paragraph (3), and

(C) by striking paragraph (5).

(d) EFFECTIVE DATE.—The amendments made by this section apply to qualifying events occurring after December 31, 1996.

SEC. 783. CREDIT FOR COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits), as amended by section 775, is amended by inserting after section 23 the following new section:

"SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year

exceeds $45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting '$2,500' for '$5,000' and '$22,500' for '$45,000'.

''(b) LIMITATION.—The amount of personal assistance expenses for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of—

''(1) $15,000, or

''(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year.

In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

''(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual

furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

''(d) OTHER DEFINITIONS.—For purposes of this section—

''(1) PERSONAL ASSISTANCE EXPENSES.—The term 'personal assistance expenses' means expenses for—

''(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

''(B) homemaker/chore services incidental to the provision of such personal assistance services,

''(C) in the case of an individual with a cognitive impairment, assistance with life skills,

''(D) communication services,

''(E) work-related support services,

''(F) coordination of services described in this paragraph,

''(G) assistive technology and devices, including assessment of the need for particular technology and devices and training of family members, and

''(H) modifications to the principal place of abode of the individual to the extent the ex-

penses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213) of such individual.

''(2) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means eating, toileting, transferring, bathing, and dressing.

''(e) SPECIAL RULES.—

''(1) PAYMENTS TO RELATED PERSONS.—No credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b)) to the taxpayer.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount taken into account in determining the credit under this section shall not be taken into account in determining the amount of the deduction under section 213.

''(3) BASIS REDUCTION.—For purposes of this subtitle, if a credit is allowed under this section for any expense with respect to any property, the increase in the basis of such property which would (but for this paragraph) result from such expense shall be reduced by the amount of the credit so allowed.

''(f) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after 1996, the $45,000 and $22,500 amounts in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to—

''(1) such dollar amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000.''

(b) TECHNICAL AMENDMENT.—Subsection (a) of section 1016 is amended by striking ''and'' at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting '', and'', and by adding at the end thereof the following new paragraph:

''(26) in the case of any property with respect to which a credit has been allowed under section 24, to the extent provided in section 24(e)(3).''

(c) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1

is amended by inserting after the item relating to section 23 the following new item:

''Sec. 24. Cost of personal assistance services required by employed individuals.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 784. DISCLOSURE OF RETURN INFORMATION FOR ADMINISTRATION OF CERTAIN PROGRAMS UNDER THE HEALTH SECURITY ACT.

(a) IN GENERAL.—Section 6103(l) (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF HEALTH SECURITY ACT.—

''(A) IN GENERAL.—The Secretary shall, upon written request, disclose current return information described in subparagraph (B) to any Federal, State, or local agency administering an assistance program under the Health Security Act.

''(B) INFORMATION.—The information described in this subparagraph is information which consists only of adjusted gross income, the untaxed portion of social security benefits,

tax-exempt interest income, marital status, and dependents.

''(C) RESTRICTION ON DISCLOSURE.—The Secretary shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, determining eligibility for, or the correct amount of, assistance provided under the Health Security Act.

''(D) EXCLUSION FROM MATCHING PROGRAM.—Any matches of information under this paragraph shall not be treated as a matching program for purposes of section 552a of title 5, United States Code.''

(b) CONFORMING AMENDMENTS.—

(1) Section 6103(a)(2) is amended by inserting ''or (15)'' after ''subsection (l)(7)(D)''.

(2) Section 6103(p)(3)(A) is amended by striking ''or (14)'' and inserting ''(14), or (15)''.

(3) Section 6103(p)(4) is amended—

(A) by striking ''or (12)'' in the matter preceding subparagraph (A) and inserting ''(12), or (15)'', and

(B) by striking ''or (14)'' in subparagraph (F)(ii) and inserting ''(14), or (15)''.

(4) Section 7213(a)(2) is amended by striking ''or (12)'' and inserting ''(12), or (15)''.

SEC. 785. SPECIAL RULE FOR DEFERRED COMPENSATION PLANS OF GROUP MEDICAL PRACTICES.

