

**Calendar No. 539**

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

**S. 2351**

**[Report No. 103-323]**

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**A BILL**

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

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AUGUST 2 (legislative day, JULY 20), 1994  
Placed on the calendar

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## 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.

1 *Be it enacted by the Senate and House of Representa-*

2 *tives of the United States of America in Congress assembled,*

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

4 (a) SHORT TITLE.—This Act may be cited as the

5 “Health Security Act”.

6 (b) UNIVERSAL COVERAGE AS PURPOSE.—It is the

7 purpose of this Act to achieve universal health insurance

8 coverage through—

1 (1) subsidies for the purchase of health insur-  
2 ance;

3 (2) affordable standardized health insurance;

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

6 (4) a permanent National Health Commission  
7 which, beginning in 1996, will make recommenda-  
8 tions every two years to the Congress on how to in-  
9 crease the number of people covered by health insur-  
10 ance;

11 (5) reduction of health costs through more open  
12 competitive markets and continued advances in med-  
13 ical education and research; and

14 (6) health care provided under the medicare  
15 and medicaid programs and health programs of the  
16 Department of Defense, Department of Veterans Af-  
17 fairs, and Indian Health Service.

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

Sec. 1. Short title; national goal; table of contents.

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 de-  
livery systems.

Subtitle B—Coordination With Other Provisions of Law

Sec. 111. McCarran-Ferguson reform.

Sec. 112. Office of Rural Health Policy.

Sec. 113. Amendments to the Employee Retirement Income Security Act of  
1974.

TITLE II—COVERAGE

Sec. 201. Coverage.

TITLE III—PREMIUM AND COST-SHARING ASSISTANCE

Sec. 301. Premium and cost-sharing assistance.

TITLE IV—ADMINISTRATIVE SIMPLIFICATION AND PRIVACY

Sec. 401. Administrative simplification.

Sec. 402. Privacy of health information.

TITLE V—MALPRACTICE AND FRAUD

Subtitle A—Federal Tort Reform

Sec. 501. Federal tort reform.

Subtitle B—Expanded Efforts To Combat Health Care Fraud and Abuse  
Affecting Federal Outlay Programs

PART I—IMPROVED ENFORCEMENT

Sec. 511. Health care fraud and abuse affecting Federal outlay programs.

Sec. 512. Definition of Federal health care offense.

Sec. 513. Use of funds by inspector general.

Sec. 514. Rewards for information leading to prosecution and conviction.

PART II—CIVIL PENALTIES AND RIGHTS OF ACTION

Sec. 521. Civil monetary penalties.

Sec. 522. Permitting parties to bring actions on own behalf.

Sec. 523. Exclusion from program participation.

PART III—AMENDMENTS TO CRIMINAL LAW

Sec. 531. Health care fraud.

Sec. 532. Theft or embezzlement.

Sec. 533. False statements.

Sec. 534. Bribery and graft.

Sec. 535. Injunctive relief relating to health care offenses.

Sec. 536. Grand jury disclosure.

Sec. 537. Forfeitures for violations of fraud statutes.

PART IV—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

Sec. 541. Amendments to Civil False Claims Act.

PART V—EFFECTIVE DATE

Sec. 551. Effective date.

TITLE VI—MEDICARE, MEDICAL EDUCATION, AND MEDICAID

Sec. 600. References to Social Security Act.

Subtitle A—Medicare

PART I—RISK CONTRACTING ENTITIES

- Sec. 601. Individual election to remain in certain health plans.
- Sec. 602. Improvements of risk contracts.

PART II—PROVISIONS RELATED TO PART A

- Sec. 611. Inpatient hospital services update for PPS hospitals.
- Sec. 612. Reduction in payments for capital-related costs for inpatient hospital services.
- Sec. 613. Reductions in disproportionate share payments.
- Sec. 614. Revised payment methodology for rehabilitation and long-term care hospitals.
- Sec. 615. Moratorium on designation of new long-term hospitals.
- Sec. 616. Extension of freeze on updates to routine service cost limits for skilled nursing facilities.
- Sec. 617. Payments for sole community hospitals with teaching programs and multihospital campuses.
- Sec. 618. Medicare-dependent, small rural hospitals.
- Sec. 619. Provisions relating to rural health transition grant program.
- Sec. 620. Limited service hospital program.
- Sec. 621. Termination of indirect medical education payments.
- Sec. 622. Subacute care study.

PART III—PROVISIONS RELATING TO PART B

- Sec. 631. Updates for physicians' services.
- Sec. 632. Substitution of real GDP to adjust for volume and intensity; repeal of restriction on maximum reduction permitted in default update.
- Sec. 633. Payment for physicians' services relating to inpatient stays in certain hospitals.
- Sec. 634. Changes in underserved area bonus payments.
- Sec. 635. Development and implementation of resource-based methodology for practice expenses.
- Sec. 636. Demonstration projects for medicare State-based performance standard rate of increase.
- Sec. 637. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 638. Eye or eye and ear hospitals.
- Sec. 639. Imposition of coinsurance on laboratory services.
- Sec. 640. Application of competitive acquisition process for part B items and services.
- Sec. 641. Application of competitive acquisition procedures for laboratory services.
- Sec. 642. Expanded coverage for physician assistants and nurse practitioners.
- Sec. 643. General part B premium.

PART IV—PROVISIONS RELATED TO PARTS A AND B

- Sec. 651. Medicare secondary payer changes.
- Sec. 652. Modification to physician referral exception.
- Sec. 653. Expansion of centers of excellence.
- Sec. 654. Medicare select.
- Sec. 655. Medigap.
- Sec. 656. Reduction in routine cost limits for home health services.
- Sec. 657. Termination of graduate medical education payments.
- Sec. 658. Extension of social health maintenance organization demonstrations.

- Sec. 659. Study on medicare spending.
- Sec. 660. Streamlined processing systems.

Subtitle B—Medical Education

- Sec. 665. Medical education.

Subtitle C—Home and Community-Based Services

- Sec. 667. State programs for home and community-based services for individuals with disabilities.

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 benefit package.

PART II—COORDINATED CARE SERVICES FOR DISABLED MEDICAID ELIGIBLES

- Sec. 672. Coordinated care services for disabled medicaid eligibles.

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.

PART IV—MEDICAID LONG-TERM CARE PROVISIONS

- Sec. 674. Payments for home or community-based care, personal care services, and frail elderly services.
- Sec. 675. Increased resource disregard for individuals receiving certain services.
- Sec. 676. Frail elderly demonstration project waivers.
- Sec. 677. Elimination of requirement of prior institutionalization with respect to habilitation services furnished under a waiver for home or community-based services.
- Sec. 678. Elimination of rule regarding availability of beds in certain institutions.

PART V—MISCELLANEOUS

- Sec. 679. Medicaid coverage of all certified nurse practitioner and clinical nurse specialist services.

TITLE VII—REVENUE PROVISIONS

- Sec. 700. Amendment of 1986 Code.

Subtitle A—Financing Provisions

PART I—INCREASE IN TAX ON TOBACCO PRODUCTS

- Sec. 701. Increase in excise taxes on tobacco products.
- Sec. 702. Modifications of certain tobacco tax provisions.
- Sec. 703. Imposition of excise tax on manufacture or importation of roll-your-own tobacco.

## PART II—HEALTH RELATED ASSESSMENTS

- Sec. 705. Assessments on insured and self-insured health plans.
- Sec. 706. Tax on high cost health plans.

## PART III—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES

- Sec. 711. Recapture of certain health care subsidies received by high-income individuals.

## PART IV—OTHER PROVISIONS

- Sec. 715. Increase in tax on certain hollow point and large caliber handgun ammunition.
- Sec. 716. Modification to self-employment tax treatment of certain S corporation shareholders and partners.
- Sec. 717. Extending medicare coverage of, and application of hospital insurance tax to, all State and local government employees.

## Subtitle B—Tax Treatment of Employer-Provided Health Care

- Sec. 721. Tax treatment of voluntary employer health care contributions.
- Sec. 722. Elimination of exclusion of health benefits provided through a flexible spending arrangement.
- Sec. 723. 2-year extension of deduction for health insurance costs of self-employed individuals.
- Sec. 724. Limitation on prepayment of medical insurance premiums.

## Subtitle C—Deduction for Individuals Purchasing Own Health Insurance

- Sec. 731. Deduction for health insurance costs of individuals.

## Subtitle D—Exempt Organizations

## PART I—HEALTH CARE ORGANIZATIONS

- Sec. 741. Qualification and disclosure requirements for nonprofit health care organizations.
- Sec. 742. Excise taxes for private inurement by tax-exempt health care organizations.
- Sec. 743. Treatment of health maintenance organizations, parent organizations, and health insurance purchasing cooperatives.
- Sec. 744. Tax treatment of taxable organizations providing health insurance and other prepaid health care services.
- Sec. 745. Organizations subject to section 833.
- Sec. 746. Tax exemption for high-risk insurance pools.

## Part II—Tax Treatment of Section 501(c)(3) Bonds

- Sec. 748. Tax treatment of 501(c)(3) bonds similar to governmental bonds.

## Subtitle E—Tax Treatment of Long-Term Care Insurance and Services

- Sec. 751. Qualified long-term care services treated as medical care.
- Sec. 752. Treatment of long-term care insurance.
- Sec. 753. Tax treatment of accelerated death benefits under life insurance contracts.
- Sec. 754. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle F—Health Care Trust Funds

Sec. 761. Establishment of health care trust funds.

Subtitle G—Other Revenue Provisions

PART I—EMPLOYMENT STATUS PROVISIONS

Sec. 771. Employment status proposal required from Department of the Treasury.

Sec. 772. Increase in services reporting penalties.

PART II—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

Sec. 775. Nonrefundable credit for certain primary health services providers.

Sec. 776. Expensing of medical equipment.

PART III—MISCELLANEOUS PROVISIONS

Sec. 781. Post-retirement medical and life insurance reserves.

Sec. 782. Coordination with health care continuation provisions.

Sec. 783. Credit for cost of personal assistance services required by employed individuals.

Sec. 784. Disclosure of return information for administration of certain programs under the Health Security Act.

Sec. 785. Special rule for deferred compensation plans of group medical practices.

Subtitle H—Ensuring Health Care Financing

Sec. 791. Ensuring health care financing.

1 **TITLE I—HEALTH INSURANCE**  
 2 **AND DELIVERY SYSTEMS RE-**  
 3 **FORM**

4 **Subtitle A—Federal Standards for**  
 5 **State Regulatory Programs**

6 **SEC. 101. STATE PLAN FOR CERTIFICATION AND REGULA-**  
 7 **TION OF HEALTH INSURANCE AND DELIVERY**  
 8 **SYSTEMS.**

9 (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
 10 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))  
 11 is amended by striking “and” at the end of paragraph  
 12 (61), by striking the period at the end of paragraph (62)

1 and inserting “; and”, and by inserting after paragraph  
 2 (62) the following new paragraph:

3 “(63) provide that the State is a participating  
 4 State under title XXI.”

5 (b) PARTICIPATING STATE PLAN FOR CERTIFI-  
 6 CATION AND REGULATION OF HEALTH INSURANCE AND  
 7 DELIVERY SYSTEMS.—The Social Security Act is amend-  
 8 ed by adding at the end the following new title:

9 **“TITLE XXI—STATE PLAN FOR**  
 10 **CERTIFICATION AND REGU-**  
 11 **LATION OF HEALTH INSUR-**  
 12 **ANCE AND DELIVERY SYS-**  
 13 **TEMS**

“TABLE OF CONTENTS

“Subtitle A—Participating State Program

“PART I—GENERAL RESPONSIBILITIES

“SUBPART A—ACCESS TO COVERAGE

“Sec. 21001. Establishment of participating State programs.

“Sec. 21002. Access to standardized health care coverage.

“Sec. 21003. Other State program responsibilities.

“Sec. 21004. General definitions relating to health plans.

“SUBPART B—ACCREDITATION, CERTIFICATION, ENFORCEMENT, AND  
 INFORMATION

“Sec. 21011. Accreditation and certification of health plans and long-term care  
 policies.

“Sec. 21012. Certification enforcement.

“Sec. 21013. Consumer information program.

“SUBPART C—OTHER STATE RESPONSIBILITIES

“Sec. 21021. Establishment of community rating areas.

“Sec. 21022. Designation of health plan service areas.

“Sec. 21023. Reinsurance and risk adjustment program.

“Sec. 21024. Specification of annual general enrollment period.

“Sec. 21025. Premium approval process for long-term care policies.

“Sec. 21026. Requirements relating to possessions of the United States.

“PART II—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

- “Sec. 21031. Single-payer system described.
- “Sec. 21032. General requirements for single-payer systems.
- “Sec. 21033. Special rules for States operating Statewide single-payer system.
- “Sec. 21034. Special rules for community rating area-specific single-payer systems.

“PART III—TREATMENT OF CERTAIN STATE LAWS

- “Sec. 21041. Preemption of State law restrictions on network plans.
- “Sec. 21042. State law restrictions on health professional licensure.
- “Sec. 21043. Preemption from State benefit mandates.
- “Sec. 21044. Preemption of State law regulating utilization management and review.

“PART IV—FEDERAL RESPONSIBILITIES

- “Sec. 21051. Federal role with respect to multistate health plans.
- “Sec. 21052. Establishment of residency rules.
- “Sec. 21053. Workplace wellness program.
- “Sec. 21054. Employee leasing rules.
- “Sec. 21055. Approval of private accreditation programs.

“PART V—DEFINITIONS AND RULES

- “Sec. 21100. Definitions and rules of general application.

“Subtitle B—Standards for Reform

“PART I—ESTABLISHMENT AND APPLICATION OF STANDARDS

- “Sec. 21101. Certified standard health plans.
- “Sec. 21102. Certified supplemental health benefits plans.
- “Sec. 21103. Certified long-term care policies.
- “Sec. 21104. General rules.

“PART II—STANDARDS APPLICABLE TO STANDARD HEALTH PLANS

“SUBPART A—INSURANCE STANDARDS

- “Sec. 21111. Guaranteed issue and renewal.
- “Sec. 21112. Enrollment.
- “Sec. 21113. Rating limitations for community-rated market.
- “Sec. 21114. Rating practices and payment of premiums.
- “Sec. 21115. Nondiscrimination based on health status.
- “Sec. 21116. Benefits offered.

“SUBPART B—DELIVERY SYSTEM STANDARDS

- “Sec. 21121. Reinsurance and risk adjustment.
- “Sec. 21122. Capital requirements.
- “Sec. 21123. Collection and provision of standardized information.
- “Sec. 21124. Quality improvement and assurance.
- “Sec. 21125. Patient protections and provider selection.
- “Sec. 21126. Alternative dispute resolution procedures relating to malpractice claims.
- “Sec. 21127. Access to essential community providers.
- “Sec. 21128. Health plan service area capacity.

- “Sec. 21129. Access to specialized services.
- “Sec. 21130. Participating physician program.
- “Sec. 21131. Out-of-area coverage.

“PART III—STANDARDS APPLICABLE TO SUPPLEMENTAL HEALTH BENEFITS PLANS

- “Sec. 21141. Imposition of requirements on supplemental health benefits plans.
- “Sec. 21142. Standards for supplemental services plans.
- “Sec. 21143. Standards for cost-sharing plans.
- “Sec. 21144. Prohibition on offering of multiple packages to individual.

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

- “Sec. 21151. Regulation of sales practices.
- “Sec. 21152. Additional responsibilities for carriers.
- “Sec. 21153. Renewal standards for issuance, and basis for cancellation of policies.
- “Sec. 21154. Benefit standards.
- “Sec. 21155. Nonforfeiture.
- “Sec. 21156. Limit of period of contestability and right to return.
- “Sec. 21157. Civil money penalty and private actions.
- “Sec. 21158. Long-term care policy defined.

“Subtitle C—Benefits and Cost-Sharing

“PART I—STANDARD BENEFITS PACKAGES

- “Sec. 21201. General description of standard benefits packages.
- “Sec. 21202. Description of categories of items and services.
- “Sec. 21203. Cost-sharing.

“PART II—NATIONAL HEALTH BENEFITS BOARD

- “Sec. 21211. Creation of National Health Benefits Board; membership.
- “Sec. 21212. Qualifications of Board members.
- “Sec. 21213. General duties and responsibilities.
- “Sec. 21214. Powers.
- “Sec. 21215. Funding.
- “Sec. 21216. Applicability of Federal Advisory Committee Act.
- “Sec. 21217. Congressional consideration of Board recommendations.

“PART III—PROVISIONS RELATING TO ABORTION AND RELIGIOUS BELIEFS

- “Sec. 21221. Regulation of abortion by the States.
- “Sec. 21222. No requirement to create or maintain abortion clinics and providers.
- “Sec. 21223. Provisions relating to religious belief or moral conviction.

“Subtitle D—Expanded Access to Health Plans

“PART I—ACCESS THROUGH EMPLOYERS

- “Sec. 21401. General employer responsibilities.
- “Sec. 21402. Maintenance of effort for coverage of children.
- “Sec. 21403. Development of large employer purchasing groups.
- “Sec. 21404. Enforcement.

“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.
- “Sec. 21412. Duties of purchasing cooperatives.
- “Sec. 21413. Agreements with certified standard health plans.
- “Sec. 21414. Provision of information.
- “Sec. 21415. Administrative fees.

“SUBPART B—ORGANIZATION AND OPERATION OF PURCHASING COOPERATIVES

- “Sec. 21417. Establishment.
- “Sec. 21418. Board of directors.
- “Sec. 21419. Prohibition against self-dealing and conflicts of interest.
- “Sec. 21420. Coordination among purchasing cooperatives.

“PART III—ACCESS THROUGH ASSOCIATION PLANS

“SUBPART A—QUALIFIED ASSOCIATION PLANS

- “Sec. 21431. Treatment of qualified association plans.
- “Sec. 21432. Modifications of standards applicable to qualified association plans.
- “Sec. 21433. Qualified association plan defined.

“SUBPART B—SPECIAL RULE FOR CHURCH AND MULTIEMPLOYER PLANS

- “Sec. 21435. Special rule for church and multiemployer plans.

“Subtitle E—Implementation of Consumer Information Programs and Quality  
Research

- “Sec. 21501. Consumer information programs.
- “Sec. 21502. Health services and quality improvement research.
- “Sec. 21503. Implementing quality improvement research.
- “Sec. 21504. Annual reports.

“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.
- “Sec. 21602. Community health group; certified community health plan; community health network; eligible entities; isolated rural facilities.

“SUBPART A—GRANTS FOR THE DEVELOPMENT AND OPERATION OF  
COMMUNITY HEALTH GROUPS

- “Sec. 21611. Grants and contracts for development of plans and networks.
- “Sec. 21612. Grants and contracts for operation of plans and networks.

“SUBPART B—CAPITAL ASSISTANCE

- “Sec. 21613. Loans, loan guarantees, and grants for capital investment.

“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.
- “Sec. 21622. Federal interagency task force.

“PART III—INSUFFICIENT AMOUNTS IN THE TRUST FUND

- “Sec. 21631. Insufficient amounts in the trust fund account.

“Subtitle G—Automobile Insurance Coordination

- “Sec. 21701. Definitions.

“PART I—REQUIREMENTS RELATING TO AUTOMOBILE INSURANCE MEDICAL SERVICES

- “Sec. 21711. Provision of automobile insurance medical services through health plans.
- “Sec. 21712. Payment for automobile insurance medical services.

“PART II—ADMINISTRATION

- “Sec. 21721. Payment facilitation.

“Subtitle H—Remedies and Enforcement

“PART I—REVIEW OF BENEFIT DETERMINATIONS FOR ENROLLED INDIVIDUALS

“SUBPART A—GENERAL RULES

- “Sec. 21801. Health plan claims procedure.
- “Sec. 21802. Review in area complaint review offices of grievances based on acts or practices by health plans.
- “Sec. 21803. Initial proceedings in complaint review offices.
- “Sec. 21804. Hearings before hearing officers in complaint review offices.
- “Sec. 21805. Review by State Health Plan Review Board.
- “Sec. 21806. Civil money penalties.

“SUBPART B—EARLY RESOLUTION PROGRAMS

- “Sec. 21811. Establishment of Early Resolution Programs in complaint review offices.
- “Sec. 21812. Initiation of participation in mediation proceedings.
- “Sec. 21813. Mediation proceedings.
- “Sec. 21814. Legal effect of participation in mediation proceedings.
- “Sec. 21815. Enforcement of settlement agreements.

“SUBPART C—FUNDING

- “Sec. 21816. Availability of trust fund amounts.

“PART II—ADDITIONAL REMEDIES AND ENFORCEMENT PROVISIONS

- “Sec. 21821. Civil enforcement.
- “Sec. 21822. Facial constitutional challenges.
- “Sec. 21823. Treatment of plans as parties in civil actions.
- “Sec. 21824. General nonpreemption of rights and remedies.



1           “(2) FEDERAL CERTIFICATION OF MULTISTATE  
2 SELF-INSURED PLANS.—For Federal certification of  
3 multistate self-insured health plans, see section  
4 21051.

5           “(3) TAX QUALIFICATION.—For favorable Fed-  
6 eral income tax treatment which is available only to  
7 certified health plans, see sections 213(f) and 4521  
8 of the Internal Revenue Code of 1986.

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

11           “(1) COMMUNITY RATING.—

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

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

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

21           “(ii) is an insured health plan which  
22 is experience-rated,

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

1           “(C) RESTRICTION ON SELF-INSURED  
2 HEALTH PLANS.—A self-insured health plan  
3 may be established or maintained only by an ex-  
4 perience-rated employer.

5           “(2) SUBSIDIZED COVERAGE.—Individuals shall  
6 be entitled to such premium and cost-sharing assist-  
7 ance as is provided under the program described in  
8 part B of title XIX.

9           “(c) ACCESS THROUGH EMPLOYERS AND PURCHAS-  
10 ING COOPERATIVES.—

11           “(1) EMPLOYERS.—

12           “(A) IN GENERAL.—Subject to the re-  
13 quirements of part I of subtitle D, a State pro-  
14 gram shall require each employer—

15           “(i) to make available to each em-  
16 ployee of the employer the opportunity to  
17 enroll through the employer in one of at  
18 least three certified standard health plans  
19 which provide the standard benefits pack-  
20 age established under subtitle C, including,  
21 if available, a fee-for-service plan and a  
22 health plan with a point-of-service option,  
23 and

24           “(ii) to provide, upon request, payroll  
25 withholding of the employee’s premiums.

1 “(B) SPECIAL RULES.—

2 “(i) PURCHASING COOPERATIVE.—An  
3 employer other than an experience-rated  
4 employer may meet the requirements of  
5 subparagraph (A)(i) through a purchasing  
6 cooperative.

7 “(ii) EXPERIENCE-RATED EM-  
8 PLOYER.—An experience-rated employer  
9 shall meet the requirements of subpara-  
10 graph (A)(i) only through offering self-in-  
11 sured or experience-rated health plans.

12 “(2) PURCHASING COOPERATIVES.—A partici-  
13 pating State shall meet the requirements of part II  
14 of subtitle D with respect to the establishment or  
15 sponsorship of purchasing cooperatives.

16 “(d) ACCESS TO ENROLLMENT OPTIONS.—A State  
17 program shall require that all certified standard and non-  
18 standard health plans and certified supplemental health  
19 benefits plans offer the classes of enrollment described in  
20 section 21113(b)(2)(B)(ii).

21 **“SEC. 21003. OTHER STATE PROGRAM RESPONSIBILITIES.**

22 “(a) SUMMARY OF RESPONSIBILITIES.—The partici-  
23 pating State responsibilities under this title include—

24 “(1) the accreditation and certification of  
25 standard health plans and nonstandard health plans,

1 including the enforcement of the insurance and de-  
2 livery system reform standards for such plans under  
3 part II of subtitle B;

4 “(2) the accreditation and certification of sup-  
5 plemental health benefits plans, including the en-  
6 forcement of standards for such plans under part III  
7 of subtitle B;

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

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

15 “(5) the establishment of community rating  
16 areas under section 21021 and State service areas  
17 under section 21022;

18 “(6) providing under section 21023 for—

19 “(A) reinsurance pools,

20 “(B) a risk adjustment program, and

21 “(C) a cost-sharing adjustment program;

22 “(7) the specification of an annual general en-  
23 rollment period under section 21024;

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

1           “(9) providing for the certification of workplace  
2 wellness programs in accordance with rules estab-  
3 lished by the Secretary under section 21053, includ-  
4 ing the receipt of employer self-certification forms,  
5 enforcement of compliance, and dispute resolution;

6           “(10) enforcing employer responsibilities under  
7 part I of subtitle D;

8           “(11) the oversight of purchasing cooperatives  
9 under part II of subtitle D;

10           “(12) supporting the program quality assur-  
11 ances under subtitle E;

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

15           “(14) providing coordination between health  
16 plans and automobile medical liability policies under  
17 subtitle G;

18           “(15) the development of program remedies and  
19 enforcement described under subtitle H; and

20           “(16) conforming State laws and procedures to  
21 the rules regarding fraud and medical malpractice  
22 under title XI.

23           “(b) DEADLINES.—

24           “(1) IN GENERAL.—Except as provided in para-  
25 graphs (2) and (3), each participating State shall es-

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

3            “(2) SUPPLEMENTAL INSURANCE.—Each par-  
4        ticipating State shall establish such State program  
5        with regard to supplemental health benefits plans by  
6        not later than January 1, 1997.

7            “(3) LONG-TERM CARE INSURANCE.—Each par-  
8        ticipating State shall establish such State program  
9        with regard to long-term care policies by not later  
10       than April 1, 1997.

11        “(c) SECRETARIAL APPROVAL, PERIODIC REVIEW,  
12       AND FUNDING OF STATE PROGRAMS.—

13            “(1) IN GENERAL.—The Secretary—

14            “(A) shall initially determine and approve  
15        the compliance of State programs with the Fed-  
16        eral guidelines under this title; and

17            “(B) shall periodically review such State  
18        programs to determine if such programs con-  
19        tinue to comply with such guidelines.

20            “(2) REPORTING REQUIREMENTS OF STATES.—

21        For purposes of paragraph (1), each participating  
22        State shall submit to the Secretary, at intervals es-  
23        tablished by the Secretary, a report on the compli-  
24        ance of the State with the Federal guidelines under  
25        this title.

1 “(3) FUNDING.—

2 “(A) AVAILABILITY OF TRUST FUND  
3 AMOUNTS.—There shall be available to the Sec-  
4 retary, from the Health Security Trust Fund  
5 established under section 9551 of the Internal  
6 Revenue Code of 1986, \$100,000,000 in fiscal  
7 1995 and \$300,000,000 in each of the fiscal  
8 years 1996 through 2004 to support participat-  
9 ing States that have submitted applications in  
10 accordance with subparagraph (C) to develop  
11 State programs. The Secretary shall develop a  
12 formula for determining the appropriate award-  
13 ing of funds to participating States submitting  
14 such applications.

15 “(B) PAYMENTS FOR INDEPENDENT RE-  
16 VIEW.—The Secretary shall develop a supple-  
17 mental payment schedule for participating  
18 States that establish independent review com-  
19 mittees to provide recommendations concerning  
20 health plans that fail certification.

21 “(C) APPLICATION.—For purposes of sub-  
22 paragraph (A), an application is in accordance  
23 with this subparagraph if the applicant submits  
24 the application to the Secretary at such time, in  
25 such manner, and containing such information

1           and assurances as the Secretary may reason-  
2           ably require.

3   **“SEC. 21004. GENERAL DEFINITIONS RELATING TO HEALTH**  
4           **PLANS.**

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

6           “(1) IN GENERAL.—The term ‘health plan’  
7           means any plan or arrangement which provides, or  
8           pays the cost of, health benefits. Such term does not  
9           include the following, or any combination thereof:

10           “(A) Coverage only for accidental death or  
11           dismemberment.

12           “(B) Coverage providing wages or pay-  
13           ments in lieu of wages for any period during  
14           which the employee is absent from work on ac-  
15           count of sickness or injury.

16           “(C) A medicare supplemental policy (as  
17           defined in section 1882(g)(1)).

18           “(D) Coverage issued as a supplement to  
19           liability insurance.

20           “(E) Worker’s compensation or similar in-  
21           surance.

22           “(F) Automobile medical-payment insur-  
23           ance.

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

1 Secretary determines that such a policy pro-  
2 vides sufficiently comprehensive coverage of a  
3 benefit so that it should be treated as a health  
4 plan).

5 “(H) An equivalent health care program.

6 “(I) Such other plan or arrangement as  
7 the Secretary determines is not a health plan.  
8 Such term includes any plan or arrangement not de-  
9 scribed in any preceding subparagraph which pro-  
10 vides for benefit payments, on a periodic basis, for  
11 a specified disease or illness or period of hospitaliza-  
12 tion without regard to the costs incurred or services  
13 rendered during the period to which the payments  
14 relate.

15 “(2) INSURED HEALTH PLAN.—

16 “(A) IN GENERAL.—The term ‘insured  
17 health plan’ means any health plan which is a  
18 hospital or medical service policy or certificate,  
19 hospital or medical service plan contract, or  
20 health maintenance organization group contract  
21 offered by an insurer.

22 “(B) INSURER.—The term ‘insurer’  
23 means—

24 “(i) a licensed insurance company,

1                   “(ii) a prepaid hospital or medical  
2                   service plan,

3                   “(iii) a health maintenance organiza-  
4                   tion, or

5                   “(iv) any other similar entity,  
6                   which is engaged in the business of providing a  
7                   plan of health insurance or health benefits or  
8                   services.

9                   “(3) SELF-INSURED HEALTH PLAN.—The term  
10                  ‘self-insured health plan’ means an employee welfare  
11                  benefit plan, church plan, government plan, or other  
12                  arrangement which—

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

16                   “(B) does not include any coverage or in-  
17                   surance described in subparagraphs (A)  
18                   through (I) of paragraph (1).

19                  “(b) STANDARD HEALTH PLAN.—For purposes of  
20                  this title, the term ‘standard health plan’ means a health  
21                  plan which provides for the standard benefits package or  
22                  the alternative standard benefits package established  
23                  under subtitle C.

24                  “(c) SUPPLEMENTAL HEALTH BENEFITS PLAN.—  
25                  For purposes of this title, the term ‘supplemental health

1 benefits plan' means an insured or self-insured health plan  
2 which provides health benefits which consist of supple-  
3 mental services or cost-sharing described in part IV of  
4 subtitle B. Such term does not include a plan which pro-  
5 vides for benefit payments, on a periodic basis, for a speci-  
6 fied disease or illness or period of hospitalization without  
7 regard to the costs incurred or services rendered during  
8 the period to which the payments relate.

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

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

14               “(1) COMMUNITY-RATED HEALTH PLAN.—The  
15 term ‘community-rated health plan’ means a health  
16 plan which meets the requirements of section 21113.

17               “(2) COMMUNITY-RATED INDIVIDUAL.—The  
18 term ‘community-rated individual’ means an individ-  
19 ual—

20                       “(A) who is not an experience-rated indi-  
21 vidual, or

22                       “(B) who is an experience-rated individual  
23 (determined without regard to this subpara-  
24 graph) who is not a full-time employee of an ex-  
25 perience-rated employer and who does not enroll

1 in a certified standard health plan offered by  
2 the employer.

3 “(3) EXPERIENCE-RATED INDIVIDUAL.—The  
4 term ‘experience-rated individual’ means an individ-  
5 ual who is an employee of an experience-rated em-  
6 ployer.

7 “(4) EXPERIENCE-RATED EMPLOYER.—

8 “(A) IN GENERAL.—The term ‘experience-  
9 rated employer’ means, with respect to any cal-  
10 endar year, any employer if, on each of 20 days  
11 during the preceding calendar year (each day  
12 being in a different week), such employer (or  
13 any predecessor) employed 100 or more full-  
14 time employees for some portion of the day.

15 “(B) SPECIAL RULE FOR LEASING BUSI-  
16 NESSES.—In the case of an employer the pri-  
17 mary trade or business of which is employee  
18 leasing—

19 “(i) all of the employees which such  
20 employer leases to other employers shall be  
21 treated as community-rated individuals un-  
22 less treated as employees of an experience-  
23 rated employer other than the leasing  
24 trade or business, and

1                   “(ii) this title shall be applied sepa-  
2                   rately with respect to its other employees.

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

9                   “(6) SPECIAL RULE FOR SPOUSES AND DE-  
10                  PENDENTS.—If any individual is offered coverage  
11                  under a health plan as the spouse or a dependent of  
12                  a primary enrollee of such plan, such individual shall  
13                  have the status of such enrollee unless such individ-  
14                  ual is eligible to elect other coverage and so elects.

15                  **“Subpart B—Accreditation, Certification,  
16                  Enforcement, and Information**

17                  **“SEC. 21011. ACCREDITATION AND CERTIFICATION OF  
18                  HEALTH PLANS AND LONG-TERM CARE POLI-  
19                  CIES.**

20                  “(a) CERTIFIED HEALTH PLANS.—

21                  “(1) IN GENERAL.—Each State program shall  
22                  provide for the accreditation and certification of  
23                  health plans as certified standard health plans, cer-  
24                  tified nonstandard health plans, and certified supple-  
25                  mental health benefits plans.

1           “(2) CERTIFIED STANDARD HEALTH PLAN.—

2           For purposes of this title, the term ‘certified stand-  
3           ard health plan’ means a health plan which—

4                   “(A) provides for the standard benefits  
5                   package or the alternative standard benefits  
6                   package established under subtitle C, and

7                   “(B) is certified by the appropriate certify-  
8                   ing authority as meeting the other applicable  
9                   requirements of this title.

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

15          “(3) CERTIFIED NONSTANDARD HEALTH  
16          PLAN.—For purposes of this title, the term ‘certified  
17          nonstandard health plan’ means a health plan  
18          which—

19                   “(A) is certified by the appropriate certify-  
20                   ing authority as meeting the applicable require-  
21                   ments of this title for a standard health plan,  
22                   except that a plan does not provide the benefits  
23                   packages established under subtitle C; and

24                   “(B) is not a certified supplemental health  
25                   benefits plan.

1           “(4) CERTIFIED SUPPLEMENTAL HEALTH BEN-  
2           EFITS PLAN.—For purposes of this title, the term  
3           ‘certified supplemental health benefits plan’ means a  
4           health plan which is certified by the appropriate cer-  
5           tifying authority as meeting the applicable require-  
6           ments of part III of subtitle B.

7           “(b) CERTIFIED LONG-TERM CARE POLICIES.—

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

12          “(2) CERTIFIED LONG-TERM CARE POLICY.—  
13          For purposes of this title, the term ‘certified long-  
14          term care policy’ means a long-term care policy  
15          which is certified by the applicable certifying author-  
16          ity as meeting the applicable requirements of part  
17          IV of subtitle B.

18          “(c) USE OF PRIVATE ACCREDITATION ENTITIES.—  
19          A State program may provide for the use of private ac-  
20          creditation entities in carrying out all or part of the duties  
21          under subsection (a) or (b).

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

1 **“SEC. 21012. CERTIFICATION ENFORCEMENT.**

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

5 “(b) COMPLAINT PROCESS.—

6 “(1) IN GENERAL.—A State program shall pro-  
7 vide for—

8 “(A) procedures for individuals and enti-  
9 ties to file written, signed complaints with the  
10 appropriate certifying authority respecting al-  
11 leged violations of the standards; and

12 “(B) responding to and investigating such  
13 complaints within 90 days.

14 “(2) CONSUMER ACCESS TO COMPLIANCE IN-  
15 FORMATION.—

16 “(A) IN GENERAL.—A State program shall  
17 provide for consumer access to complaints filed  
18 with the appropriate certifying authority with  
19 respect to health plans and long-term care poli-  
20 cies.

21 “(B) CONFIDENTIALITY.—The access pro-  
22 vided under subparagraph (A) shall be limited  
23 to the extent required to protect the confiden-  
24 tiality of individual enrollees and policyholders.

25 “(c) ENFORCEMENT RESPONSE.—

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

5           “(A) the imposition of a corrective pro-  
6 gram;

7           “(B) State operation of the plan or policy  
8 to provide transitional access;

9           “(C) the suspension of new enrollment of  
10 individuals;

11           “(D) the penalty-free withdrawal of enroll-  
12 ees or policyholders from the plan or policy;

13           “(E) other intermediate sanctions; and

14           “(F) withdrawal of certification after the  
15 plan or policy has been given a reasonable op-  
16 portunity to make corrections.

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

1 which shall apply to civil money penalties under this  
2 subsection in the same manner as such provisions  
3 apply to a penalty or proceeding under section  
4 1128A(a).

5 **“SEC. 21013. CONSUMER INFORMATION PROGRAM.**

6 “(a) ESTABLISHMENT OF PROGRAM.—

7 “(1) IN GENERAL.—Each State program shall  
8 establish and operate a consumer information pro-  
9 gram to provide consumers in the State with com-  
10 parative value information on the performance of all  
11 health plans in each community rating area in the  
12 State.

13 “(2) FUNCTIONS DESCRIBED.—The consumer  
14 information program established under paragraph  
15 (1) shall conduct annual surveys described in sub-  
16 section (b)(1), annually publish comparative value  
17 information described in subsection (b)(2), and per-  
18 form the additional functions described in subsection  
19 (b)(3).

20 “(b) FUNCTIONS.—

21 “(1) ANNUAL SURVEYS.—The consumer infor-  
22 mation program shall conduct annual surveys (in ac-  
23 cordance with a national standard survey design and  
24 sampling strategy to be determined by the Secretary  
25 under subtitle E) of health care consumers in the

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

5 “(2) PUBLICATION OF COMPARATIVE VALUE IN-  
6 FORMATION.—

7 “(A) IN GENERAL.—The consumer infor-  
8 mation program shall annually publish the fol-  
9 lowing comparative value information collected  
10 pursuant to section 21123 on all health plans  
11 offered in the participating State, listed by com-  
12 munity rating area, in a standard format to be  
13 determined by the Secretary:

14 “(i) Descriptive data, including—

15 “(I) the certification status of the  
16 plan;

17 “(II) benefits offered under the  
18 plan;

19 “(III) premiums, cost-sharing,  
20 and administrative charges under the  
21 plan;

22 “(IV) risk and referral arrange-  
23 ments under the plan;

24 “(V) health care providers used  
25 under the plan;

1           “(VI) the enrollee complaint and  
2           appeals process used under the plan;  
3           and

4           “(VII) other appropriate infor-  
5           mation as determined by the Sec-  
6           retary.

7           “(ii) Data regarding the national  
8           measures of quality performance developed  
9           under section 21501(b) and adjusted for  
10          case-mix (as the Secretary determines ap-  
11          propriate).

12          “(iii) Data from the annual surveys  
13          described in paragraph (1).

14          “(iv) A subset of quality measures for  
15          each health care provider.

16          “(B) INTERSTATE COMPARATIVE VALUE  
17          INFORMATION.—The participating State may  
18          join with one or more other State programs to  
19          prepare comparative value information for a ge-  
20          ographic area approved by the Secretary that  
21          includes adjoining portions of contiguous par-  
22          ticipating States.

23          “(C) DISTRIBUTION OF COMPARATIVE  
24          VALUE INFORMATION.—Comparative value in-  
25          formation prepared by the consumer informa-

1           tion program shall be distributed by the pro-  
2           gram in a manner that ensures access to such  
3           information by health care consumers and that  
4           is in accordance with standards established by  
5           the Secretary. The program shall distribute the  
6           comparative value information through various  
7           entities, including employers.

8           “(3) ADDITIONAL FUNCTIONS.—The consumer  
9           information program shall—

10                   “(A) educate consumers about comparabil-  
11                   ity of health plan characteristics and quality;

12                   “(B) provide information and make refer-  
13                   rals to assist in health plan enrollment and re-  
14                   ceipt of subsidies, including the availability and  
15                   specific eligibility schedules regarding pregnant  
16                   women and children;

17                   “(C) conduct outreach to underserved and  
18                   at-risk populations to educate such populations  
19                   on consumer responsibilities and rights to en-  
20                   sure full participation of such populations in  
21                   the health care system; and

22                   “(D) receive and seek to resolve com-  
23                   plaints, and have appropriate access to relevant  
24                   information to resolve the complaints.

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

5       “(d) ADDITIONAL REQUIREMENTS.—Each State pro-  
6 gram shall meet the requirements specified under subtitles  
7 B and C of title XI with respect to certified health plans.

8           **“Subpart C—Other State Responsibilities**

9       **“SEC. 21021. ESTABLISHMENT OF COMMUNITY RATING**  
10                           **AREAS.**

11       “(a) ESTABLISHMENT.—Each participating State  
12 under the State program shall, by not later than January  
13 1, 1996, provide for the inclusion of all areas of the State  
14 into 1 or more community rating areas. The program may  
15 revise the boundaries of such areas from time to time con-  
16 sistent with this section.

17       “(b) MULTIPLE AREAS.—With respect to a commu-  
18 nity rating area—

19           “(1) no metropolitan statistical area or primary  
20 metropolitan statistical area in a State may be di-  
21 vided into more than 1 community rating area in  
22 such State;

23           “(2) the number of individuals residing within  
24 a community rating area may not be less than  
25 250,000; and



1       “(b) GUIDELINES.—The Secretary shall establish  
2 guidelines for the designation of health plan service  
3 areas—

4           “(1) which prevent the isolation of low-income  
5 and vulnerable populations by preventing the divi-  
6 sion of governmental boundaries of counties, towns,  
7 or cities; and

8           “(2) which include adjacent designated urban  
9 or rural underserved areas.

10 **“SEC. 21023. REINSURANCE AND RISK ADJUSTMENT PRO-**  
11 **GRAM.**

12       “Each State program under this part shall provide  
13 for—

14           “(1) a reinsurance pool for community-rated  
15 standard health plans and a reinsurance pool for  
16 self-insured standard health plans (other than  
17 multistate self-insured health plans) by January 1,  
18 1996;

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

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

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

3 **“SEC. 21024. SPECIFICATION OF ANNUAL GENERAL EN-**  
4 **ROLLMENT PERIOD.**

5 “Each participating State under the State program  
6 shall specify for the State (or for each community rating  
7 area) an annual period, of not less than 30 days, during  
8 which individuals in the State (or area) may enroll in  
9 health plans or change the health plans in which the indi-  
10 vidual is enrolled.

11 **“SEC. 21025. PREMIUM APPROVAL PROCESS FOR LONG-**  
12 **TERM CARE POLICIES.**

13 “(a) IN GENERAL.—Each State program shall pro-  
14 vide for a process for approving or disapproving proposed  
15 premium increases or decreases with respect to long-term  
16 care policies.

17 “(b) APPLICATION.—

18 “(1) IN GENERAL.—Except as provided in para-  
19 graph (2), this section shall not apply to a group  
20 long-term care policy issued to a group described in  
21 section 4(E)(1) of the NAIC Long Term Care Insur-  
22 ance Model Act (effective January 1991), except  
23 that such group policy shall, pursuant to guidelines  
24 developed by the Secretary, in consultation with the  
25 NAIC, provide notice to policyholders and certificate

1 holders of any premium change under such group  
2 policy.

3 “(2) EXCEPTION.—Paragraph (1) shall not  
4 apply to—

5 “(A) group conversion policies;

6 “(B) the group continuation feature of a  
7 group policy if the carrier separately rates em-  
8 ployee and continuation coverages; and

9 “(C) group policies where the function of  
10 the employer is limited solely to collecting pre-  
11 miums (through payroll deductions or dues  
12 checkoff) and remitting such premiums to the  
13 carrier.