(a) IN GENERAL.—Section 457(e) is amended by adding at the end the following new paragraph:

''(14) TREATMENT OF EXCESS BENEFIT ARRANGEMENTS OF CERTAIN GROUP MEDICAL PRACTICES.—

''(A) IN GENERAL.—In the case of an individual who—

''(i) is a member of a group medical practice which is exempt from taxation under section 501(a) and which is described in section 501(c)(3), and

''(ii) is a participant in an eligible deferred compensation plan maintained by such practice which is an excess benefit plan,

subsections (b)(2) and (c)(1) shall not apply in determining the maximum amount which may be deferred under such plan for a taxable year.

''(B) EXCESS BENEFIT PLAN.—For purposes of subparagraph (A), the term 'excess benefit plan' means a plan (or separable part

thereof) which is maintained by an employer solely for purposes of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415.''

(b) EFFECTIVE DATE.—The amendments made by this section apply to taxable years beginning after December 31, 1994.

Subtitle H—Ensuring Health Care Financing

SEC. 791. ENSURING HEALTH CARE FINANCING.

(a) PURPOSE.—

(1) IN GENERAL.—The purpose of this section is to ensure that programs established under this Act, and unanticipated increases in other Federal health spending, do not increase the Federal deficit.

(2) DEFINITION.—For purposes of this subsection, the term ''other Federal health spending'' includes medicare expenditures, medicaid expenditures, and the revenue losses associated with the employee exclusion of employer-provided accident and health coverage and the deductibility of individual medical expenses in excess of 7.5 percent of adjusted gross income.

(b) LEGAL ENTITLEMENTS CONTINGENT.—Any entitlement provided by this Act to premium and cost-sharing assistance, or to tax deductions for health insurance premiums provided by section 731 of this Act, shall be subject to the operation of this section.

(c) DETERMINATION OF UNFINANCED HEALTH SPENDING.—

(1) CURRENT HEALTH SPENDING ESTIMATE.—

(A) FISCAL YEARS THROUGH 2004.—Not later than the date that is 60 days after the date of enactment of this Act, the President shall issue an executive order setting forth the current health spending estimate for fiscal year 1995 and for each subsequent fiscal year through 2004, which shall consist of estimates (for each year) projecting what Federal outlays or revenues would have been if this Act had not been enacted, for the following:

(i) total outlays under the Medicare and Medicaid programs (including administrative costs and offsetting receipts); and

(ii) revenue losses associated with—

(I) the employee exclusion of employer-provided accident and health coverage; and

(II) the deductibility of individual medical expenses in excess of 7.5 percent of adjusted gross income.

(B) FISCAL YEARS AFTER 2004.—For each fiscal year following fiscal year 2004, the current health spending estimate is the estimate set forth in the executive order for fiscal year 2004, modified by an annual adjustment factor set forth in such order.

(2) PRESIDENT'S BUDGET TO INCLUDE HEALTH REFORM ESTIMATES.—

(A) ESTIMATES FOR UPCOMING FISCAL YEAR AND CURRENT YEAR.—When the President submits the budget for fiscal year 1996 (as required by section 1105 of title 31), and for each fiscal year thereafter, the President shall include a health reform estimate (as specified in paragraph (3)) with respect to the upcoming fiscal year and the current fiscal year.

(B) DETERMINATIONS FOR PRIOR FISCAL YEAR.—When the President submits the budget for fiscal year 1997 (as required by section 1105 of title 31), and for each fiscal year thereafter, the President shall include determinations for the fiscal year which ended the prior Sep-

tember, with respect to the items specified in the health reform estimate (as specified in paragraph (3)).

(3) HEALTH REFORM ESTIMATE.—

(A) IN GENERAL.—The health reform estimate is a calculation, for the applicable fiscal year, of—

(i) updated projections for the applicable fiscal year for each item set forth in the current health estimate (as set forth in paragraph (1)); plus

(ii) the health reform outlays set forth in subparagraph (B); minus

(iii) the net health reform revenues set forth in subparagraph (C).

(B) HEALTH REFORM OUTLAYS.—Health reform outlays equal—

(i) total outlays for premium and cost sharing assistance (including administrative costs) projected for the fiscal year; plus

(ii) other changes in outlays resulting from this Act, including discretionary appropriations enacted pursuant to this Act.

(C) NET HEALTH REFORM REVENUES.—Net health reform revenues equal—

(i) total new revenues projected for the applicable fiscal year due to the increase in the tobacco excise tax and the tax on high cost health plans provided in this Act; minus

(ii) total revenue losses projected for the applicable fiscal year due to the deduction for purchase by individuals and the self-employed of health insurance policies provided by section 731 of this Act; plus or minus

(iii) other changes in revenues resulting from this Act (which are not reflected in the updated current health estimate as set forth in subparagraph (A)(i)).

(4) DETERMINATION OF UNFINANCED HEALTH SPENDING AND EXCESS HEALTH FINANCING.—Each health reform estimate required by this subsection shall be accompanied by a comparison of such estimate with the current health spending estimate for the applicable fiscal year. If the applicable health reform estimate exceeds the applicable current health spending estimate, the President shall report the

amount of the excess as unfinanced health spending for the applicable fiscal year. If the applicable health reform estimate is less than the applicable current health spending estimate, the President shall report such difference as excess health financing for the applicable fiscal year.

(d) OFFSETTING UNFINANCED HEALTH SPENDING.—

(1) REQUIREMENT TO FULLY OFFSET UNFINANCED HEALTH SPENDING.—If the President's budget includes a determination of unfinanced health spending pursuant to subsection (c)(4) for the upcoming fiscal year, the current fiscal year, or the fiscal year which ended the prior October, such determination shall be accompanied by an executive order effective on October 1 of that calendar year which fully offsets in the fiscal year beginning October 1 the sum of such unfinanced health spending (for the upcoming fiscal year, the current fiscal year, and the prior fiscal year) in the manner provided in this subsection. Such executive order shall be accompanied by such regulations as are required under subsection (d)(4).

(2) OFFSETS.—The offsets required by this subsection shall be accomplished through a combination of—

(A) subject to the provisions of paragraph (3)—

(i) in the case of the premium assistance program, reducing the percentages otherwise in effect for the fiscal year under clauses (i) and (ii) of section 1952 (a)(2)(A) of the Social Security Act, and

(ii) in the case of the cost-sharing assistance program, reducing payments to the States under section 1957 of such Act;

(B) reducing the percentage specified in section 213(f)(1) of the Internal Revenue Code of 1986; and

(C) increasing out-of-pocket limits in the standard and alternative benefits packages as imposed by the National Health Benefits Board pursuant to this Act, to the extent such actions will produce measurable Federal outlay savings.

(3) ELIGIBILITY PERCENTAGE FOR PREGNANT WOMEN AND CHILDREN REDUCED LAST.—Any reduction under paragraph (2)(A)—

(A) shall be made first by reducing the percentages under sections 1952(a)(2)(A)(i) of the Social Security Act and by reducing the payments to States under 1957 of such Act; and

(B) to the extent sufficient offsets may not be made under subparagraph (A), shall then be made by reducing the percentage under section 1952(a)(2)(A)(ii) of such Act.

(4) PROPORTIONALITY.—The President shall apply the offset mechanisms provided in paragraph (2) (A), (B), and (C) proportionally, to the extent possible, but in no case shall the total amount of offsets be less than the amount required by subsection (d)(1).

(5) CONSULTATION.—In making the determinations required by this subsection, the President shall consult with the Director of the Office of Management and Budget, the Secretary of the Treasury, and the National Health Benefits Board. Any order modifying the new tax deductions shall be accompanied by Treasury regulations implementing such modification. Any order modifying out-of-pocket limits shall be accompanied by National Health Bene-

fits Board regulations implementing such modification.

(e) CARRYOVER OF EXCESS HEALTH FINANCING.—If the President's budget includes a determination of excess health financing pursuant to subsection (c)(4) for a fiscal year, such amount shall be included in calculating the health reform estimate for the subsequent fiscal year, by including such amount in the calculation of total net revenues projected for that year under subsection (c)(3)(C)(iii).

(f) RECOMMENDATIONS FOR ALTERNATIVE REDUCTIONS.—If the President's budget for a fiscal year is accompanied by an executive order under subsection (d)(1), the National Health Care Commission shall, within a reasonable time, transmit to the Speaker of the House of Representatives and the President of the Senate a report including alternative proposals to offset the projected excess outlays.

(g) GAO AUDIT OF REDUCTIONS.—If the President has issued an executive order under subsection (d)(1), the General Accounting Office shall report to Congress, as soon thereafter as possible following the date of transmittal of the President's budget, an analysis of whether the executive order has fully complied with the requirements of this section.