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

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

1 **“SEC. 21026. REQUIREMENTS RELATING TO POSSESSIONS**  
2 **OF THE UNITED STATES.**

3 “(a) IN GENERAL.—A possession of the United  
4 States shall be a participating State meeting the require-  
5 ments of this title only if there is an agreement in effect  
6 between the United States and such possession pursuant  
7 to which—

8 “(1) the laws of such possession impose a part  
9 B premium recapture assessment (as defined in sub-  
10 section (b));

11 “(2) nothing in any provision of law, including  
12 the law of such possession, permits such possession  
13 to reduce or remit in any way, directly or indirectly,  
14 any liability to such possession by reason of such as-  
15 sessment;

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

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

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

3 “(5) the possession complies with such other re-  
4 quirements as may be prescribed by the Secretary  
5 and the Secretary of the Treasury to carry out the  
6 purposes of this paragraph, including requirements  
7 prescribing the information individuals to whom  
8 such assessment may apply shall furnish to the Sec-  
9 retary and the Secretary of the Treasury.

10 “(b) QUALIFIED PART B PREMIUM RECAPTURE AS-  
11 SESSMENT.—In subsection (a), the term ‘qualified medi-  
12 care part B premium recapture assessment’ means an as-  
13 sessment imposed and collected by such a possession that  
14 is—

15 “(1) equivalent to the assessment imposed  
16 under section 59B of the Internal Revenue Code of  
17 1986; and

18 “(2) imposed on all individuals who are bona  
19 fide residents of the possession, to the extent such  
20 individuals have not paid the assessment imposed  
21 under such section 59B to the United States by rea-  
22 son of subsection (d)(5) of such section.

1   **“PART II—REQUIREMENTS FOR STATE SINGLE-**  
2                                   **PAYER SYSTEMS**

3   **“SEC. 21031. SINGLE-PAYER SYSTEM DESCRIBED.**

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

7                   “(1) meets the requirements of section 21032;  
8           and

9                   “(2)(A) in the case of a system offered through-  
10           out a State, meets the requirements for a Statewide  
11           single-payer system under section 21033; or

12                   “(B) in the case of a system offered in a single  
13           community rating area of a State, meets the require-  
14           ments for an area specific single-payer system under  
15           section 21034.

16   **“SEC. 21032. GENERAL REQUIREMENTS FOR SINGLE-PAYER**  
17                                   **SYSTEMS.**

18           “Each single-payer system shall meet the following  
19 requirements:

20                   “(1) ESTABLISHMENT BY STATE.—The system  
21           is established under State law, and State law pro-  
22           vides for mechanisms to enforce the requirements of  
23           the system.

24                   “(2) OPERATION BY STATE.—The system is op-  
25           erated by the State or a designated agency of the  
26           State.

1 “(3) ENROLLMENT OF INDIVIDUALS.—

2 “(A) MANDATORY ENROLLMENT OF ALL  
3 COMMUNITY-RATED INDIVIDUALS.—The system  
4 shall provide for the enrollment of all commu-  
5 nity-rated individuals residing in the State (or,  
6 in the case of an area-specific single-payer sys-  
7 tem, in the community rating area) who are not  
8 medicare-eligible individuals.

9 “(B) OPTIONAL ENROLLMENT OF MEDI-  
10 CARE-ELIGIBLE INDIVIDUALS.—At the option of  
11 the State and if the Secretary has approved an  
12 application submitted by the State, the system  
13 may provide for the enrollment of medicare-eli-  
14 gible individuals residing in the State (or, in the  
15 case of an area-specific single-payer system, in  
16 the community rating area).

17 “(C) OPTIONAL ENROLLMENT OF EXPERI-  
18 ENCE-RATED INDIVIDUALS.—

19 “(i) IN GENERAL.—Except as pro-  
20 vided in clause (ii), at the option of the  
21 State, a single-payer system may provide  
22 for the enrollment of experience-rated indi-  
23 viduals residing in the State (or,  
24 in the case of an area-specific single-payer  
25 system, in the community rating area).

1           “(ii) PARTICIPATION BY CERTAIN  
2           MULTISTATE PLANS.—The system shall  
3           not require participation by any experi-  
4           ence-rated individual who is enrolled in a  
5           certified multistate self-insured standard  
6           health plan which is a multiemployer plan  
7           described in section 21435(c)(2), or which  
8           is sponsored by an experience-rated em-  
9           ployer sponsor with at least 5,000 full-time  
10          employees.

11          “(4) DIRECT PAYMENT TO PROVIDERS.—

12                 “(A) IN GENERAL.—With respect to pro-  
13                 viders who furnish items and services included  
14                 in the standard benefits package established  
15                 under subtitle C to individuals enrolled in the  
16                 system, the State shall make payments directly,  
17                 or through fiscal intermediaries, to such provid-  
18                 ers and assume (subject to subparagraph (B))  
19                 all financial risk associated with making such  
20                 payments.

21                 “(B) CAPITATED PAYMENTS PER-  
22                 MITTED.—Nothing in subparagraph (A) shall  
23                 be construed to prohibit providers furnishing  
24                 items and services under the system from re-

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

3           “(5) PROVISION OF STANDARD BENEFITS PACK-  
4           AGE.—

5                   “(A) IN GENERAL.—The system shall pro-  
6           vide for coverage of the standard benefits pack-  
7           age established under subtitle C, including the  
8           cost-sharing provided under the package (sub-  
9           ject to subparagraph (B)), to all individuals en-  
10          rolled in the system.

11                   “(B) IMPOSITION OF REDUCED COST-  
12          SHARING.—The system may decrease the cost-  
13          sharing otherwise provided in the standard ben-  
14          efits package established under subtitle C with  
15          respect to any individuals enrolled in the system  
16          or any class of services included in the package,  
17          so long as the system does not increase the  
18          cost-sharing otherwise imposed with respect to  
19          any other individuals or services.

20                   “(6) FEDERAL PAYMENTS.—The system shall  
21          provide for mechanisms to ensure, in a manner sat-  
22          isfactory to the Secretary, that Federal payments to  
23          a single-payer State or community rating area shall  
24          be limited to the payments that would have been

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

3 “(7) INCREASED COVERAGE OR IMPROVED COST  
4 CONTAINMENT.—The system, when fully imple-  
5 mented, shall be expected by the State to—

6 “(A) reduce the number of residents of the  
7 State (or, in the case of an area-specific single-  
8 payer system, the community rating area) who  
9 are without health insurance coverage (as de-  
10 fined in section 2202(b)(2)) by at least 10 per-  
11 cent, or

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

16 compared to baseline projections developed by the  
17 State on the basis of the most recent data, including  
18 data provided by the National Health Care Commis-  
19 sion established under section 2201.

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

24 “(A) the system does not have the author-  
25 ity provided to standard health plans under sec-

1           tion 21111(e) (relating to permissible limita-  
 2           tions on the enrollment of community-rated eli-  
 3           gible individuals on the basis of limits on the  
 4           plan’s capacity); and

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

9   **“SEC. 21033. SPECIAL RULES FOR STATES OPERATING**  
 10                   **STATEWIDE SINGLE-PAYER SYSTEM.**

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

13                   “(1) the State shall operate the system  
 14 throughout the State; and

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

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

23                   “(1) ESTABLISHMENT OF COMMUNITY RATING  
 24 AND SERVICE AREAS.—The requirements of sections  
 25 21021 (relating to the establishment of community

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

3 “(2) OTHER REFERENCES INAPPLICABLE.—  
4 Any requirement which the Secretary determines is  
5 not appropriate to apply to a State single-payer sys-  
6 tem.

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

11 **“SEC. 21034. SPECIAL RULES FOR COMMUNITY RATING**  
12 **AREA-SPECIFIC SINGLE-PAYER SYSTEMS.**

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

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

18 “(2) the community rating area in which the  
19 system is operated shall meet the requirements of  
20 subsection (c).

21 “(b) OTHER REFERENCES INAPPLICABLE.—Any re-  
22 quirement which the Secretary determines is not appro-  
23 priate to apply to a community rating area specific single-  
24 payer system.



1           “(5) a State may not prohibit or limit a net-  
2 work plan from limiting the number and types of  
3 participating providers;

4           “(6) a State may not prohibit or limit a net-  
5 work plan from using single source suppliers for  
6 pharmacy services, medical equipment, and other  
7 supplies and services; and

8           “(7) a State may not prohibit or limit the cor-  
9 porate practice of medicine.

10          “(b) DEFINITIONS.—In this section:

11           “(1) NETWORK PLAN.—The term ‘network  
12 plan’ means a health plan—

13           “(A) which—

14           “(i) limits coverage of covered items  
15 and services to those provided by partici-  
16 pating providers, or

17           “(ii) provides, with respect to such  
18 items and services provided by persons who  
19 are not participating providers, for cost-  
20 sharing which is greater than that per-  
21 mitted under the standard benefits pack-  
22 age established under subtitle C for par-  
23 ticipating providers;

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

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

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

11           “(C) which provides benefits for covered  
12 items and services not furnished by participat-  
13 ing providers if the services are medically nec-  
14 essary and immediately required because of an  
15 unforeseen illness, injury, or condition; and

16           “(D) which provides out-of-area coverage.

17           “(2) PARTICIPATING PROVIDER.—The term  
18 ‘participating provider’ means an entity or individual  
19 which provides, sells, or leases health care services  
20 under a contract with a network plan, which con-  
21 tract does not permit—

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

1           “(B) any enrollee charges (for covered  
2           items or services) in excess of such cost-shar-  
3           ing.

4   **“SEC. 21042. STATE LAW RESTRICTIONS ON HEALTH PRO-**  
5           **FESSIONAL LICENSURE.**

6           “(a) IN GENERAL.—Except as otherwise provided in  
7           this section, nothing in this title shall be construed as lim-  
8           iting any State’s authority to enact and enforce laws with  
9           respect to the licensure or certification of any class of  
10          health professional or the provision of any class of health  
11          professional services.

12          “(b) SCOPE OF PRACTICE.—Effective as of January  
13          1, 1996, a State may not restrict through licensure or oth-  
14          erwise the practice of any class of health professionals be-  
15          yond what is justified by the skills and training of such  
16          professionals.

17          “(c) ACADEMIC DEGREE.—Effective as of January 1,  
18          1996, a State may not restrict the participation, reim-  
19          bursement, or indemnification of a health professional  
20          solely on the basis of the academic degree of such profes-  
21          sional if the professional is acting within the scope of the  
22          professional’s license under applicable State law.

1 **“SEC. 21043. PREEMPTION FROM STATE BENEFIT MAN-**  
2 **DATES.**

3 “Effective as of January 1, 1996, no State shall es-  
4 tablish or enforce any law or regulation that requires any  
5 standard health plan to cover items and services that are  
6 different from the items and services specified pursuant  
7 to subtitle C.

8 **“SEC. 21044. PREEMPTION OF STATE LAW REGULATING**  
9 **UTILIZATION MANAGEMENT AND REVIEW.**

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

13 **“PART IV—FEDERAL RESPONSIBILITIES**

14 **“SEC. 21051. FEDERAL ROLE WITH RESPECT TO**  
15 **MULTISTATE SELF-INSURED HEALTH PLANS.**

16 “(a) IN GENERAL.—In the case of a multistate self-  
17 insured health plan or a multistate self-insured supple-  
18 mental health benefits plan, the Secretary of Labor shall  
19 carry out activities under this title in the same manner  
20 as a participating State program would carry out activities  
21 under part I with respect to a health plan subject to such  
22 part.

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

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

5 “(c) APPLICABILITY OF ERISA ENFORCEMENT  
6 MECHANISMS.—The provisions of sections 502 (relating  
7 to civil enforcement), 504 (relating to investigative author-  
8 ity), and 506 (relating to criminal enforcement) of the  
9 Employee Retirement Income Security Act of 1974 shall  
10 apply to enforcement by the Secretary of Labor of the ap-  
11 plicable requirements for experience-rated employers de-  
12 scribed in subsection (b) in the same manner and to the  
13 same extent as such provisions apply to enforcement of  
14 title I of such Act.

15 **“SEC. 21052. ESTABLISHMENT OF RESIDENCY RULES.**

16 “The Secretary shall establish rules relating to identi-  
17 fying the State (and community rating area) in which indi-  
18 viduals reside. Such rules shall be based on the principal  
19 residence of such an individual.

20 **“SEC. 21053. WORKPLACE WELLNESS PROGRAM.**

21 “(a) IN GENERAL.—The Secretary shall develop cer-  
22 tification criteria for workplace wellness programs.

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

1 percent, to employers maintaining certified workplace  
2 wellness programs.

3 **“SEC. 21054. EMPLOYEE LEASING RULES.**

4 “The Secretary of Labor shall promulgate such regu-  
5 lations as may be necessary to prevent the avoidance of  
6 any requirements of this title through the use of employee  
7 leasing businesses.

8 **“SEC. 21055. APPROVAL OF PRIVATE ACCREDITATION PRO-**  
9 **GRAMS.**

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

12 **“PART V—DEFINITIONS AND RULES**

13 **“SEC. 21100. DEFINITIONS AND RULES OF GENERAL APPLI-**  
14 **CATION.**

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

17 “(1) APPROPRIATE CERTIFYING AUTHORITY.—

18 The term ‘appropriate certifying authority’ means—

19 “(A) except as provided in subparagraph

20 (B), in the case of a standard or nonstandard

21 health plan, a supplemental health benefits

22 plan, or a long-term care policy, the State com-

23 missioner or superintendent of insurance or

24 other State authority in the participating State;

25 or

1           “(B) in the case of a multistate self-in-  
2           sured health plan or a multistate self-insured  
3           supplemental health benefits plan, the Secretary  
4           of Labor.

5           “(2) COVERED ITEMS AND SERVICES.—The  
6           term ‘covered items and services’ means items and  
7           services included in benefit packages established  
8           under subtitle C.

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

14          “(4) DEPENDENT.—The term ‘dependent’  
15          means, with respect to any individual, any person—

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

19                 “(B) who is—

20                         “(i) under 25 years of age and un-  
21                         married, or

22                         “(ii) permanently and totally disabled  
23                         (within the meaning of section  
24                         151(c)(5)(C) of such Code).

1           “(5) EMPLOYER, EMPLOYEE, EMPLOYMENT,  
2           AND WAGES DEFINED.—

3           “(A) IN GENERAL.—Except as otherwise  
4           provided in this subtitle—

5           “(i) the terms ‘wages’ and ‘employ-  
6           ment’ have the meanings given such terms  
7           under section 3121 of the Internal Reve-  
8           nue Code of 1986,

9           “(ii) the term ‘employee’ has the  
10          meaning given such term under section  
11          3121 of such Code, subject to the provi-  
12          sions of chapter 25 of such Code, and

13          “(iii) the term ‘employer’ has the  
14          same meaning as the term “employer” as  
15          used in such section 3121.

16          “(B) EXCEPTIONS.—For purposes of sub-  
17          paragraph (A)—

18                 “(i) EMPLOYMENT.—

19                         “(I) EMPLOYMENT INCLUDED.—  
20                         Paragraphs (1), (2), (5), (7) (other  
21                         than clauses (i) through (iv) of sub-  
22                         paragraph (C) and clauses (i) through  
23                         (v) of subparagraph (F)), (8), (9),  
24                         (10), (11), (13), (15), (18), and (19)

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

3 “(II) EXCLUSION OF INMATES AS  
4 EMPLOYEES.—Employment shall not  
5 include services performed in a penal  
6 institution by an inmate thereof or in  
7 a hospital or other health care institu-  
8 tion by a patient thereof.

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

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

22 “(V) CONSIDERATION OF INDUS-  
23 TRY PRACTICE.—As provided under  
24 regulation by the Secretary of Labor,  
25 an employee shall be considered to be

1 employed on a full-time basis by an  
2 employer (and to be a full-time em-  
3 ployee of an employer) for a month  
4 (or for all months in a 12-month pe-  
5 riod) if the employee is employed by  
6 that employer on a continuing basis  
7 that, taking into account the structure  
8 or nature of employment in the indus-  
9 try, represents full-time employment  
10 in that industry.

11 “(ii) WAGES.—

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

15 “(II) TIPS NOT INCLUDED.—The  
16 term ‘wages’ does not include cash  
17 tips.

18 “(iii) EMPLOYEES.—

19 “(I) TREATMENT OF SELF-EM-  
20 PLOYED.—The term ‘employee’ in-  
21 cludes a self-employed individual.

22 “(II) EXCLUSION OF CERTAIN  
23 FOREIGN EMPLOYMENT.—The term  
24 ‘employee’ does not include an individ-  
25 ual with respect to service, if the indi-

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

4           “(C) AGGREGATION RULES FOR EMPLOY-  
5           ERS.—For purposes of this title—

6           “(i) all employers treated as a single  
7           employer under subsection (a) or (b) of  
8           section 52 of the Internal Revenue Code of  
9           1986 shall be treated as a single employer,  
10          and

11          “(ii) under regulations of the Sec-  
12          retary of the Treasury, all employees of or-  
13          ganizations which are under common con-  
14          trol with one or more organizations which  
15          are exempt from income tax under subtitle  
16          A of the Internal Revenue Code of 1986  
17          shall be treated as employed by a single  
18          employer.

19          The regulations prescribed under clause (ii)  
20          shall be based on principles similar to the prin-  
21          ciples which apply to taxable organizations  
22          under clause (i).

23          “(6) EQUIVALENT HEALTH CARE PROGRAM.—

24          The term ‘equivalent health care program’ means—

1           “(A) part A or part B of the medicare pro-  
2           gram under title XVIII of the Social Security  
3           Act,

4           “(B) the medicaid program under title  
5           XIX of the Social Security Act,

6           “(C) the health care program for active  
7           military personnel under title 10, United States  
8           Code,

9           “(D) the veterans health care program  
10          under chapter 17 of title 38, United States  
11          Code,

12          “(E) the Civilian Health and Medical Pro-  
13          gram of the Uniformed Services (CHAMPUS),  
14          as defined in section 1073(4) of title 10, United  
15          States Code,

16          “(F) the Indian health service program  
17          under the Indian Health Care Improvement Act  
18          (25 U.S.C. 1601 et seq.), and

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

21          “(7) FAMILY.—The term ‘family’ includes an  
22          individual, the individual’s spouse, and the individ-  
23          ual’s dependents (if any), as defined in paragraph  
24          (4).

1           “(8) HEALTH PLAN SPONSOR.—The term  
2 ‘health plan sponsor’ means, with respect to—

3           “(A) an insured health plan, the insurer,  
4 and

5           “(B) a self-insured health plan, the experi-  
6 ence-rated employer sponsor.

7           “(9) HEALTH PROFESSIONAL.—The term  
8 ‘health professional’ means an individual who is le-  
9 gally authorized to provide services in the State in  
10 which such services are provided.

11           “(10) LEGALLY AUTHORIZED.—The term ‘le-  
12 gally authorized’ means, with respect to a provider,  
13 authorization under licensing or certification laws of  
14 a State.

15           “(11) NAIC.—The term ‘NAIC’ means the Na-  
16 tional Association of Insurance Commissioners.

17           “(12) PARTICIPATING STATE.—The term ‘par-  
18 ticipating State’ means a State establishing a State  
19 program under this title.

20           “(13) PROVIDER.—The term ‘provider’ includes  
21 a health professional.

22           “(14) PURCHASING COOPERATIVE.—The term  
23 ‘purchasing cooperative’ means a health insurance  
24 purchasing cooperative established under section  
25 21411.



1 guidelines for an accreditation, certification, en-  
2 forcement, and information program for partici-  
3 pating States by not later than July 1, 1995.

4 “(B) ADAPTATION TO DELIVERY SYS-  
5 TEMS.—The Secretary shall adapt the stand-  
6 ards specified in subpart B of part II with re-  
7 spect to each particular delivery system.

8 “(C) ESTABLISHMENT OF PROVISIONAL  
9 STANDARDS.—With respect to any health plan  
10 operating in an underserved area (as designated  
11 by the State or the Secretary under section  
12 21601), the Secretary may adopt provisional  
13 standards for use for not more than 3 years in  
14 lieu of the standards specified in subpart B of  
15 part II.

16 “(2) ESTABLISHMENT OF STANDARDS FOR RE-  
17 INSURANCE AND RISK ADJUSTMENT PROGRAMS.—

18 “(A) IN GENERAL.—The Secretary shall  
19 develop standards under subparagraphs (B),  
20 (C), and (D), for participating States to provide  
21 reinsurance pools, risk adjustment programs,  
22 and subsidy adjustment programs under section  
23 21023 for participation by standard health  
24 plans as provided in section 21121.

1           “(B) MANDATORY REINSURANCE POOLS.—

2           The standards developed by the Secretary  
3           under this subparagraph shall include a system  
4           of mandatory reinsurance which—

5                   “(i) specifies the manner of creation,  
6                   structure, and operation of the system, in-  
7                   cluding—

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

13                           “(II) the type and level of rein-  
14                          surance coverage provided;

15                          “(ii) provides for such health plans to  
16                          make payments to the State-established re-  
17                          insurance program for the purpose of  
18                          eliminating incentives for plans to discrimi-  
19                          nate against individuals on the basis of  
20                          their expected utilization of health services;  
21                          and

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

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

3 “(C) RISK ADJUSTMENT PROGRAM.—

4 “(i) IN GENERAL.—The standards de-  
5 veloped by the Secretary under this sub-  
6 paragraph shall include a risk adjustment  
7 program which—

8 “(I) assures that payments to  
9 community-rated standard health  
10 plans reflect the expected relative uti-  
11 lization and expenditures for health  
12 care services by each plan’s enrollees  
13 compared to the average utilization  
14 and expenditures for community-rated  
15 individuals; and

16 “(II) protects plans that enroll a  
17 disproportionate share of such individ-  
18 uals with respect to whom expected  
19 utilization of health care services and  
20 expected health care expenditures for  
21 such services are greater than the av-  
22 erage utilization and expenditures for  
23 such eligible individuals.

24 “(ii) FACTORS TO BE CONSIDERED.—

25 In developing the standards for a risk ad-

1           justment program, the Secretary may take  
2           into account the following factors with re-  
3           spect to enrollees:

4                   “(I) Demographic characteristics.

5                   “(II) Health status.

6                   “(III) Socio-economic status.

7                   “(IV) Subsidy status.

8                   “(V) Other factors determined  
9           appropriate by the Secretary.

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

18                   “(D) COST-SHARING ADJUSTMENT PRO-  
19           GRAM.—The standards developed by the Sec-  
20           retary under this subparagraph shall include a  
21           cost-sharing adjustment program which redis-  
22           tributes losses among all standard health plans,  
23           except multistate self-insured health plans, re-  
24           sulting from the reduced cost-sharing obliga-  
25           tions of individuals receiving assistance as is

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

3 “(3) ESTABLISHMENT OF CAPITAL STAND-  
4 ARDS.—

5 “(A) IN GENERAL.—The Secretary shall  
6 develop, in consultation with the NAIC, by not  
7 later than July 1, 1995, a risk-based capital  
8 standards formula for health plans under sec-  
9 tion 21122.

10 “(B) NO PREEMPTION.—Nothing in this  
11 title shall preclude or preempt State law on, or  
12 regulation of, health plan deposit reserve re-  
13 quirements.

14 “(4) CONSULTATION WITH SECRETARY OF  
15 LABOR.—

16 “(A) IN GENERAL.—Except as provided in  
17 subparagraph (B), in the case of multistate  
18 self-insured health plans, the Secretary, in con-  
19 sultation with the Secretary of Labor, shall de-  
20 velop and publish the standards for such plans.

21 “(B) REINSURANCE PROGRAM.—The Sec-  
22 retary of Labor shall develop, by not later than  
23 July 1, 1995, standards for a reinsurance pro-  
24 gram for multistate self-insured health plans  
25 under section 21121.

1       “(c) NATIONAL HEALTH PLAN STANDARDS AND  
2 QUALITY ADVISORY COMMITTEE.—

3           “(1) ESTABLISHMENT.—The Secretary shall es-  
4 tablish a National Health Plan Standards and Qual-  
5 ity Advisory Committee (hereafter referred to in this  
6 subsection as the ‘Committee’) by March 1, 1995, to  
7 advise the Secretary on—

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

10          “(B) the use and accountability of funds  
11 from the Health Security Trust Fund to sup-  
12 port State establishment of accreditation, cer-  
13 tification, enforcement, and information pro-  
14 grams; and

15          “(C) national measures of quality perform-  
16 ance, comparative value information criteria,  
17 population health status measures, and other  
18 aspects of quality and consumer information.

19          “(2) NUMBER AND APPOINTMENT.—The Com-  
20 mittee shall be composed of the Administrator of the  
21 Agency for Health Care Policy and Research, the  
22 Administrator of the Health Care Financing Admin-  
23 istration, and 11 members appointed by the Sec-  
24 retary. The appointed members shall be broadly rep-

1 representative of the population of the United States  
2 and shall include—

3 “(A) a representative of State insurance  
4 commissioners or State health departments;

5 “(B) a representative of health plans;

6 “(C) a representative of employers pur-  
7 chasing health care;

8 “(D) a representative of health care pro-  
9 viders;

10 “(E) a representative of consumers of  
11 health care;

12 “(F) a representative of associations of  
13 private accreditation entities; and

14 “(G) individuals distinguished in the fields  
15 of law, medicine, economics, public health, and  
16 health services research.

17 “(3) TERMS.—

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

21 “(B) STAGGERED ROTATION.—Of the  
22 members first appointed to the Committee  
23 under paragraph (2), the Secretary shall ap-  
24 point 4 members to serve for a term of 4 years,

1           4 members to serve for a term of 3 years, 3  
2           members to serve for a term of 2 years.

3           “(C) SERVICE BEYOND TERM.—An ap-  
4           pointed member of the Committee may continue  
5           to serve after the expiration of the term of the  
6           member until a successor is appointed.

7           “(4) VACANCIES.—If an appointed member of  
8           the Committee does not serve the full term applica-  
9           ble under paragraph (3), the individual appointed to  
10          fill the resulting vacancy shall be appointed for the  
11          remainder of the term of the predecessor of the indi-  
12          vidual.

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

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

19          “(7) COMPENSATION AND REIMBURSEMENT OF  
20          EXPENSES.—Members of the Committee shall re-  
21          ceive compensation for each day (including travel  
22          time) engaged in carrying out the duties of the Com-  
23          mittee. Such compensation may not be in an amount  
24          in excess of the maximum rate of basic pay payable

1 for level IV of the Executive Schedule under section  
2 5315 of title 5, United States Code.

3 “(8) STAFF.—The Secretary shall provide to  
4 the Committee such staff, information, and other as-  
5 sistance as may be necessary to carry out the duties  
6 of the Committee.

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

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

14 **“SEC. 21102. CERTIFIED SUPPLEMENTAL HEALTH BENE-**  
15 **FITS PLANS.**

16 “(a) IN GENERAL.—A supplemental health benefits  
17 plan shall meet the applicable reform standards estab-  
18 lished under subsection (b).

19 “(b) ESTABLISHMENT OF STANDARDS.—

20 “(1) IN GENERAL.—Except as provided in para-  
21 graph (2), the Secretary shall develop and publish  
22 specific standards to implement the standards speci-  
23 fied in part III by not later than January 1, 1996.

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

1 supplemental health benefits plans, the Secretary, in  
2 consultation with the Secretary of Labor, shall de-  
3 velop and publish the standards described in para-  
4 graph (1).

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

9 **“SEC. 21103. CERTIFIED LONG-TERM CARE POLICIES.**

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

13 “(b) ESTABLISHMENT OF STANDARDS.—

14 “(1) IN GENERAL.—Except as provided in para-  
15 graph (2), the Secretary, in consultation with the  
16 NAIC, shall develop and publish specific standards  
17 to implement the standards specified in part IV by  
18 not later than September 1, 1996.

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

1 not be inconsistent with any of the standards speci-  
2 fied in part IV.

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

7 **“SEC. 21104. GENERAL RULES.**

8 “(a) CONSTRUCTION.—Whenever in this subtitle a  
9 requirement or standard is imposed on a health plan, sup-  
10 plemental health benefits plan, or long-term care policy,  
11 the requirement or standard is deemed to have been im-  
12 posed on the insurer or sponsor of the plan or policy in  
13 relation to that plan or policy.

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

21 “(c) REFERENCE TO REFORM STANDARDS.—For  
22 purposes of this title, the term ‘reform standards’ means  
23 the standards developed under this subtitle and applicable  
24 under parts II, III, and IV.

1           **“PART II—STANDARDS APPLICABLE TO**  
2                           **STANDARD HEALTH PLANS**

3                           **“Subpart A—Insurance Standards**

4   **“SEC. 21111. GUARANTEED ISSUE AND RENEWAL.**

5           “(a) ISSUE.—

6                   “(1) IN GENERAL.—Except as otherwise pro-  
7           vided in this section, a standard health plan spon-  
8           sor—

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

12                           “(B) offering an experience-rated health  
13           plan or a self-insured health plan shall offer  
14           such plan to any experience-rated individual eli-  
15           gible for coverage under the plan through the  
16           individual’s experience-rated employer.

17           “(2) AVAILABILITY.—

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

24                           “(B) GEOGRAPHIC LIMITATIONS.—A com-  
25           munity-rated standard health plan may deny  
26           coverage under the plan to a community-rated

1 individual who resides outside the community  
2 rating area in which such plan is offered, but  
3 only if such denial is applied uniformly, without  
4 regard to health status or insurability of indi-  
5 viduals.

6 “(3) APPLICATION OF CAPACITY LIMITS.—

7 “(A) IN GENERAL.—Subject to subpara-  
8 graph (B), an insured standard health plan  
9 may apply to the appropriate certifying author-  
10 ity to cease enrolling individuals under the plan  
11 if—

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

14 “(ii) the plan can demonstrate to the  
15 applicable certifying authority that its fi-  
16 nancial or provider capacity to serve pre-  
17 viously covered groups or individuals (and  
18 additional individuals who will be expected  
19 to enroll because of affiliation with such  
20 previously covered groups or individuals)  
21 will be impaired if it is required to enroll  
22 other individuals.

23 “(B) FIRST-COME-FIRST-SERVED.—An in-  
24 sured standard health plan is only eligible to ex-  
25 ercise the limitations provided for in subpara-

1 graph (A) if such plan provides for enrollment  
2 of individuals on a first-come-first-served basis  
3 (except in the case of additional individuals de-  
4 scribed in subparagraph (A)(ii)).

5 “(b) RENEWAL.—

6 “(1) IN GENERAL.—Except as provided in para-  
7 graph (2), a standard health plan that is issued to  
8 an individual shall be renewed at the option of the  
9 individual.

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

14 “(A) nonpayment of premiums;

15 “(B) fraud on the part of the individual; or

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

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

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

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

11 “(e) APPLICATION OF INTERIM STANDARDS.—

12 “(1) IN GENERAL.—During the interim stand-  
13 ards application period, a health plan sponsor may  
14 only offer a health plan in a State if such plan meets  
15 the standards specified in paragraph (2).

16 “(2) SPECIFIED STANDARDS.—

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

20 “(B) RENEWAL.—The standards specified  
21 in subsection (b).

22 “(C) EXIT FROM MARKET.—

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

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

4            “(I) elects not to renew all of its  
5            insured health plans using such deliv-  
6            ery system issued to all such individ-  
7            uals in a State; and

8            “(II) provides notice to the ap-  
9            propriate certifying authority and to  
10           each such individual covered under  
11           the plan of such termination at least  
12           180 days before the date of expiration  
13           of the plan.

14           “(ii) PROHIBITION ON MARKET RE-  
15           ENTRY.—In the case of such a termi-  
16           nation, such insurer may not provide for  
17           the issuance of any insured health plan  
18           using such a delivery system to a commu-  
19           nity-rated individual in such State during  
20           the 5-year period beginning on the date of  
21           the termination of the last plan not so re-  
22           newed.

23           “(3) INTERIM STANDARDS APPLICATION PERI-  
24           ODS.—The interim standards application period is—

1           “(A) in the case of the standard specified  
2           in paragraph (2)(A), on or after January 1,  
3           1995, and before January 1, 1996;

4           “(B) in the case of the standards specified  
5           in paragraph (2)(B), on or after June 28,  
6           1994, and before January 1, 1996; and

7           “(C) in the case of the standard specified  
8           in paragraph (2)(C), on or after the date of the  
9           enactment of this title, and before January 1,  
10          1996.

11          “(4) PREEMPTION.—The requirements of this  
12          subsection do not preempt any State law unless  
13          State law directly conflicts with such requirements.  
14          The provision of additional protections under State  
15          law shall not be considered to directly conflict with  
16          such requirements. The Secretary may issue letter  
17          determinations with respect to whether this sub-  
18          section preempts a provision of State law.

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

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

1 regarding the application of this subsection in the  
2 case of health plans (or groups of such plans) which  
3 are transferred from one health plan sponsor to an-  
4 other sponsor through assumption, acquisition, or  
5 otherwise.

6 **“SEC. 21112. ENROLLMENT.**

7 “(a) ENROLLMENT PROCESS.—

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

11 “(2) INITIAL ENROLLMENT PERIOD.—Each in-  
12 dividual shall have an initial enrollment period in  
13 which to enroll in a standard health plan—

14 “(A) except as provided in subparagraph  
15 (B), beginning on January 1, 1996, and ending  
16 on March 31, 1996,

17 “(B) with respect to premium subsidy eli-  
18 gible individuals described in section  
19 1952(a)(2)(A)(i) in States which have not es-  
20 tablished a premium subsidy program in 1996,  
21 beginning on January 1, 1997, and ending on  
22 March 31, 1997.

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

1 each general annual enrollment period specified by  
2 the appropriate certifying authority under section  
3 21024.

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

6 “(A) through marriage, separation, di-  
7 vorce, birth or adoption of a child, death, or  
8 similar circumstances, experiences a change in  
9 family composition;

10 “(B) experiences a change in employment  
11 status (including a significant change in the  
12 terms and conditions of employment) or in con-  
13 tinuation coverage;

14 “(C) changes residence to another commu-  
15 nity rating area;

16 “(D) disenrolls for cause from a standard  
17 health plan; or

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

20 each standard health plan shall provide for a special  
21 enrollment period in which the employee or individ-  
22 ual is permitted to change the individual or family  
23 basis of coverage or the plan in which the employee  
24 or individual is enrolled. The circumstances under  
25 which such special enrollment periods are required

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

3 “(b) COMMENCEMENT OF COVERAGE.—

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

11 “(2) NEWBORNS.—In the event of the birth or  
12 adoption of a child of an enrollee, coverage of such  
13 child under such enrollee’s standard health plan (re-  
14 gardless of the class of enrollment) shall begin on  
15 the date of such birth or adoption and shall con-  
16 tinue, in the absence of any enrollment of such child  
17 during a special enrollment period provided under  
18 subsection (a)(4), for at least 45 days.

19 **“SEC. 21113. RATING LIMITATIONS FOR COMMUNITY-RATED**  
20 **MARKET.**

21 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-  
22 MUNITY-RATED ELIGIBLE INDIVIDUALS.—Each standard  
23 health plan which covers community-rated individuals  
24 shall establish within each community rating area in which

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

3 “(1) the standard benefits package established  
4 under subtitle C, and

5 “(2) the alternative standard benefits package  
6 established under subtitle C.

7 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
8 ING AREAS.—

9 “(1) IN GENERAL.—Subject to paragraphs (2)  
10 and (3), the standard premium for each package de-  
11 scribed in subsection (a) for all community-rated in-  
12 dividuals within a community rating area shall be  
13 the same and shall not include the costs of premium  
14 processing, enrollment, and marketing that would  
15 vary depending on whether the method of enrollment  
16 is through a purchasing cooperative, or directly  
17 through a health plan, an employer, or a broker.

18 “(2) APPLICATION TO ENROLLEES.—

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

23 “(i) the standard premium (estab-  
24 lished under paragraph (1));

1           “(ii) in the case of enrollment other  
2 than individual enrollment, the family ad-  
3 justment factor specified under subpara-  
4 graph (B); and

5           “(iii) the age adjustment factor (spec-  
6 ified under subparagraph (C)).

7           “(B) FAMILY ADJUSTMENT FACTOR.—

8           “(i) IN GENERAL.—The reform stand-  
9 ards shall specify family adjustment fac-  
10 tors that reflect the relative actuarial costs  
11 of benefit packages based on family classes  
12 of enrollment (as compared with such costs  
13 for individual enrollment).

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

17           “(I) Coverage only of an individ-  
18 ual (other than an individual de-  
19 scribed in subclause (II)) (referred to  
20 in this title as the ‘individual’ enroll-  
21 ment or class of enrollment).

22           “(II) Coverage only of an individ-  
23 ual who has not attained age 18 (re-  
24 ferred to in this title as the ‘single

1 child' enrollment or class of enroll-  
2 ment).

3 “(III) Coverage only of two or  
4 more children (referred to in this title  
5 as the ‘multiple children’ enrollment  
6 or class of enrollment).

7 “(IV) Coverage of a married cou-  
8 ple without children (referred to in  
9 this title as the ‘couple-only’ enroll-  
10 ment or class of enrollment).

11 “(V) Coverage of an individual  
12 and one or more children (referred to  
13 in this title as the ‘single parent’ en-  
14 rollment or class of enrollment).

15 “(VI) Coverage of a married cou-  
16 ple and one or more children (referred  
17 to in this title as the ‘dual parent’ en-  
18 rollment or class of enrollment).

19 “(iii) REFERENCES TO FAMILY AND  
20 COUPLE CLASSES OF ENROLLMENT.—In  
21 this title:

22 “(I) FAMILY.—The terms ‘family  
23 enrollment’ and ‘family class of enroll-  
24 ment’ refer to enrollment in a class of  
25 enrollment described in any subclause

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

3 “(II) COUPLE.—The term ‘couple  
4 class of enrollment’ refers to enroll-  
5 ment in a class of enrollment de-  
6 scribed in subclause (IV) or (VI) of  
7 clause (ii).

8 “(iv) SPOUSE; MARRIED; COUPLE.—

9 “(I) IN GENERAL.—In this title,  
10 the terms ‘spouse’ and ‘married’  
11 mean, with respect to an individual,  
12 another individual who is the spouse  
13 of, or is married to, the individual, as  
14 determined under applicable State  
15 law.

16 “(II) COUPLE.—The term ‘cou-  
17 ple’ means an individual and the indi-  
18 vidual’s spouse.

19 “(C) AGE ADJUSTMENT FACTOR.—The  
20 Secretary, in consultation with the NAIC, shall  
21 specify uniform age categories and rating incre-  
22 ments for age adjustment factors that reflect  
23 the relative actuarial costs of benefit packages  
24 among enrollees. For individuals who have at-  
25 tained age 18 but not age 65, the highest age

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

3 “(3) ADMINISTRATIVE CHARGES.—

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

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

20 “(C) DISALLOWANCE OF SEPARATE  
21 CHARGE ON COOPERATIVE.—No standard  
22 health plan which covers community-rated indi-  
23 viduals may impose a separately-stated adminis-  
24 trative charge for enrollment through any pur-  
25 chasing cooperative.



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

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

7 “(B) the rating methods are actuarially  
8 sound.

9 Each such sponsor shall retain a copy of such state-  
10 ment at its principal place of business for examina-  
11 tion by any individual.

12 “(b) PAYMENT OF PREMIUMS.—

13 “(1) IN GENERAL.—With respect to a new en-  
14 rollee in a standard health plan, the plan may re-  
15 quire advanced payment of an amount equal to the  
16 monthly applicable premium for the plan at the time  
17 such individual is enrolled.

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

1 **“SEC. 21115. NONDISCRIMINATION BASED ON HEALTH STA-**  
2 **TUS.**

3 “(a) IN GENERAL.—Except as provided under sub-  
4 section (b), a standard health plan may not—

5 “(1) deny, limit, or condition the coverage  
6 under (or benefits of) the plan;

7 “(2) engage, directly or through contractual ar-  
8 rangements, in any activity, including the selection  
9 of a service area; and

10 “(3) in the case of a self-insured standard  
11 health plan, vary the premium,  
12 based on the health status, medical condition, claims expe-  
13 rience, receipt of health care, medical history, anticipated  
14 need for health care expenses, disability, or lack of evi-  
15 dence of insurability, of an individual.

16 “(b) TREATMENT OF PREEXISTING CONDITION EX-  
17 CLUSIONS FOR ALL SERVICES.—

18 “(1) IN GENERAL.—Subject to paragraph (4), a  
19 standard health plan may impose a limitation or ex-  
20 clusion of benefits relating to treatment of a condi-  
21 tion based on the fact that the condition preexisted  
22 the effective date of the plan with respect to an indi-  
23 vidual only if—

24 “(A) the condition was diagnosed or treat-  
25 ed during the 3-month period ending on the day  
26 before the date of enrollment under the plan;

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

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

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

9           “(2) CREDITING OF PREVIOUS COVERAGE.—A  
10 standard health plan shall provide that if an individ-  
11 ual under such plan is in a period of continuous cov-  
12 erage as of the date of enrollment under such plan,  
13 any period of exclusion of coverage with respect to  
14 a preexisting condition shall be reduced by 1 month  
15 for each month in the period of continuous coverage.

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

17           “(A) PERIOD OF CONTINUOUS COV-  
18 ERAGE.—The term ‘period of continuous cov-  
19 erage’ means the period beginning on the date  
20 an individual is enrolled under a health plan or  
21 health care program which provides benefits  
22 equivalent to those provided by the plan in  
23 which the individual is seeking to enroll with re-  
24 spect to coverage of a preexisting condition and  
25 ends on the date the individual is not so en-

1           rolled for a continuous period of more than 3  
2           months.

3           “(B) PREEEXISTING CONDITION.—The term  
4           ‘preexisting condition’ means, with respect to  
5           coverage under a standard health plan, a condi-  
6           tion which was diagnosed, or which was treated,  
7           within the 3-month period ending on the day  
8           before the date of enrollment (without regard to  
9           any waiting period).

10          “(4) SPECIAL RULE FOR 1996.—This subsection  
11          shall be applied for calendar year 1996 by substitut-  
12          ing ‘6-month’ for ‘3-month’ in paragraph (1)(A).

13          “(5) PROHIBITION ON PREEEXISTING CONDITION  
14          EXCLUSION DURING AMNESTY PERIOD.—This sub-  
15          section shall not apply during an initial enrollment  
16          period described in section 21112(a)(2).

17          “(c) APPLICATION OF INTERIM STANDARDS.—

18                 “(1) IN GENERAL.—During the interim stand-  
19                 ards application period, a health plan sponsor may  
20                 only offer a self-insured health plan in a State if  
21                 such plan meets the standards specified in para-  
22                 graph (2).

23                 “(2) SPECIFIED STANDARDS.—

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

4           “(B) COVERAGE.—A self-insured health  
5 plan may not reduce or limit coverage of any  
6 condition or course of treatment that is ex-  
7 pected to cost not less than \$5,000 during any  
8 12-month period.

9           “(3) INTERIM STANDARDS APPLICATION PERI-  
10 ODS.—The interim standards application period is—

11           “(A) in the case of the standard specified  
12 in paragraph (2)(A), on or after January 1,  
13 1995, and before January 1, 1996; and

14           “(B) in the case of the standards specified  
15 in paragraph (2)(B), on or after June 28,  
16 1994, and before January 1, 1996.

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

20 **“SEC. 21116. BENEFITS OFFERED.**

21           “A standard health plan shall offer to all enrollees  
22 in the plan the standard benefits package or the alter-  
23 native standard benefits package established under sub-  
24 title C.

1           **“Subpart B—Delivery System Standards**

2   **“SEC. 21121. REINSURANCE, RISK ADJUSTMENT, AND COST-**  
3           **SHARING ADJUSTMENT.**

4           “(a) COMMUNITY-RATED PLANS.—Each community-  
5 rated standard health plan shall participate in a reinsur-  
6 ance pool, risk adjustment program, and cost-sharing ad-  
7 justment program of the State described in section  
8 21101(b)(2).

9           “(b) EXPERIENCE-RATED PLANS.—Each experience-  
10 rated health plan shall participate in a cost-sharing ad-  
11 justment program described in section 21101(b)(2).

12          “(c) SELF-INSURED PLANS.—

13           “(1) IN GENERAL.—Except as provided in para-  
14 graph (2), each self-insured standard health plan  
15 shall participate in a reinsurance pool and the cost-  
16 sharing adjustment program of the State described  
17 in section 21101(b)(2).

18           “(2) MULTISTATE PLANS.—Each multistate  
19 self-insured standard health plan shall participate in  
20 a reinsurance program developed under section  
21 21101(b)(4)(B).

22           “(d) HOLD-HARMLESS PROTECTIONS.—Each stand-  
23 ard health plan shall hold individual providers harmless  
24 from the effects of the cost-sharing assistance program  
25 under section 1953(b).

1 **“SEC. 21122. CAPITAL REQUIREMENTS.**

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

5 **“SEC. 21123. COLLECTION AND PROVISION OF STANDARD-**  
6 **IZED INFORMATION.**

7 “(a) HEALTH PLANS REQUIRED TO SUBMIT INFOR-  
8 MATION TO PROGRAM.—Each standard health plan of-  
9 fered or operated in a State shall submit to the consumer  
10 information program of such State established under sec-  
11 tion 21013 the program descriptive information regard-  
12 ing—

13 “(1) certification status of the plan;

14 “(2) benefits offered under the plan;

15 “(3) premiums, cost-sharing, and administra-  
16 tive charges under the plan;

17 “(4) risk and referral arrangements under the  
18 plan;

19 “(5) health care providers used under the plan  
20 and the availability of such providers;

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

23 “(7) other appropriate information as deter-  
24 mined by the Secretary.

1 The submission of such information shall be in the form  
2 of nonidentifiable health information (as defined in section  
3 11702(7)).

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

7 **“SEC. 21124. QUALITY IMPROVEMENT AND ASSURANCE.**

8 “(a) IN GENERAL.—Each standard health plan  
9 shall—

10 “(1) develop and implement an internal quality  
11 improvement program designed to measure, assess,  
12 and improve enrollee health status, enrollee out-  
13 comes, enrollee processes of care, and enrollee satis-  
14 faction;

15 “(2) develop and implement quality improve-  
16 ment goals based on the results of population health  
17 status measurements conducted under subtitle E;  
18 and

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

23 “(b) UTILIZATION MANAGEMENT.—

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

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

3 “(2) ADDITIONAL STANDARDS.—Each standard  
4 health plan shall base utilization management on  
5 current scientific knowledge, stress the efficient de-  
6 livery of health care and outcomes, rely primarily on  
7 evaluating and comparing practice patterns rather  
8 than routine case-by-case review, and be consistent  
9 and timely in application.

10 “(3) NO FINANCIAL INCENTIVES.—Utilization  
11 management by each standard health plan may not  
12 create direct financial incentives for reviewers to re-  
13 duce or limit medically necessary or appropriate  
14 services.

15 “(4) CONSUMER DISCLOSURE.—Each standard  
16 health plan shall disclose, upon request, to enrollees  
17 (and prospective enrollees) and to participating pro-  
18 viders (and prospective providers) the utilization re-  
19 view protocols used by the plan, while protecting  
20 proprietary business information to the extent speci-  
21 fied by the Secretary in the reform standards.

22 “(c) CREDENTIALING.—Each standard health plan  
23 shall—

24 “(1) credential participating physicians and  
25 practitioners; and

1           “(2) ensure that participating providers and fa-  
2           cilities are appropriately accredited, certified, and li-  
3           censed.

4           “(d) CONTINUITY OF CARE.—Each standard health  
5           plan shall develop and implement mechanisms for coordi-  
6           nating the delivery of care across provider settings.

7           “(e) MEDICAL RECORDKEEPING.—Each standard  
8           health plan shall assure that pertinent information is read-  
9           ily available to appropriate professionals.

10       **“SEC. 21125. PATIENT PROTECTIONS AND PROVIDER SE-**  
11                               **LECTION.**

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

15           “(b) INFORMATION REGARDING A PATIENT’S RIGHT  
16           TO SELF-DETERMINATION IN HEALTH CARE SERV-  
17           ICES.—Each standard health plan shall—

18                       “(1) provide written information to each indi-  
19           vidual enrolling in such plan of—

20                               “(A) such individual’s right under State  
21           law (whether statutory or as recognized by the  
22           courts of the State) to make decisions concern-  
23           ing medical care, including the right to accept  
24           or refuse medical treatment and the right to

1           formulate advance directives (as defined in sec-  
2           tion 1866(f)(3)), and

3                   “(B) the written policies of the plan with  
4           respect to such right;

5                   “(2) provide for educational activities for pa-  
6           tients and participating providers; and

7                   “(3) require participating primary care physi-  
8           cians to include in their patients’ charts the wishes  
9           of the patient concerning advance directives.

10           “(c) CONFIDENTIALITY OF PATIENT RECORDS.—  
11   Each standard health plan shall have explicit procedures  
12   to protect the confidentiality of individual patient informa-  
13   tion consistent with the rules established under subtitle  
14   C of title XI.

15           “(d) MARKETING.—No insurer may engage in selec-  
16   tive marketing that would have the effect of avoiding high-  
17   risk subscribers within a community rating area. Market-  
18   ing materials may not contain false or materially mislead-  
19   ing information.

20           “(e) NO PATIENT LIABILITY FOR UNPAID PLAN OB-  
21   LIGATIONS.—Each standard health plan shall hold enroll-  
22   ees harmless with respect to any plan obligations for pay-  
23   ment to providers.

24           “(f) REMEDIES AND ENFORCEMENT.—

1           “(1) IN GENERAL.—Each standard health plan  
2 shall comply with the remedies and enforcement re-  
3 quirements described in subtitle H.

4           “(2) GRIEVANCE PROCESS.—Each standard  
5 health plan shall establish a grievance process for  
6 enrollees dissatisfied with matters other than the de-  
7 nial of payment or provision of benefits by the plan.

8           “(g) PROVIDER SELECTION.—

9           “(1) IN GENERAL.—In selecting among provid-  
10 ers of health services for membership in a provider  
11 network, or in establishing the terms and conditions  
12 of such membership, a standard health plan may not  
13 engage in any practice that discriminates against a  
14 provider based on the health status of a patient of  
15 the provider.

16           “(2) NO DISCRIMINATION BASED ON ACADEMIC  
17 DEGREE.—No standard health plan may discrimi-  
18 nate in participation, reimbursement, or indemnifica-  
19 tion against a health professional solely on the basis  
20 of the academic degree of such professional if the  
21 professional is acting within the scope of the profes-  
22 sional’s license under applicable State law.

23           “(3) NUMBER AND TYPE.—Nothing in this title  
24 shall—

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

4           “(B) require any such plan to contract  
5           with any type of provider legally authorized to  
6           provide services in the State in which such serv-  
7           ices are provided; or

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

11          “(h) PHYSICIAN INCENTIVE PLANS.—A standard  
12          health plan may not operate a physician incentive plan un-  
13          less such incentive plan meets the requirements of section  
14          1876(i)(8)(A).

15          “(i) PHYSICIAN PARTICIPATION.—

16                 “(1) IN GENERAL.—Each standard health plan  
17                 shall establish mechanisms through which physicians  
18                 have input into matters affecting patient care and  
19                 through which patients have the ability to choose  
20                 any primary care physician from available practition-  
21                 ers.

22                 “(2) CONTRACT PROCEDURES.—Each standard  
23                 health plan shall provide not less than 30 days noti-  
24                 fication to physicians of decisions to cancel or deny  
25                 renewal of contracts and shall establish an informal,

1 non-binding, and advisory review process for ap-  
2 peals.

3 “(j) ETHICAL BUSINESS CONDUCT.—Each standard  
4 health plan shall develop and implement a code of ethical  
5 business conduct for its activities, including those of its  
6 components, and assure proficient management and plan-  
7 ning functions.

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

11 **“SEC. 21126. ALTERNATIVE DISPUTE RESOLUTION PROCE-  
12 DURES RELATING TO MALPRACTICE CLAIMS.**

13 “Each standard health plan shall establish and main-  
14 tain an alternative dispute resolution procedures program  
15 that complies with the standards developed under section  
16 1129.

17 **“SEC. 21127. ACCESS TO ESSENTIAL COMMUNITY PROVID-  
18 ERS.**

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

1 ary 1, 1996. The Secretary may require participation  
2 agreements to be offered to more than one essential com-  
3 munity provider in each category if the Secretary deter-  
4 mines extra capacity is required to serve the needs of en-  
5 rollees in a particular health plan service area.

6 “(b) PARTICIPATION AGREEMENT.—A participation  
7 agreement between a standard health plan sponsor and  
8 an essential community provider under this subsection  
9 shall provide that the plan agrees to treat the provider  
10 in accordance with terms and conditions at least as favor-  
11 able as those that are applicable to other providers with  
12 a participation agreement with the plan with respect to  
13 the scope of services and the basis for which payment is  
14 made by the plan to the provider.

15 “(c) ESSENTIAL COMMUNITY PROVIDERS DE-  
16 SCRIBED.—In this section, an ‘essential community pro-  
17 vider’ means any of the following entities certified by the  
18 Secretary:

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

22 “(2) COMMUNITY HEALTH CENTERS.—A recipi-  
23 ent or subrecipient of a grant under section 330 of  
24 such Act.

1           “(3) HOMELESS PROGRAM PROVIDERS.—A re-  
2 recipient or subrecipient of a grant under section 340  
3 of such Act.

4           “(4) PUBLIC HOUSING PROVIDERS.—A recipi-  
5 ent or subrecipient of a grant under section 340A of  
6 such Act.

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

9           “(6) INDIAN HEALTH PROGRAMS.—A service  
10 unit of the Indian Health Service, a tribal organiza-  
11 tion, or an urban Indian program, as defined in the  
12 Indian Health Care Improvement Act.

13           “(7) HIV PROVIDERS UNDER RYAN WHITE  
14 ACT.—A public or private nonprofit health care pro-  
15 vider that is a recipient or subrecipient of a grant  
16 under title XXVI of the Public Health Service Act.

17           “(8) MATERNAL AND CHILD HEALTH PROVID-  
18 ERS.—A public or private nonprofit entity that pro-  
19 vides prenatal care, pediatric care, or ambulatory  
20 services to children, including children with special  
21 health care needs, and that receives funding for such  
22 care or services under title V of the Social Security  
23 Act.

24           “(9) FEDERALLY QUALIFIED HEALTH CEN-  
25 TERS.—A Federally qualified health center (as de-

1        fined in section 1861(aa)(4)) or an entity that would  
2        be such a center but for its failure to meet the re-  
3        quirement described in section 329(f)(2)(G)(i) of the  
4        Public Health Service Act or the requirement de-  
5        scribed in section 330(e)(3)(G)(i) of such Act (relat-  
6        ing to the composition of the entity’s governing  
7        board).

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

10           “(11) PROVIDER OF SCHOOL HEALTH SERV-  
11        ICES.—A provider of school health services.

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

15           “(13) CERTAIN HOSPITALS.—A public hospital  
16        or non-profit hospital meeting the criteria for public  
17        hospitals which are covered entities under section  
18        340B of the Public Health Service Act, with a dis-  
19        proportionate patient percentage (as defined in sec-  
20        tion 1886(d)(5)(F)(vi)) greater than 11.75 percent.

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

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

1 additional health professionals and institutions as essen-  
2 tial community providers to the extent the Secretary deter-  
3 mines that standard health plans would not be able to as-  
4 sure adequate access to the standard benefits package es-  
5 tablished under subtitle C in a health plan service area  
6 without such designation.

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

10 “(1) is receiving funding from such a grant  
11 under a contract with the principal recipient of such  
12 a grant, and

13 “(2) meets the requirements established to be a  
14 recipient of such a grant.

15 “(e) STUDY.—During the 5-year period described in  
16 subsection (a), the Office of Technology Assessment shall  
17 conduct a continuing study on improving access in under-  
18 served areas.

19 **“SEC. 21128. HEALTH PLAN SERVICE AREA CAPACITY.**

20 “(a) AVAILABILITY OF SERVICES IN ENTIRE  
21 HEALTH PLAN SERVICE AREA.—On and after January  
22 1, 2001, each standard health plan shall have the capacity  
23 within the plan’s network, or through contracts with a suf-  
24 ficient number, distribution, and variety of providers, to  
25 deliver to all parts of any health plan service area (des-

1 igned under section 21022) in which such plan is of-  
2 fered, with reasonable promptness and in a manner which  
3 assures continuity, the standard benefits package estab-  
4 lished under subtitle C and any benefits offered by such  
5 sponsor through certified supplemental health benefits  
6 plans. Such capacity shall include the provision of emer-  
7 gency services 24 hours a day, 7 days a week.

8       “(b) CAPABILITY.—Each standard health plan shall  
9 make available and accessible translation, case manage-  
10 ment, and transportation services, if necessary, to deliver  
11 the benefits and services described in subsection (a).

12       “(c) DIVERSITY.—Each standard health plan shall  
13 ensure that criteria for the selection of participating pro-  
14 viders take into account the needs of diverse populations  
15 within a health plan service area served by the plan.

16       “(d) APPLICATION OF STANDARDS TO SELF-IN-  
17 SURED PLANS.—The standards specified in this section  
18 shall apply to self-insured standard health plans, but only  
19 to the extent necessary to deliver services to individuals  
20 enrolled in such plans.

21 **“SEC. 21129. ACCESS TO SPECIALIZED SERVICES.**

22       “(a) IN GENERAL.—Each standard health plan shall  
23 have within the plan’s network, or contract with, a suffi-  
24 cient number, distribution, and variety of providers of spe-  
25 cialized services to assure that such services are available

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

3 “(b) CENTERS OF EXCELLENCE.—

4 “(1) IN GENERAL.—A standard health plan  
5 may satisfy the standard under subsection (a) by  
6 contracting with, and demonstrating sufficient refer-  
7 rals (as determined by standards set by the Sec-  
8 retary) of, adults, infants, children, and persons with  
9 disabilities requiring specialized services to centers  
10 of excellence designated by the Secretary under sub-  
11 section (a). For children, such specialized treatment  
12 expertise shall be in pediatrics.

13 “(2) REQUIREMENTS FOR CENTERS.—The Sec-  
14 retary shall designate centers of excellence in the  
15 field of institutional care that meet evaluation cri-  
16 teria established by the Secretary for the delivery of  
17 care for complex cases requiring specialized treat-  
18 ment and also meet 2 or more of the following re-  
19 quirements:

20 “(A) Provide specialized education and  
21 training through approved graduate medical  
22 education programs with multi-specialty, multi-  
23 disciplinary teaching and services in both inpa-  
24 tient and outpatient settings, with medical staff

1 with faculty appointments at an affiliated medi-  
2 cal school.

3 “(B) Attract patients from outside the cen-  
4 ter’s local geographic region.

5 “(C) Either sponsor or participate in, or  
6 have medical staff who participate in, peer-re-  
7 viewed research.

8 “(c) OTHER EVALUATION CRITERIA FOR SPECIAL-  
9 IZED SERVICES STANDARDS.—Reform standards shall in-  
10 clude evaluation criteria determined by the Secretary for  
11 the standard under subsection (a) for standard health  
12 plans which choose to provide specialized services within  
13 a network setting, including requirements for staff creden-  
14 tials and experience, and requirements for measured out-  
15 comes in the diagnosis and treatment of patients. For chil-  
16 dren, such specialized treatment expertise shall be in pedi-  
17 atrics.

18 “(d) OUTCOMES CRITERIA.—The Secretary shall de-  
19 velop evaluation criteria for outcomes of specialized serv-  
20 ices as research findings become available.

21 **“SEC. 21130. PARTICIPATING PHYSICIAN PROGRAM.**

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

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

5 **“SEC. 21131. OUT-OF-AREA COVERAGE.**

6 “Each standard health plan shall provide for urgent  
7 and emergency out-of-area coverage for enrollees of the  
8 plan.

9 **“PART III—STANDARDS APPLICABLE TO**  
10 **SUPPLEMENTAL HEALTH BENEFITS PLANS**

11 **“SEC. 21141. IMPOSITION OF REQUIREMENTS ON SUPPLE-**  
12 **MENTAL HEALTH BENEFITS PLANS.**

13 “(a) IN GENERAL.—In the case of a supplemental  
14 health benefits plan—

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

19 “(2) which is a cost-sharing plan (as defined in  
20 subsection (b)(3)), the requirements of section  
21 21143 shall be met with respect to the plan.

22 “(b) PLANS DEFINED.—In this title:

23 “(1) SUPPLEMENTAL HEALTH BENEFITS  
24 PLAN.—The term ‘supplemental health benefits plan’

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

3 “(2) SUPPLEMENTAL SERVICES PLAN.—The  
4 term ‘supplemental services plan’ means a health  
5 plan which provides—

6 “(A) coverage for services and items not  
7 included in the standard benefits package estab-  
8 lished under subtitle C,

9 “(B) coverage for items and services in-  
10 cluded in such package but not covered because  
11 of a limitation in amount, duration, or scope of  
12 benefits, or

13 “(C) both.

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

19 **“SEC. 21142. STANDARDS FOR SUPPLEMENTAL SERVICES**  
20 **PLANS.**

21 “(a) APPLICATION OF CERTAIN HEALTH PLAN  
22 STANDARDS.—

23 “(1) IN GENERAL.—Except as provided in para-  
24 graph (3), the standards specified in paragraph (2)  
25 shall apply with respect to each supplemental serv-

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

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

6            “(A) Section 21111 (relating to guaran-  
7        teed issue and renewal).

8            “(B) Section 21112 (relating to enroll-  
9        ment).

10          “(C) Section 21113 (relating to rating lim-  
11        itations for community-rated market).

12          “(D) Section 21114 (relating to rating  
13        practices and payment of premiums).

14          “(E) Section 21115 (relating to non-  
15        discrimination based on health status).

16          “(F) Section 21123 (relating to collection  
17        and provision of standardized information).

18          “(G) Section 21124 (relating to quality im-  
19        provement and assurance).

20          “(H) Section 21125 (relating to patient  
21        protections and provider selection).

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

1 plan that duplicates any coverage provided under the med-  
2 icare program under title XVIII.

3 “(c) RESTRICTIONS ON MARKETING ABUSES.—Not  
4 later than January 1, 1996, the Secretary shall develop  
5 (in consultation with the States) minimum standards that  
6 prohibit marketing practices by entities offering supple-  
7 mental services plans that involve—

8 “(1) providing monetary incentives for, or tying  
9 or otherwise conditioning, the sale of the plan to en-  
10 rollees in a certified standard health plan of the en-  
11 tity;

12 “(2) using or disclosing to any party informa-  
13 tion about the health status or claims experience of  
14 participants in a certified standard health plan for  
15 the purpose of marketing a supplemental services  
16 plan; and

17 “(3) providing a supplemental services plan by  
18 a managed care plan to an individual not enrolled in  
19 such managed care plan.

20 **“SEC. 21143. STANDARDS FOR COST-SHARING PLANS.**

21 “(a) RULES FOR OFFERING OF PLANS.—A cost-shar-  
22 ing plan may be offered to an individual only if—

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

1           “(2) the certified standard health plan offers  
2           the cost-sharing plan to all individuals enrolled in  
3           the certified standard health plan and only such in-  
4           dividuals; and

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

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

11          “(b) EQUIVALENT COVERAGE FOR ALL SERVICES.—  
12          Each cost-sharing plan shall provide coverage for items  
13          and services in the standard benefits package established  
14          under subtitle C to the same extent as the applicable cer-  
15          tified standard health plan provides coverage for all items  
16          and services in such package.

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

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

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

1 **“SEC. 21144. PROHIBITION ON OFFERING OF MULTIPLE**  
2 **PACKAGES TO INDIVIDUAL.**

3 “A supplemental health benefits plan may not be of-  
4 fered to an individual who is covered under another such  
5 plan, unless the individual’s coverage under the new plan  
6 begins only after the individual’s coverage under the origi-  
7 nal plan is terminated.

8 **“PART IV—STANDARDS APPLICABLE TO LONG-**  
9 **TERM CARE POLICIES**

10 **“SEC. 21151. REGULATION OF SALES PRACTICES.**

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

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

16 “(2) POLICY REPLACEMENT FORM.—With re-  
17 spect to any individual who elects to replace or effect  
18 a change in a long-term care policy, the carrier that  
19 is selling such policy shall ensure that such individ-  
20 ual completes a policy replacement form developed  
21 as part of the reform standards. A copy of such  
22 form shall be provided to such individual and addi-  
23 tional copies shall be delivered by the carrier to the  
24 old policy carrier and kept on file by the new carrier  
25 for inspection by the appropriate certifying author-  
26 ity.

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

4           “(A) MISLEADING REPRESENTATION.—  
5           Knowingly making any misleading representa-  
6 tion (including the inaccurate completion of  
7 medical histories) or incomplete or fraudulent  
8 comparison of any long-term care policy or in-  
9 surers for the purpose of inducing, or tending  
10 to induce, any person to retain or effect a  
11 change with respect to a long-term care policy.

12           “(B) UNDUE PRESSURE.—Employing any  
13 method of marketing having the effect of, or in-  
14 tending to, induce the purchase of long-term  
15 care policy through force, fright, threat or  
16 undue pressure, whether explicit or implicit.

17           “(C) MISLEADING MARKETING.—Making  
18 use directly or indirectly of any method of mar-  
19 keting which fails to disclose in a conspicuous  
20 manner that a purpose of the method of mar-  
21 keting is solicitation of insurance and that con-  
22 tact will be made by an insurance agent or in-  
23 surance company.

1           “(D) OTHERS.—Engaging in such other  
2           practices determined inappropriate under the  
3           reform standards.

4           “(b) FINANCIAL NEEDS STANDARDS.—The reform  
5 standards shall include minimum financial needs stand-  
6 ards (including both income and asset criteria) for the  
7 purpose of advising individuals as to the costs and  
8 amounts of insurance needed when considering the pur-  
9 chase of a long-term care policy.

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

14          “(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-  
15 CATE SERVICE-BENEFIT POLICIES.—A carrier may not  
16 sell or issue a service-benefit long-term care policy to an  
17 individual—

18           “(1) knowing that the policy provides for cov-  
19 erage that duplicates coverage already provided in  
20 another service-benefit long-term care policy held by  
21 such individual (unless the policy is intended to re-  
22 place such other policy); or

23           “(2) for the benefit of an individual unless the  
24 individual (or a representative of the individual) pro-

1 provides a written statement to the effect that the cov-  
2 erage—

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

6 “(B) will replace another service-benefit  
7 long-term care policy.

8 In this subsection, the term ‘service-benefit long-term care  
9 policy’ means a long-term care policy which provides for  
10 benefits based on the type and amount of services fur-  
11 nished.

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

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

23 “(g) AGENT TRAINING AND CERTIFICATION RE-  
24 QUIREMENTS.—The reform standards shall include re-

1 requirements for long-term care insurance agent training  
2 and certification that—

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

6 “(2) specify procedures for certifying and  
7 recertifying agents who have completed such train-  
8 ing and who are qualified to sell or offer for sale  
9 long-term care policies.

10 **“SEC. 21152. ADDITIONAL RESPONSIBILITIES FOR CAR-**  
11 **RIERS.**

12 “(a) REFUND OF PREMIUMS.—If an application for  
13 a long-term care policy (or for a certificate under a group  
14 long-term care policy) is denied or an applicant returns  
15 a policy or certificate within 30 days of the date of its  
16 issuance pursuant to subsection 21156, the carrier shall,  
17 not later than 30 days after the date of the denial or re-  
18 turn, refund directly to the applicant, or in the case of  
19 an employer to whomever remits the premium, any pre-  
20 miums paid with respect to such a policy (or certificate).  
21 Any such refund shall not be made by delivery by the car-  
22 rier.

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

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

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

8 “(1) provide a written explanation of the rea-  
9 sons for the denial;

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

12 “(3) provide a written explanation of the man-  
13 ner in which to appeal the denial.

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

19 “(d) REPORTING OF INFORMATION.—A carrier that  
20 issues one or more long-term care policies shall periodi-  
21 cally (not less often than annually) report, in a form and  
22 in a manner specified by the reform standards, to the ap-  
23 propriate certifying authority for the State in which the  
24 policy is delivered, and shall make available to the Sec-

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

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

5 “(2) the most recent premiums for such policies  
6 and the premiums imposed for such policies since  
7 the initial issuance of such policies;

8 “(3) the lapse rate, replacement rate, and re-  
9 scission rates by policy; and

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

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

18 “(e) STANDARDS ON COMPENSATION FOR SALE OF  
19 POLICIES.—

20 “(1) IN GENERAL.—Until the Secretary, in con-  
21 sultation with the NAIC, promulgates mandatory  
22 standards concerning compensation for the sale of  
23 long-term care policies, a carrier that issues one or  
24 more long-term care policies may provide a commis-  
25 sion or other compensation to an agent or other rep-

1       representative for the sale of such a policy only if the  
2       first year commission or other first year compensa-  
3       tion to be paid does not exceed the greater of—

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

7               “(B) 50 percent of the premium paid on  
8               the first year policy.

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

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

21             “(4) COMPENSATION DEFINED.—As used in  
22             this subsection, the term ‘compensation’ includes pe-  
23             cuniary or nonpecuniary remuneration of any kind  
24             relating to the sale or renewal of the policy, includ-



1           “(3) BASIS FOR CONVERSION.—For purposes of  
2 paragraph (1), a policy provides a basis for conver-  
3 sion of coverage if the policy entitles each individ-  
4 ual—

5                   “(A) whose coverage under the group pol-  
6 icy would otherwise be terminated for any rea-  
7 son; and

8                   “(B) who has been continuously insured  
9 under the policy (or group policy which was re-  
10 placed) for at least 6 months before the date of  
11 the termination;

12 to issuance of a policy providing benefits not less  
13 than, substantially equivalent to, or in excess of,  
14 those of the policy being terminated, without evi-  
15 dence of insurability.

16           “(4) TREATMENT OF SUBSTANTIAL EQUIVA-  
17 LENCE.—In determining under this subsection  
18 whether benefits are substantially equivalent, consid-  
19 eration should be given to the difference between  
20 managed care and non-managed care plans.

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

1 date of termination. Coverage under the new group  
2 policy shall not result in any exclusion for preexist-  
3 ing conditions that would have been covered under  
4 the group policy being replaced.

5 “(c) STANDARDS FOR ISSUANCE.—

6 “(1) IN GENERAL.—

7 “(A) GUARANTEE.—A carrier that sells or  
8 issues long-term care policies shall guarantee  
9 that such policies shall be sold or issued to an  
10 individual, or eligible individual in the case of a  
11 group plan, if such individual meets the mini-  
12 mum medical underwriting requirements of  
13 such policy.

14 “(B) PREMIUM FOR CONVERTED POL-  
15 ICY.—If the group policy from which conversion  
16 is made replaced previous group coverage, the  
17 premium for the converted policy shall be cal-  
18 culated on the basis of the insured’s age at in-  
19 ception of coverage under the group policy.

20 “(2) UPGRADE FOR CURRENT POLICIES.—The  
21 reform standards shall specify standards, including  
22 those providing guidance on medical underwriting  
23 and age rating, with respect to the access of individ-  
24 uals to policies offering upgraded benefits.

1           “(3) RATE STABILIZATION.—The reform stand-  
2           ards shall specify standards for premium rate sta-  
3           bilization.

4           “(d) EFFECT OF INCAPACITATION.—

5           “(1) IN GENERAL.—

6           “(A) PROHIBITION.—Except as provided  
7           in paragraph (2), a long-term care policy in ef-  
8           fect as of the effective date of the reform stand-  
9           ards may not be canceled for nonpayment if the  
10          policy holder is determined by a long-term care  
11          provider, physician or other health care provider  
12          (independent of the issuer of the policy), to be  
13          cognitively or mentally incapacitated so as to  
14          not make payments in a timely manner.

15          “(B) REINSTATEMENT.—A long-term care  
16          policy shall include a provision that provides for  
17          the reinstatement of such coverage, in the event  
18          of lapse, if the carrier is provided with proof of  
19          cognitive or mental incapacitation. Such rein-  
20          statement option shall remain available for a  
21          period of not less than 5 months after termi-  
22          nation and shall allow for the collection of past  
23          due premium.

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

4                   “(A) the period of such nonpayment is in  
5 excess of 30 days; and

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

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

14 **“SEC. 21154. BENEFIT STANDARDS.**

15       “(a) USE OF STANDARD DEFINITIONS AND TERMI-  
16 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-  
17 FITS.—Pursuant to the reform standards, each long-term  
18 care policy shall, with respect to services, providers or fa-  
19 cilities—

20                   “(1) use uniform language and definitions, ex-  
21 cept that such language and definitions may take  
22 into account the differences between States with re-  
23 spect to definitions and terminology used for long-  
24 term care services and providers; and

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

3           “(b) DISCLOSURE.—

4           “(1) OUTLINE OF COVERAGE.—

5           “(A) REQUIREMENT.—Each carrier that  
6 sells or offers for sale a long-term care policy  
7 shall provide in a uniform format an outline of  
8 coverage to each individual policyholder under  
9 such policy that meets the reform standards  
10 and complies with the requirements of subpara-  
11 graph (B).

12           “(B) CONTENTS.—The outline of coverage  
13 for each long-term care policy shall substan-  
14 tially and accurately reflect the contents of the  
15 policy or the master policy and shall include at  
16 least the following:

17           “(i) A description of the benefits and  
18 coverage under the policy.

19           “(ii) A statement of the exclusions, re-  
20 ductions, and limitations contained in the  
21 policy.

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

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

3 “(iv) Consumer protection informa-  
4 tion, including the manner in which to file  
5 a claim and to register complaints.

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

13 “(vi) A description of the terms, speci-  
14 fied in section 21156, under which a policy  
15 or certificate may be returned and pre-  
16 mium refunded.

17 “(vii) Information on—

18 “(I) national average costs for  
19 nursing facility and home health care  
20 and information (in graph form) on  
21 the relationship of the value of the  
22 benefits provided under the policy to  
23 such national average costs and State  
24 average costs; and

1                   “(II) other public and private  
2                   long-term care products and long-term  
3                   care programs made available by the  
4                   Federal Government or by a State  
5                   government.

6                   “(viii) A statement of the percentage  
7                   limit on annual premium increases that is  
8                   provided under the policy pursuant to this  
9                   section.

10                  “(2) CERTIFICATES.—A certificate issued pur-  
11                  suant to a group long-term care policy shall in-  
12                  clude—

13                         “(A) a description of the principal benefits  
14                         and coverage provided in the policy;

15                         “(B) a statement of the principal exclu-  
16                         sions, reductions, and limitations contained in  
17                         the policy; and

18                         “(C) a statement that the group master  
19                         policy determines governing contractual provi-  
20                         sions.

21                  “(3) LONG-TERM CARE AS PART OF LIFE IN-  
22                  SURANCE.—In the case of a long-term care policy is-  
23                  sued as a part of, or a rider on, a life insurance pol-  
24                  icy, at the time of policy delivery there shall be pro-  
25                  vided a policy summary that includes—

1           “(A) an explanation of how the long-term  
2 care benefits interact with other components of  
3 the policy (including deductions from death  
4 benefits);

5           “(B) an illustration of the amount of bene-  
6 fits, the length of benefits, and the guaranteed  
7 lifetime benefits (if any) for each covered per-  
8 son; and

9           “(C) any exclusions, reductions, and limi-  
10 tations on benefits of long-term care.

11       “(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM  
12 BENEFITS.—

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

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

17           “(B) for any benefit on the medical neces-  
18 sity for such benefit;

19           “(C) for benefits furnished by licensed or  
20 certified providers in compliance with conditions  
21 which are in addition to those required for li-  
22 censure or certification under State law, or if  
23 no State licensure or certification laws exists, to  
24 those developed by the Secretary, in consulta-  
25 tion with the NAIC; or

1           “(D) for residential care (if covered under  
2 the policy) only—

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

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

9           “(2) HOME HEALTH CARE OR COMMUNITY-  
10 BASED SERVICES.—If a long-term care policy pro-  
11 vides benefits for the payment of specified home  
12 health care or community-based services, the pol-  
13 icy—

14           “(A) may not limit such benefits to serv-  
15 ices provided by registered nurses or licensed  
16 practical nurses;

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

21           “(C) may not limit such benefits to serv-  
22 ices provided by agencies or providers certified  
23 under title XVIII of the Social Security Act;  
24 and

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

4           “(3) NURSING FACILITY SERVICES.—If a long-  
5           term care policy provides benefits for the payment of  
6           specified nursing facility services, the policy shall  
7           provide such benefits with respect to all nursing fa-  
8           cilities in the State. Except as provided in the re-  
9           form standards establishing uniform language and  
10          definitions under section 21154(a)(1)), the term  
11          ‘nursing facilities’ has the meaning given such term  
12          by section 1919(a).

13          “(4) PER DIEM POLICIES.—

14                 “(A) DEFINITION.—For purposes of this  
15                 part, the term ‘per diem long-term care policy’  
16                 means a long-term care policy (or certificate  
17                 under a group long-term care policy) that pro-  
18                 vides for benefit payments on a periodic basis  
19                 due to cognitive impairment or loss of func-  
20                 tional capacity without regard to the expenses  
21                 incurred or services rendered during the period  
22                 to which the payments relate.

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

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

3           “(d) PROHIBITION OF DISCRIMINATION.—A long-  
4 term care policy may not, with respect to benefits under  
5 the policy, treat an individual with Alzheimer’s disease,  
6 with any related progressive degenerative dementia of an  
7 organic origin, with any organic or inorganic mental ill-  
8 ness, or with mental retardation or any other cognitive or  
9 mental impairment, differently from an individual having  
10 a functional impairment for which such benefits may be  
11 made available.

12           “(e) LIMITATION ON USE OF PREEXISTING CONDI-  
13 TION LIMITS.—

14           “(1) INITIAL ISSUANCE.—

15           “(A) IN GENERAL.—Subject to subpara-  
16 graph (B), a long-term care policy may not ex-  
17 clude or condition benefits based on a medical  
18 condition for which the policyholder received  
19 treatment or was otherwise diagnosed before  
20 the issuance of the policy.

21           “(B) 6-MONTH LIMIT.—A long-term care  
22 policy or certificate issued under this part may  
23 impose a limitation or exclusion of benefits re-  
24 lating to treatment of a condition based on the  
25 fact that the condition preexisted the effective

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

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

7 “(ii) the limitation or exclusion ex-  
8 tends for a period not more than 6 months  
9 after the date of coverage under the policy  
10 or certificate.

11 “(2) REPLACEMENT POLICIES.—If a long-term  
12 care policy replaces another long-term care policy,  
13 the issuer of the replacing policy shall waive any  
14 time periods applicable to preexisting conditions,  
15 waiting periods, elimination periods, and probation-  
16 ary periods in the new policy for similar benefits to  
17 the extent such time was spent under the original  
18 policy.

19 “(f) ELIGIBILITY FOR BENEFITS.—

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

22 “(A) describe the level of benefits available  
23 under the policy; and

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

1           or mental impairment required in order to re-  
2           ceive benefits under the policy.

3           “(2) FUNCTIONAL ASSESSMENT.—In order to  
4           be determined eligible for benefits under any long-  
5           term care policy, each claimant shall have a profes-  
6           sional functional assessment of the claimant’s func-  
7           tional or cognitive abilities. Such initial assessment  
8           shall be conducted by an individual or entity, meet-  
9           ing the qualifications established by the Secretary.  
10          The individual or entity conducting such assessment  
11          may not control, or be controlled by, the issuer of  
12          the policy.

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

17          “(4) APPEALS PROCESS.—

18                 “(A) IN GENERAL.—Each long-term care  
19                 policy shall provide for a timely and independ-  
20                 ent appeals process, meeting the requirements  
21                 of sections 21802 through 21815, for individ-  
22                 uals who dispute the results of the claims re-  
23                 view conducted under paragraph (3) or the pol-  
24                 icyholder’s functional assessment conducted  
25                 under paragraph (2).

1           “(B) INDEPENDENT ASSESSMENT.—An  
2 appeals process under this paragraph shall in-  
3 clude, at the request of the claimant, an inde-  
4 pendent assessment of the claimant’s functional  
5 or cognitive abilities.

6           “(C) CONDUCT.—An independent assess-  
7 ment under subparagraph (B) shall be con-  
8 ducted by an individual or entity meeting the  
9 qualifications established by the Secretary to  
10 assure the professional competence and credibil-  
11 ity of such individual or entity and any applica-  
12 ble State licensure and certification require-  
13 ments and may not be conducted—

14           “(i) by an individual who has a direct  
15 or indirect significant or controlling inter-  
16 est in, or direct affiliation or relationship  
17 with, the issuer of the policy;

18           “(ii) by an entity that provides serv-  
19 ices to the policyholder or certificate holder  
20 for which benefits are available under the  
21 long-term care policy; or

22           “(iii) by an individual or entity con-  
23 trolled by the issuer of the policy.

24           “(5) CONTROL DEFINED.—For purposes of  
25 paragraphs (2) and (4), the term ‘control’ means the

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

7 “(g) INFLATION PROTECTION.—

8 “(1) OPTION TO PURCHASE.—A carrier may  
9 not offer a long-term care policy unless the carrier  
10 also offers to the proposed policyholder, including  
11 each group policyholder, the option to purchase a  
12 long-term care policy that provides for increases in  
13 benefit levels, with benefit maximums or reasonable  
14 durations that are meaningful, to account for rea-  
15 sonably anticipated increases in the costs of long-  
16 term care services covered by the policy. A carrier  
17 may not offer to a policyholder an inflation protec-  
18 tion feature that is less favorable to the policyholder  
19 than one of the following:

20 “(A) With respect to policies that provide  
21 for automatic periodic increases in benefits, the  
22 policy provides for an annual increase in bene-  
23 fits in a manner so that such increases are  
24 computed annually at a rate of not less than 5  
25 percent.

1           “(B) With respect to policies that provide  
2           for periodic opportunities to elect an increase in  
3           benefits, the policy guarantees that the insured  
4           individual will have the right to periodically in-  
5           crease the benefit levels under the policy with-  
6           out providing evidence of insurability or health  
7           status so long as the option for the previous pe-  
8           riod was not declined. The amount of any such  
9           additional benefit may not be less than the dif-  
10          ference between—

11                   “(i) the existing policy benefit; and

12                   “(ii) such existing benefit compounded  
13                   annually at a rate of at least 5 percent for  
14                   the period beginning on the date on which  
15                   the existing benefit is purchased and ex-  
16                   tending until the year in which the offer of  
17                   increase is made.

18           “(C) With respect to service-benefit long-  
19           term care policies, the policy covers a specified  
20           percentage of the actual or reasonable charges  
21           and does not include a maximum specified in-  
22           demnity amount or limit.

23           “(2) EXCEPTION.—The requirements of para-  
24           graph (1) shall not apply to life insurance policies or  
25           riders containing accelerated long-term care benefits.

1           “(3) REQUIRED INFORMATION.—Carriers shall  
2 include the following information in or together with  
3 the outline of coverage provided under this part:

4           “(A) A comparison (shown as a graph) of  
5 the benefit levels of a policy that increases ben-  
6 efits over the policy period with a policy that  
7 does not increase benefits. Such comparison  
8 shall show benefit levels over not less than a  
9 20-year period.

10           “(B) Any expected premium increases or  
11 additional premiums required to pay for any  
12 automatic or optional benefit increases, whether  
13 the individual who purchases the policy obtains  
14 the inflation protection initially or whether such  
15 individual delays purchasing such protection  
16 until a future time.

17           “(4) CONTINUATION OF PROTECTION.—Benefit  
18 increases under a policy described in paragraph (1)  
19 shall continue without regard to an insured’s age,  
20 claim status or claim history, or the length of time  
21 the individual has been insured under the policy.

22           “(5) CONSTANT PREMIUM.—A policy described  
23 in paragraph (1) that provides for automatic benefit  
24 increases shall include an offer of a premium that  
25 the carrier expects to remain constant. Such offer

1 shall disclose in a conspicuous manner that the pre-  
2 mium may change in the future unless the premium  
3 is guaranteed to remain constant.

4 “(6) REJECTION.—Inflation protection under  
5 this subsection shall be included in a long-term care  
6 policy unless a carrier obtains a written rejection of  
7 such protection signed by the policyholder.

8 **“SEC. 21155. NONFORFEITURE.**

9 “(a) IN GENERAL.—Each long-term care policy (or  
10 certificate) shall provide that if the policy lapses after the  
11 policy has been in effect for a minimum period as specified  
12 under the reform standards, the policy will provide, with-  
13 out payment of any additional premiums, nonforfeiture  
14 benefits as determined appropriate by such standards.

15 “(b) ESTABLISHMENT OF STANDARDS.—The reform  
16 standards shall provide that the percentage or amount of  
17 benefits under subsection (a) shall increase based upon the  
18 policyholder’s equity in the policy.

19 **“SEC. 21156. LIMIT OF PERIOD OF CONTESTABILITY AND**  
20 **RIGHT TO RETURN.**

21 “(a) CONTESTABILITY.—A carrier may not cancel or  
22 renew a long-term care policy or deny a claim under the  
23 policy based on fraud or intentional misrepresentation re-  
24 lating to the issuance of the policy unless notice of such

1 fraud or misrepresentation is provided within a time pe-  
2 riod to be determined by the reform standards.

3 “(b) RIGHT TO RETURN.—Each applicant for a long-  
4 term care policy shall have the right to return the policy  
5 (or certificates) within 30 days of the date of its delivery  
6 (and to have the premium refunded) if, after examination  
7 of the policy or certificate, the applicant is not satisfied  
8 for any reason.

9 **“SEC. 21157. CIVIL MONEY PENALTY AND PRIVATE**  
10 **ACTIONS.**

11 “(a) CARRIER.—Any carrier that sells, or offers for  
12 sale, or issues a long-term care policy and that—

13 “(1) violates any sales practice under section  
14 21151;

15 “(2) fails to make a refund in accordance with  
16 section 21152(a);

17 “(3) fails to transmit a policy in accordance  
18 with section 21152(b);

19 “(4) provides a commission or compensation in  
20 violation of section 21152(e);

21 “(5) fails to provide an outline of coverage in  
22 violation of section 21154(b)(1); or

23 “(6) issues a policy without obtaining certain  
24 information in violation of section 21154(f);

1 is subject to a civil money penalty of not to exceed \$25,000  
2 for each such violation.

3 “(b) AGENTS.—Any agent that sells or offers for sale  
4 a long-term care policy and that—

5 “(1) violates any sales practice under section  
6 21151;

7 “(2) fails to make a refund in accordance with  
8 section 21152(a);

9 “(3) fails to transmit a policy in accordance  
10 with section 21152(b);

11 “(4) fails to provide an outline of coverage in  
12 violation of section 21154(b)(1); or

13 “(5) issues a policy without obtaining certain  
14 information in violation of section 21154(f);

15 is subject to a civil money penalty of not to exceed \$15,000  
16 for each such violation.

17 “(c) EFFECT ON STATE LAW.—Nothing in this sec-  
18 tion shall be construed as preempting or otherwise limiting  
19 stricter penalties that may be imposed by a State for the  
20 types of conduct described in this section.

21 “(d) PRIVATE ACTIONS.—An individual may com-  
22 mence a civil action in an appropriate State or United  
23 States district court to enforce the provisions of this title  
24 with respect to long-term care policies and may be award-  
25 ed appropriate relief and reasonable attorney’s fees.

1 **“SEC. 21158. LONG-TERM CARE POLICY DEFINED.**

2       “(a) IN GENERAL.—As used in this part, the term  
3 ‘long-term care policy’ means any insurance policy, rider,  
4 or certificate advertised, marketed, offered, or designed to  
5 provide coverage for not less than 12 consecutive months  
6 for each covered person on an expense incurred, indemnity  
7 prepaid or other basis, for one or more necessary diag-  
8 nostic, preventive, therapeutic, rehabilitative, maintenance  
9 or personal care services, provided in a setting other than  
10 an acute care unit of a hospital. Such term includes—

11               “(1) group and individual annuities and life in-  
12 surance policies, riders, or certificates that provide  
13 directly, or that supplement, long-term care insur-  
14 ance; and

15               “(2) a policy, rider, or certificates that provides  
16 for payment of benefits based on cognitive impair-  
17 ment or the loss of functional capacity.

18       “(b) ISSUANCE.—

19               “(1) IN GENERAL.—Long-term care policies  
20 may be issued by any carrier.

21               “(2) CARRIER.—As used in this part, the term  
22 ‘carrier’ means—

23                       “(A) an insurer;

24                       “(B) a fraternal benefit society;

25                       “(C) a nonprofit health, hospital, or medi-  
26 cal service corporation;

1           “(D) a prepaid health plan;

2           “(E) a health maintenance organization; or

3           “(F) any similar organization to the extent

4           such organization is otherwise authorized to

5           issue life or health insurance.

6           “(c) POLICIES EXCLUDED.—The term ‘long-term  
7 care policy’ shall not include any insurance policy, rider,  
8 or certificate that is offered primarily to provide basic  
9 medicare supplement coverage, basic hospital expense cov-  
10 erage, basic medical-surgical expense coverage, hospital  
11 confinement indemnity coverage, major medical expense  
12 coverage, disability income or related asset-protection cov-  
13 erage, accident only coverage, specified disease or specified  
14 accident coverage, or limited benefit health coverage. With  
15 respect to life insurance, such term shall not include life  
16 insurance policies, riders, or certificates—

17           “(1) that accelerate the death benefit specifi-  
18 cally for one or more of the qualifying events of ter-  
19 minal illness, medical conditions requiring extraor-  
20 dinary medical intervention, or permanent institu-  
21 tional confinement,

22           “(2) that provide the option of a lump-sum pay-  
23 ment for those benefits, or

1           “(3) with respect to which neither the benefits  
2           nor the eligibility for the benefits is conditioned  
3           upon the receipt of long-term care.

4           “(d) APPLICATIONS.—Notwithstanding any other  
5           provision of this part, this part shall apply to any product  
6           advertised, marketed, or offered as a long-term insurance  
7           policy, rider or certificate.

8           **“Subtitle C—Benefits and Cost-**  
9           **Sharing**

10          **“PART I—STANDARD BENEFITS PACKAGES**

11          **“SEC. 21201. GENERAL DESCRIPTION OF STANDARD BENE-**  
12          **FITS PACKAGES.**

13          “(a) STANDARD BENEFITS PACKAGE.—For purposes  
14          of this title, a standard benefits package is a benefits  
15          package that—

16                 “(1)(A) provides all of the items and services  
17                 under the categories of health care items and serv-  
18                 ices described in section 21202 as determined by the  
19                 Board under section 21213(b)(4); and

20                 “(B) provides for a cost-sharing schedule de-  
21                 scribed in section 21203(a)(1); and

22                 “(2) has an actuarial value that is equivalent to  
23                 the actuarial value of the benefits package provided  
24                 by the Blue Cross/Blue Shield Standard Option  
25                 under the Federal Employees Health Benefits Pro-



1           “(1) Inpatient and outpatient care, including  
2 hospital and health professional services (as defined  
3 in subsection (c)).

4           “(2) Emergency services, including appropriate  
5 transport services.

6           “(3) Clinical preventive services, including serv-  
7 ices for high risk populations, immunizations, tests,  
8 and clinician visits.

9           “(4) Mental illness and substance abuse serv-  
10 ices.

11           “(5) Family planning services and services for  
12 pregnant women.

13           “(6) Prescription drugs and biologicals.

14           “(7) Hospice care services.

15           “(8) Home health care services.

16           “(9) Outpatient laboratory, radiology, and diag-  
17 nostic services and medical equipment.

18           “(10) Outpatient rehabilitation services.

19           “(11) Vision care, dental care, and hearing aids  
20 for individuals under 22 years of age.

21           “(12) Patient care costs associated with inves-  
22 tigational treatments (excluding the direct costs of  
23 an investigational treatment) that are part of a peer-  
24 reviewed and approved research program (as defined  
25 by the Secretary) or research trials approved by the

1 Secretary, the Directors of the National Institutes of  
2 Health, the Commissioner of the Food and Drug  
3 Administration, the Secretary of Veterans Affairs,  
4 the Secretary of Defense, or a qualified nongovern-  
5 mental research entity as defined in guidelines of the  
6 National Institutes of Health, including guidelines  
7 for cancer center support grants designated by the  
8 National Cancer Institute.

9 “(b) LIMITATION.—

10 “(1) IN GENERAL.—Items and services under  
11 the categories described in subsection (a) shall be  
12 furnished to health plan enrollees only when medi-  
13 cally necessary or appropriate.

14 “(2) CLINICAL PREVENTIVE SERVICES.—For  
15 purposes of paragraph (1), any clinical preventive  
16 service furnished in accordance with a periodicity  
17 schedule established by the Board under section  
18 21213(b)(2)(B) shall be medically necessary or ap-  
19 propriate.

20 “(3) EMERGENCY SERVICES.—For purposes of  
21 paragraph (1), any emergency service furnished to  
22 an individual with an emergency medical condition  
23 (as defined in section 1867(e)(1)) shall be medically  
24 necessary or appropriate.

1       “(c) DEFINITION OF HEALTH PROFESSIONAL SERV-  
2 ICES.—For purposes of this subtitle, the term ‘health pro-  
3 fessional services’ means professional services that are  
4 lawfully provided by a physician or another health profes-  
5 sional who is legally authorized to provide such services  
6 in the State in which the services are provided.

7       “(d) DEFINITION OF MEDICALLY NECESSARY OR AP-  
8 PROPRIATE.—For purposes of this subtitle, an item or  
9 service is medically necessary or appropriate—

10           “(1) with respect to an enrollee who is 22 years  
11 of age or older, if the item or service is—

12                   “(A) for the treatment or diagnosis of a  
13 health condition;

14                   “(B) generally regarded as being safe and  
15 effective;

16                   “(C) indicated for the enrollee; and

17                   “(D) intended to maintain or improve the  
18 biological, psychological, or functional condition  
19 of the enrollee or to prevent or mitigate an ad-  
20 verse health outcome or limitation in functional  
21 capacity for the enrollee; and

22           “(2) with respect to an enrollee under 22 years  
23 of age, if the item or service—

24                   “(A) is appropriate for the age and health  
25 status of the enrollee;

1           “(B) will prevent or ameliorate the effects  
2 of a condition, illness, injury, or disorder;

3           “(C) will aid the overall physical and men-  
4 tal growth and development of the enrollee; or

5           “(D) will assist in achieving or maintaining  
6 maximum functional capacity in performing  
7 daily activities.

8 **“SEC. 21203. COST-SHARING.**

9           “(a) IN GENERAL.—

10           “(1) STANDARD BENEFITS PACKAGE.—Except  
11 as provided in paragraph (3), each standard benefits  
12 package shall include a cost-sharing schedule devel-  
13 oped by the Board for such package under section  
14 21213(c).

15           “(2) ALTERNATIVE STANDARD BENEFITS PACK-  
16 AGE.—Except as provided in paragraph (3), each al-  
17 ternative standard benefits package shall include the  
18 cost-sharing schedule developed by the Board for  
19 such package under section 21213(c).

20           “(3) INCREASES IN OUT-OF-POCKET LIMITS  
21 BASED ON HEALTH SPENDING.—In the case of any  
22 calendar year for which an increase in the out-of-  
23 pocket limits under any cost-sharing schedule devel-  
24 oped by the Board for a benefits package is required  
25 under section 801 of the Health Security Act, the

1 out-of-pocket limits under such schedule shall be as  
2 specified in the Executive Order issued pursuant to  
3 section 801(d) of such Act.

4 “(b) DEDUCTIBLES, COST-SHARING, AND OUT-OF-  
5 POCKET LIMITS ON COST-SHARING.—

6 “(1) APPLICATION ON AN ANNUAL BASIS.—The  
7 deductibles and out-of-pocket limits on cost-sharing  
8 for a year under the schedules referred to in sub-  
9 section (a) shall be applied based upon expenses in-  
10 curred for items and services furnished in the year.

11 “(2) INDIVIDUAL AND FAMILY GENERAL  
12 DEDUCTIBLES.—

13 “(A) INDIVIDUAL.—Subject to subpara-  
14 graph (B), with respect to an individual en-  
15 rolled under a health plan (regardless of the  
16 class of enrollment), any individual general de-  
17 ductible in the cost-sharing schedule offered by  
18 the plan represents the amount of countable ex-  
19 penses (as defined in subparagraph (C)) that  
20 the individual may be required to incur in a  
21 year before the plan incurs liability for expenses  
22 for such items and services furnished to the in-  
23 dividual.

24 “(B) FAMILY.—In the case of an individ-  
25 ual enrolled under a health plan under a family

1 class of enrollment (as defined in section  
2 21113(b)(2)(B)(iii)(I)), the individual general  
3 deductible under subparagraph (A) shall not  
4 apply to countable expenses incurred by the in-  
5 dividual or any member of the individual's fam-  
6 ily in a year at such time as the family has in-  
7 curred, in the aggregate, countable expenses in  
8 the amount of the family general deductible for  
9 the year.

10 “(C) COUNTABLE EXPENSE.—In this para-  
11 graph, the term ‘countable expense’ means,  
12 with respect to an individual for a year, an ex-  
13 pense for an item or service covered by the  
14 standard benefit package that is subject to the  
15 general deductible and for which, but for such  
16 deductible and any other cost-sharing under  
17 this subtitle, a health plan is liable for payment.  
18 The amount of countable expenses for an indi-  
19 vidual for a year under this paragraph shall not  
20 exceed the individual general deductible for the  
21 year.

22 “(3) COINSURANCE AND COPAYMENTS.—After  
23 a general or separate deductible that applies to an  
24 item or service covered by the standard benefit pack-  
25 age has been satisfied for a year, subject to para-

1 graph (4), coinsurance and copayments are amounts  
2 (expressed as a percentage of an amount otherwise  
3 payable or as a dollar amount, respectively) that an  
4 individual may be required to pay with respect to the  
5 item or service.

6 “(4) INDIVIDUAL AND FAMILY LIMITS ON COST-  
7 SHARING.—

8 “(A) INDIVIDUAL.—Subject to subpara-  
9 graph (B), with respect to an individual en-  
10 rolled under a health plan (regardless of the  
11 class of enrollment), the individual out-of-pock-  
12 et limit on cost-sharing in the cost-sharing  
13 schedule offered by the plan represents the  
14 amount of expenses that the individual may be  
15 required to incur under the plan in a year be-  
16 cause of a general deductible, separate  
17 deductibles, copayments, and coinsurance before  
18 the plan may no longer impose any cost-sharing  
19 with respect to items or services covered by the  
20 standard benefit package that are provided to  
21 the individual.

22 “(B) FAMILY.—In the case of an individ-  
23 ual enrolled under a health plan under a family  
24 class of enrollment (as defined in section  
25 21113(b)(2)(B)(iii)(I)), the family out-of-pocket

1 limit on cost-sharing in the cost-sharing sched-  
2 ule offered by the plan represents the amount  
3 of expenses that members of the individual's  
4 family, in the aggregate, may be required to  
5 incur under the plan in a year because of a gen-  
6 eral deductible, separate deductibles,  
7 copayments, and coinsurance before the plan  
8 may no longer impose any cost-sharing with re-  
9 spect to items or services covered by the stand-  
10 ard benefit package that are provided to any  
11 member of the individual's family.

12 **“PART II—NATIONAL HEALTH BENEFITS BOARD**

13 **“SEC. 21211. CREATION OF NATIONAL HEALTH BENEFITS**  
14 **BOARD; MEMBERSHIP.**

15 “(a) IN GENERAL.—There is hereby established in  
16 the Department of Health and Human Services a National  
17 Health Benefits Board.

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

24 “(c) CHAIR.—The President shall designate one of  
25 the members of the Board as chair.

1       “(d) TERMS.—

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

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

12              “(3) CONTINUATION IN OFFICE.—Upon the ex-  
13 piration of a term of office, a member shall continue  
14 to serve until a successor is appointed and qualified.

15       “(e) VACANCIES.—

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

22              “(2) NO IMPAIRMENT OF FUNCTION.—A va-  
23 cancy in the membership of the Board does not im-  
24 pair the authority of the remaining members to exer-  
25 cise all of the powers of the Board.

1           “(3) ACTING CHAIR.—The Board may des-  
2           ignate a member to act as chair during any period  
3           in which there is no chair designated by the Presi-  
4           dent.

5           “(f) MEETINGS; QUORUM.—

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

10           “(2) QUORUM.—Four members of the Board  
11           shall constitute a quorum thereof.

12   **“SEC. 21212. QUALIFICATIONS OF BOARD MEMBERS.**

13           “(a) CITIZENSHIP.—Each member of the Board shall  
14           be a citizen of the United States.

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

21           “(c) EXCLUSIVE EMPLOYMENT.—During the term of  
22           appointment, Board members shall serve as employees of  
23           the Federal Government and shall hold no other employ-  
24           ment.

1       “(d) PROHIBITION OF CONFLICT OF INTEREST.—  
2 During the period in which an individual is a member of  
3 the Board, such individual may not have a pecuniary inter-  
4 est in or hold an official relation to any health plan, health  
5 care provider, insurance company, pharmaceutical com-  
6 pany, medical equipment company, or other affected in-  
7 dustry. Before entering upon the duties as a member of  
8 the Board, the member shall certify under oath compliance  
9 with this requirement.

10       “(e) COMPENSATION OF BOARD MEMBERS.—Each  
11 member of the Board (other than the chair) shall receive  
12 an annual salary at the annual rate payable from time  
13 to time for level IV of the Executive Schedule. The chair  
14 of the Board, during the period of service as chair, shall  
15 receive an annual salary at the annual rate payable from  
16 time to time for level III of the Executive Schedule.

17 **“SEC. 21213. GENERAL DUTIES AND RESPONSIBILITIES.**

18       “(a) CRITERIA FOR DETERMINING MEDICAL NECES-  
19 SITY OR APPROPRIATENESS.—The Board shall define the  
20 standards to be used by a health plan in determining  
21 whether an item or service under the categories of health  
22 care items and services described in section 21202 is medi-  
23 cally necessary or appropriate for an enrollee in the plan.

24       “(b) CLARIFICATION AND REFINEMENT OF ITEMS  
25 AND SERVICES.—

1           “(1) IN GENERAL.—The Board shall promul-  
2           gate such regulations or establish such guidelines as  
3           may be necessary to clarify and refine the items and  
4           services under the categories of health care items  
5           and services described in section 21202 in accord-  
6           ance with standards of medical necessity or appro-  
7           priateness. In performing its duties under the pre-  
8           ceding sentence, the Board shall—

9                   “(A) develop interim coverage decisions in  
10                  limited circumstances;

11                  “(B) clarify and refine the items and serv-  
12                  ices in the categories of health care items and  
13                  services in a manner that prevents adverse risk  
14                  selection;

15                  “(C) not specify types of providers;

16                  “(D) not specify particular procedures or  
17                  treatments or classes of procedures or treat-  
18                  ments; and

19                  “(E) give priority to—

20                          “(i)(I) parity for mental illness and  
21                          substance abuse services with other medi-  
22                          cal services using the standards of medical  
23                          necessity or appropriateness for the en-  
24                          rollee receiving the services in order to en-  
25                          sure that arbitrary day or visit limits or

1 cost-sharing requirements applied to men-  
2 tal illness and substance abuse services  
3 that are not different from those applied to  
4 medical health services, and

5 “(II) encouraging the use of out-  
6 patient treatments in delivering mental ill-  
7 ness and substance abuse services to the  
8 greatest extent possible;

9 “(ii) the needs of children and vulner-  
10 able populations (including rural and un-  
11 derserved individuals); and

12 “(iii) improving the health of individ-  
13 uals through prevention.

14 “(2) SCHEDULES FOR ITEMS AND SERVICES.—

15 “(A) IN GENERAL.—The Board shall es-  
16 tablish and update periodicity schedules for the  
17 items and services in the categories of health  
18 care items and services described in section  
19 21202.

20 “(B) SPECIAL RULE WITH RESPECT TO  
21 CLINICAL PREVENTIVE SERVICES.—With re-  
22 spect to clinical preventive services, the  
23 Board—

24 “(i) shall specify and define specific  
25 items and services as clinical preventive

1 services for high risk populations and shall  
2 establish and update a periodicity schedule  
3 for such items and services;

4 “(ii) shall establish and update the  
5 periodicity schedules for the age-appro-  
6 priate immunizations, tests, and clinician  
7 visits;

8 “(iii) shall establish rules with respect  
9 to coverage for an immunization, test, or  
10 clinician visit that is not provided to an in-  
11 dividual during the age range for such im-  
12 munization, test, or clinician visit that is  
13 specified under clause (ii); and

14 “(iv) may otherwise modify clinical  
15 preventive services taking into account age  
16 and other risk factors.

17 “(3) INVESTIGATIONAL TREATMENTS.—The  
18 Board shall refine policies regarding coverage of pa-  
19 tient care costs associated with investigational treat-  
20 ments that are part of approved research trials.

21 “(4) ITEMS AND SERVICES PROVIDED BY  
22 STANDARD BENEFITS PACKAGE.—The regulations  
23 promulgated by the Board under this subsection  
24 shall provide that each standard benefits package  
25 shall provide for the same items and services in the

1 categories of health care items and services de-  
2 scribed in section 21202, as clarified and refined  
3 under this subsection, and provide for such items  
4 and services in the same amount, duration, or scope.

5 “(5) ITEMS AND SERVICES PROVIDED BY AL-  
6 TERNATIVE STANDARD BENEFITS PACKAGE.—The  
7 regulations promulgated by the Board under this  
8 subsection shall specify the items and services in the  
9 categories of health care items and services de-  
10 scribed in section 21202 that an alternative stand-  
11 ard benefits package must provide.

12 “(c) COST-SHARING.—The Board shall establish  
13 cost-sharing schedules to be provided by a standard bene-  
14 fits package or an alternative standard benefits package.  
15 In establishing such cost-sharing schedules, the Board  
16 shall meet the following requirements:

17 “(1) ANNUAL BASIS.—The Board shall estab-  
18 lish cost sharing schedules on an annual basis.

19 “(2) OUT-OF-POCKET LIMITS.—Each cost shar-  
20 ing schedule developed by the Board shall include  
21 out-of-pocket limits.

22 “(3) LIFETIME LIMITS.—No cost-sharing  
23 schedule established by the Board may include life-  
24 time limits.

1           “(4) STANDARD BENEFITS PACKAGE.—In es-  
2           tablishing cost sharing schedules for standard bene-  
3           fits packages, the Board shall ensure that the sched-  
4           ules permit a variety of delivery systems. A standard  
5           benefit package that provides for the cost sharing  
6           schedule established by the Board under this para-  
7           graph that has the lowest actuarial value relative to  
8           the actuarial values of all other cost sharing sched-  
9           ules established by the Board under this paragraph,  
10          shall have an actuarial value that is equivalent to  
11          the actuarial value of the benefits package provided  
12          by the Blue Cross/Blue Shield Standard Option  
13          under the Federal Employees Health Benefits Pro-  
14          gram, adjusted for an average population (as deter-  
15          mined by the Board).

16          “(5) ALTERNATIVE STANDARD BENEFITS PACK-  
17          AGE.—The Board shall establish only one cost shar-  
18          ing schedule for the alternative standard benefits  
19          package. Such cost sharing schedule shall provide  
20          for a higher deductible than any deductible under a  
21          schedule established by the Board for a standard  
22          benefits package.

23          “(6) CLINICAL PREVENTIVE SERVICES.—No  
24          cost sharing schedule established by the Board may  
25          include cost sharing for clinical preventive services.

1           “(7) COST SHARING RULES.—The cost sharing  
2 schedules developed under this subsection shall be  
3 consistent with the provisions of section 21203(b).

4           “(d) COST-SHARING ASSISTANCE.—

5           “(1) IN GENERAL.—For purposes of providing  
6 cost-sharing assistance under section 1953, the  
7 Board shall determine an appropriate reduction in  
8 the cost-sharing applicable to cost-sharing subsidy  
9 eligible individuals (as defined in section 1953(a)(2))  
10 under certified standard health plans.

11           “(2) CONSIDERATIONS.—The Board shall as-  
12 sure that reductions in cost-sharing are determined  
13 under paragraph (1) in a manner that reflects—

14           “(A) the extent to which an individual’s  
15 family income is below the poverty line (as de-  
16 fined in section 1958(5)); and

17           “(B) whether an individual may enroll in a  
18 low-cost-sharing plan.

19           “(e) LEGISLATIVE RECOMMENDATIONS.—

20           “(1) IN GENERAL.—The Board may submit  
21 recommendations to Congress for such modifications  
22 to the provisions of this subtitle as the Board deter-  
23 mines appropriate in accordance with section  
24 21217(a)(1).

1           “(2) CONSULTATIONS.—In performing its du-  
2           ties under this subsection, the Board shall consult  
3           with the President and Congress.

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

7           **“SEC. 21214. POWERS.**

8           “(a) STAFF; CONTRACT AUTHORITY.—The Board  
9           shall have authority, subject to the provisions of the civil-  
10          service laws and chapter 51 and subchapter III of chapter  
11          53 of title 5, United States Code, to appoint such officers  
12          and employees as are necessary to carry out its functions.  
13          The Board may contract with any person (including an  
14          agency of the Federal Government) for studies and analy-  
15          sis as required to execute its functions. Any employee of  
16          the Executive Branch may be detailed to the Board to as-  
17          sist the Board in carrying out its duties.

18          “(b) CONSULTATIONS WITH EXPERTS.—The Board  
19          may consult with any outside expert individuals or groups  
20          that the Board determines appropriate in performing its  
21          duties under section 21213. The Board may establish ad-  
22          visory committees.

23          “(c) ACCESS TO INFORMATION.—The Board may se-  
24          cure directly from any department or agency of the United  
25          States information necessary to enable it to carry out its

1 functions, to the extent such information is otherwise  
2 available to a department or agency of the United States.  
3 Upon request of the chair, the head of that department  
4 or agency shall furnish that information to the Board.

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

13 “(e) RULEMAKING.—The National Health Board is  
14 authorized to establish such rules as may be necessary to  
15 carry out this subtitle.

16 **“SEC. 21215. FUNDING.**

17 “(a) AUTHORIZATION OF APPROPRIATIONS.—There  
18 are authorized to be appropriated to the Board such sums  
19 as may be necessary to carry out the purposes of this part.

20 “(b) SUBMISSION OF BUDGET.—Under the proce-  
21 dures of chapter 11 of title 31, United States Code, the  
22 budget for the Board for a fiscal year shall be reviewed  
23 by the Director of the Office of Management and Budget  
24 and submitted to the Congress as part of the President’s

1 submission of the Budget of the United States for the fis-  
2 cal year.

3 **“SEC. 21216. APPLICABILITY OF FEDERAL ADVISORY COM-  
4 MITTEE ACT.**

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

7 **“SEC. 21217. CONGRESSIONAL CONSIDERATION OF BOARD  
8 RECOMMENDATIONS.**

9 “(a) IN GENERAL.—

10 “(1) TIMING FOR SUBMISSION.—The Board  
11 shall submit any recommendations to Congress  
12 under section 21213(e) by not later than March 1  
13 of any year.

14 “(2) EFFECTIVENESS.—Except as provided in  
15 subsection (c), the recommendations submitted  
16 under paragraph (1) shall take effect unless by Sep-  
17 tember 15 of the year in which such recommenda-  
18 tions are submitted Congress enacts a joint resolu-  
19 tion disapproving such recommendations in accord-  
20 ance with subsection (b).

21 “(b) CONGRESSIONAL DISAPPROVAL PROCE-  
22 DURES.—

23 “(1) CONTENTS OF RESOLUTION.—For pur-  
24 poses of subsection (a), ‘joint resolution’ means only  
25 a joint resolution introduced after the date on which

1 the recommendations of the Board are received by  
2 Congress the matter after the resolving clause of  
3 which is as follows: ‘That Congress disapproves the  
4 recommendations of the National Health Benefits  
5 Board submitted to the Congress on \_\_\_\_\_.’  
6 (the blank space being appropriately filled in).

7 “(2) REFERRAL TO COMMITTEE.—A resolution  
8 described in paragraph (1) introduced in the House  
9 of Representatives shall be referred to the Commit-  
10 tee on Ways and Means of the House of Representa-  
11 tives. A resolution described in paragraph (1) intro-  
12 duced in the Senate shall be referred to the Commit-  
13 tee on Finance of the Senate.

14 “(3) DISCHARGE OF COMMITTEE.—If the com-  
15 mittee to which is referred a resolution described in  
16 paragraph (1) has not reported such resolution (or  
17 an identical resolution) by July 1, such committee  
18 shall be deemed to be discharged from further con-  
19 sideration of such resolution and such resolution  
20 shall be placed on the appropriate calendar of the  
21 House involved.

22 “(4) FLOOR CONSIDERATION.—

23 “(A) IN GENERAL.—When the committee  
24 to which a resolution is referred has reported,  
25 or has been deemed to be discharged (under

1 paragraph (3)) from further consideration of, a  
2 resolution described in paragraph (1), it is at  
3 any time thereafter in order (even though a  
4 previous motion to the same effect has been dis-  
5 agreed to) for any Member of the respective  
6 House to move to proceed to the consideration  
7 of the resolution, and all points of order against  
8 the resolution (and against consideration of the  
9 resolution) are waived. The motion is highly  
10 privileged in the House of Representatives and  
11 is privileged in the Senate and is not debatable.  
12 The motion is not subject to amendment, or to  
13 a motion to postpone, or to a motion to proceed  
14 to the consideration of other business. A motion  
15 to reconsider the vote by which the motion is  
16 agreed to or disagreed to shall not be in order.  
17 If a motion to proceed to the consideration of  
18 the resolution is agreed to, the respective House  
19 shall immediately proceed to consideration of  
20 the joint resolution without intervening motion,  
21 order, or other business, and the resolution  
22 shall remain the unfinished business of the re-  
23 spective House until disposed of.

24 “(B) DEBATE.—Debate on the resolution,  
25 and on all debatable motions and appeals in

1 connection therewith, shall be limited to not  
2 more than 2 hours, which shall be divided  
3 equally between those favoring and those oppos-  
4 ing the resolution. A motion further to limit de-  
5 bate is in order and not debatable. An amend-  
6 ment to, or a motion to postpone, or a motion  
7 to proceed to the consideration of other busi-  
8 ness, or a motion to recommit the resolution is  
9 not in order. A motion to reconsider the vote by  
10 which the resolution is agreed to or disagreed to  
11 is not in order.

12 “(C) VOTE ON FINAL PASSAGE.—Imme-  
13 diately following the conclusion of the debate on  
14 a resolution described in paragraph (1), and a  
15 single quorum call at the conclusion of the de-  
16 bate if requested in accordance with the rules of  
17 the appropriate House, the vote on final pas-  
18 sage of the resolution shall occur.

19 “(D) RULINGS OF THE CHAIR ON PROCE-  
20 DURE.—Appeals from the decisions of the Chair  
21 relating to the application of the rules of the  
22 Senate or the House of Representatives, as the  
23 case may be, to the procedure relating to a res-  
24 olution described in paragraph (1) shall be de-  
25 cided without debate.

1           “(5) COORDINATION WITH ACTION BY OTHER  
2 HOUSE.—

3           “(A) IN GENERAL.—If, before the passage  
4 by one House of a resolution of that House de-  
5 scribed in paragraph (1), that House receives  
6 from the other House a resolution described in  
7 paragraph (1), then the following procedures  
8 shall apply:

9           “(i) The resolution of the other House  
10 shall not be referred to a committee except  
11 in the case of final passage as provided in  
12 clause (ii)(II).

13           “(ii) With respect to a resolution de-  
14 scribed in paragraph (1) of the House re-  
15 ceiving the resolution—

16           “(I) the procedure in that House  
17 shall be the same as if no resolution  
18 had been received from the other  
19 House; but

20           “(II) the vote on final passage  
21 shall be on the resolution of the other  
22 House.

23           “(B) DISPOSITION.—Upon disposition of  
24 the resolution received from the other House, it

1 shall no longer be in order to consider the reso-  
2 lution that originated in the receiving House.

3 “(6) RULES OF HOUSE OF REPRESENTATIVES  
4 AND SENATE.—This subsection is enacted by Con-  
5 gress—

6 “(A) as an exercise of the rulemaking  
7 power of the Senate and House of Representa-  
8 tives, respectively, and as such it is deemed a  
9 part of the rules of each House, respectively,  
10 but applicable only with respect to the proce-  
11 dure to be followed in that House in the case  
12 of a resolution described in paragraph (1), and  
13 it supersedes other rules only to the extent that  
14 it is inconsistent with such rules; and

15 “(B) with full recognition of the constitu-  
16 tional right of either House to change the rules  
17 (so far as relating to the procedure of that  
18 House) at any time, in the same manner, and  
19 to the same extent as in the case of any other  
20 rule of that House.

21 “(c) RECOMMENDATIONS IN 2002.—Subsection  
22 (a)(2) shall not apply to any recommendations submitted  
23 to Congress by the Board during 2002.

1 **“PART III—PROVISIONS RELATING TO ABORTION**

2 **AND RELIGIOUS BELIEFS**

3 **“SEC. 21221. REGULATION OF ABORTION BY THE STATES.**

4 “Nothing in this title shall be construed to conflict  
5 with any constitutionally permissible regulation of abor-  
6 tion by a State.

7 **“SEC. 21222. NO REQUIREMENT TO CREATE OR MAINTAIN**

8 **ABORTION CLINICS AND PROVIDERS.**

9 “Nothing in this title shall be construed to—

10 “(1) require the creation or maintenance of  
11 abortion clinics or other abortion providers within a  
12 State or any region of a State; or

13 “(2) authorize any Federal agency or State  
14 to—

15 “(A) require the creation or maintenance  
16 of abortion clinics or other abortion providers;  
17 or

18 “(B) deny certification, or any other bene-  
19 fit granted by this title, to a health plan based  
20 on the number of, or the presence or absence  
21 of, abortion clinics or other abortion providers  
22 in or affiliated with the plan.

23 **“SEC. 21223. PROVISIONS RELATING TO RELIGIOUS BELIEF**

24 **OR MORAL CONVICTION.**

25 “Nothing in this title shall be construed to—

1           “(1) prevent any individual from purchasing a  
2           standard benefits package which excludes coverage  
3           of abortion services, if the individual objects to abor-  
4           tion on the basis of a religious belief or moral con-  
5           viction;

6           “(2) prevent any employer from contributing to  
7           the purchase of a standard benefits package which  
8           excludes coverage of abortion or other services, if the  
9           employer objects to such services on the basis of a  
10          religious belief or moral conviction;

11          “(3) require any health professional or health  
12          facility to perform or assist in the performance of  
13          any health care service, if the health professional or  
14          facility objects to performing or assisting in the per-  
15          formance of such a service on the basis of a religious  
16          belief or moral conviction; and

17          “(4) require any commercial insurance com-  
18          pany, Blue Cross plan, integrated health plan, or  
19          any other organization that assumes health insur-  
20          ance risk to offer a package including abortion or  
21          other services, if the health plan sponsor objects to  
22          covering such services on the basis of a religious be-  
23          lief or moral conviction.

1    **“Subtitle D—Expanded Access to**  
2                   **Health Plans**

3           **“PART I—ACCESS THROUGH EMPLOYERS**

4    **“SEC. 21401. GENERAL EMPLOYER RESPONSIBILITIES.**

5           “(a) AVAILABILITY OF COVERAGE.—

6                 “(1) IN GENERAL.—Each employer shall meet  
7           the requirement under section 21002(c)(1)(A)(i) to  
8           make available to each employee of the employer the  
9           opportunity to enroll through the employer in any of  
10          the certified standard health plans described in such  
11          section.

12                 “(2) WAIVER OF ACCESS REQUIREMENT.—If  
13          the Governor of a participating State waives the re-  
14          quirement under section 21413(a)(2) that a pur-  
15          chasing cooperative offer at least 3 certified plans in  
16          certain rural areas of the State, any employer lo-  
17          cated in such rural area shall not be required to  
18          offer 3 certified standard health plans in such area.

19           “(b) FORWARDING OF INFORMATION.—

20                 “(1) INFORMATION REGARDING PLANS.—An  
21          employer must provide each employee of such em-  
22          ployer—

23                         “(A) with information provided by the  
24                         State under section 21013 regarding all cer-  
25                         tified standard health plans offered in the com-

1 community rating area in which the employer is lo-  
2 cated, and

3 “(B) if the employer knows that an em-  
4 ployee resides in another community rating  
5 area, information regarding how to obtain infor-  
6 mation on certified standard health plans of-  
7 fered to residents of such other community rat-  
8 ing area.

9 “(2) INFORMATION REGARDING EMPLOYEES.—  
10 An employer shall forward the name and address  
11 (and any other necessary identifying information  
12 specified by the Secretary) of each employee enroll-  
13 ing through the employer—

14 “(A) to the certified standard health plan  
15 in which such employee is enrolling, or

16 “(B) to the purchasing cooperative (if any)  
17 through which such employee is enrolling.

18 “(c) PAYROLL DEDUCTION.—

19 “(1) IN GENERAL.—If—

20 “(A) a certified standard plan, or purchas-  
21 ing cooperative on behalf of such a plan, re-  
22 quests an employer under this section to with-  
23 hold premiums with respect to any employee en-  
24 rolled in the plan, or

1           “(B) an employee requests an employer to  
2 withhold premiums to a certified standard  
3 health plan in which the employee is enrolled or  
4 enrolling,

5 the employer shall deduct and withhold such pre-  
6 miums (less any employer contribution) through  
7 payroll deduction and pay the amounts deducted and  
8 withheld to the plan or to the purchasing coopera-  
9 tive.

10           “(2) PAYROLL DEDUCTIONS.—

11           “(A) FREQUENCY.—In the case of an em-  
12 ployee who is paid wages or other compensa-  
13 tion—

14           “(i) on a monthly or more frequent  
15 basis, the employer shall deduct and with-  
16 hold, and pay, such premiums at the same  
17 time as the payment of such wages or  
18 other compensation, or

19           “(ii) less frequently than monthly, the  
20 employer shall pay such premiums on a  
21 monthly basis.

22           “(B) EMPLOYEE PROTECTIONS.—

23           “(i) WITHHOLDING CONSTITUTES  
24 SATISFACTION OF OBLIGATION.—If an em-  
25 ployee notifies the health plan sponsor that

1 the employee has requested the employer  
2 withholding of a certain amount, the with-  
3 holding of such an amount by the employer  
4 under subparagraph (A) shall constitute  
5 satisfaction of the employee's obligation to  
6 pay the standard health plan with respect  
7 to such amount.

8 “(ii) DIRECT PAYMENT ALLOWED IN  
9 CASE OF NONPAYMENT.—In the case of  
10 the nonpayment to a standard health plan  
11 of any amount withheld by an employer,  
12 the plan shall notify such employee of such  
13 nonpayment and shall allow the employee  
14 to make direct payments to the plan effec-  
15 tive with the next succeeding payment pe-  
16 riod.

17 “(3) AUTHORITY TO CHARGE ADMINISTRATIVE  
18 FEE.—Any employer providing a payroll deduction  
19 for a premium with respect to a health plan may  
20 charge a nominal administrative fee to cover the  
21 marginal costs of processing such deduction, except  
22 that this paragraph shall not apply to any plan of-  
23 fered through the employer (including any plan of-  
24 fered through a purchasing cooperative on behalf of  
25 the employer).

1       “(d) TIME PERIOD FOR EMPLOYERS.—An employer  
2 shall meet the requirements of this section with respect  
3 to any new employee within the 30-day period beginning  
4 on the date of hire.

5       **“SEC. 21402. MAINTENANCE OF EFFORT FOR COVERAGE OF**  
6                                   **CHILDREN.**

7       “Each employer making an employer contribution to-  
8 ward the coverage of the children of the employees of such  
9 employer as of July 1, 1994, shall continue such contribu-  
10 tion to the certified standard health plan offering the  
11 standard benefits package chosen by the employee.

12       **“SEC. 21403. DEVELOPMENT OF LARGE EMPLOYER PUR-**  
13                                   **CHASING GROUPS.**

14       “(a) IN GENERAL.—Nothing in this title shall be con-  
15 strued as prohibiting 2 or more experience-rated employ-  
16 ers from joining together to purchase insurance for their  
17 employees, except that each such employer shall be respon-  
18 sible for meeting the employer’s requirements under this  
19 title with respect to its employees.

20       “(b) NO USE OF PURCHASING COOPERATIVES.—An  
21 experience-rated employer shall be ineligible to purchase  
22 health insurance through a purchasing cooperative.

23       **“SEC. 21404. ENFORCEMENT.**

24       “A State program shall provide for the monitoring  
25 and enforcement of the requirements of this part. In the

1 case of any employer which fails to meet any requirement  
2 under this part with respect to any employee, the State  
3 program shall impose a civil money penalty on such em-  
4 ployer in an amount not more than 25 percent of the  
5 wages of such employee during the period of such failure.  
6 The State program shall provide that provisions similar  
7 to the provisions of section 1128A (other than subsections  
8 (a) and (b)) shall apply to civil money penalties imposed  
9 under this section in the same manner as they apply to  
10 a penalty or proceeding under section 1128A(a).

11 **“PART II—ACCESS THROUGH HEALTH**

12 **INSURANCE PURCHASING COOPERATIVES**

13 **“Subpart A—Functions of Purchasing Cooperatives**

14 **“SEC. 21411. ENROLLMENT OF COMMUNITY-RATED INDIVID-**

15 **UALS IN CERTIFIED STANDARD HEALTH**

16 **PLANS.**

17 “(a) IN GENERAL.—A purchasing cooperative shall  
18 offer, on behalf of all certified standard health plans with  
19 which an agreement was entered into under section 21413  
20 and in accordance with the enrollment procedures of such  
21 plans, enrollment in the plans only to community-rated in-  
22 dividuals residing or employed in the community rating  
23 area served by the purchasing cooperative.

24 “(b) OUTREACH.—In carrying out its responsibilities  
25 under subsection (a), a purchasing cooperative shall per-

1 form such activities, including outreach, as may be nec-  
2 essary to actively seek the enrollment of community-rated  
3 individuals, including children and pregnant women who  
4 are eligible for subsidies under part B of title XIX or indi-  
5 viduals who reside in medically underserved areas.

6 **“SEC. 21412. DUTIES OF PURCHASING COOPERATIVES.**

7 “(a) IN GENERAL.—Subject to subsection (b), each  
8 purchasing cooperative shall—

9 “(1) enroll community-rated individuals in cer-  
10 tified standard health plans in accordance with sec-  
11 tion 21411;

12 “(2) collect premiums from individuals enrolled  
13 in certified standard health plans through the pur-  
14 chasing cooperative and forward such premiums to  
15 the plans;

16 “(3) enter into agreements only with certified  
17 standard health plans under section 21413;

18 “(4) ensure that the services of the purchasing  
19 cooperative are accessible throughout the community  
20 rating area;

21 “(5) ensure such accessibility by providing in-  
22 formation in accordance with section 21414;

23 “(6) establish a process for the receipt and dis-  
24 position of complaints regarding the performance of  
25 its duties;

1           “(7) coordinate activities with other purchasing  
2 cooperatives under section 21420;

3           “(8) report to the participating State such in-  
4 formation regarding marketing, enrollment, and ad-  
5 ministrative expenses as the Secretary requires;

6           “(9) comply with such fiduciary responsibilities  
7 as the Secretary requires; and

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

10          “(b) LIMITATION ON ACTIVITIES.—A purchasing co-  
11 operative shall not—

12           “(1) approve and enforce payment rates for  
13 providers;

14           “(2) regulate premium rates for health plans;

15           “(3) certify or enforce compliance of certified  
16 standard health plans with the requirements of sub-  
17 title B;

18           “(4) assume financial risk in relation to any  
19 such plan; or

20           “(5) perform other activities identified by the  
21 participating State as being inconsistent with the  
22 performance of its duties under subsection (a).

23          “(c) PERFORMANCE OF DUTIES.—

24           “(1) IN GENERAL.—If the participating State  
25 finds that a purchasing cooperative is not carrying

1 out its duties as required under subsections (a) and  
 2 (b), the State shall notify the Board of Directors of  
 3 such finding and permit such Board an opportunity  
 4 to take such action as may be necessary for the pur-  
 5 chasing cooperative to carry out such duties.

6 “(2) CORRECTIVE ACTION.—If, after such an  
 7 opportunity, the deficiency has not been corrected,  
 8 the participating State may—

9 “(A) order the purchasing cooperative to  
 10 hold a new election for members of the Board,

11 “(B) take such other action as may be ap-  
 12 propriate in order to assure the performance of  
 13 such duties, or

14 “(C) take actions described in both sub-  
 15 paragraphs (A) and (B).

16 “(3) PERFORMANCE CRITERIA.—The participat-  
 17 ing State shall develop criteria relating to the per-  
 18 formance of duties by purchasing cooperatives.

19 **“SEC. 21413. AGREEMENTS WITH CERTIFIED STANDARD**  
 20 **HEALTH PLANS.**

21 “(a) AGREEMENTS.—

22 “(1) IN GENERAL.—Except as provided in para-  
 23 graph (2), each purchasing cooperative for a commu-  
 24 nity rating area may enter into an agreement under  
 25 this section with any certified standard health plan

1 the purchasing cooperative desires to be made avail-  
2 able through such purchasing cooperative.

3 “(2) MINIMUM REQUIREMENT.—

4 “(A) IN GENERAL.—Except as provided in  
5 subparagraph (B), each purchasing coopera-  
6 tive—

7 “(i) shall enter into an agreement  
8 under paragraph (1) with at least 3 com-  
9 munity-rated certified standard health  
10 plans which provide the standard benefit  
11 package under subtitle C, including, if  
12 available, a fee-for-service plan and a  
13 health plan with a point-of-service option,  
14 and

15 “(ii) may enter into an agreement  
16 with community-rated certified standard  
17 health plans which provide the alternative  
18 standard benefit package under subtitle C  
19 or with community-rated certified supple-  
20 mental health benefit plans.

21 “(B) WAIVER OF REQUIREMENT.—The  
22 Governor of a participating State may waive the  
23 requirement under subparagraph (A) for any  
24 purchasing cooperative in a rural area of such  
25 State which demonstrates an insufficient popu-

1           lation density to support 3 community-rated  
2           certified standard health plans.

3           “(3) TERMINATION OF AGREEMENT.—An  
4           agreement under paragraph (1) shall remain in ef-  
5           fect for a 12-month period, except that the purchas-  
6           ing cooperative may terminate an agreement under  
7           paragraph (1) if the certified standard health plan’s  
8           certification under section 21101 is terminated or  
9           for other good cause shown.

10           “(4) NO PROHIBITION ON OFFERING OF  
11           PLANS.—Nothing in this subsection shall be con-  
12           strued as prohibiting a certified standard health  
13           plan with which a purchasing cooperative has de-  
14           clined to enter into an agreement under paragraph  
15           (1) from being offered to community-rated individ-  
16           uals within a community rating area.

17           “(b) RECEIPT OF PREMIUMS ON BEHALF OF  
18           PLANS.—

19           “(1) IN GENERAL.—An agreement under this  
20           section shall provide that—

21                   “(A) payment of premiums to which sub-  
22                   paragraph (B) does not apply shall be made by  
23                   individuals directly to the purchasing coopera-  
24                   tive for the benefit of the plan, and

1           “(B) payments of premiums which an em-  
2           ployer is required to make under section  
3           21401(c) shall be made by the employer directly  
4           to the purchasing cooperative for the benefit of  
5           the plan.

6           “(2) PAYMENT OF PREMIUMS.—The purchasing  
7           cooperative may provide for reasonable penalties and  
8           grace periods for late payment.

9           “(3) CERTIFIED STANDARD HEALTH PLANS RE-  
10          TAIN RISK OF NONPAYMENT.—Nothing in this sub-  
11          section shall be construed as placing upon a pur-  
12          chasing cooperative any risk associated with the fail-  
13          ure of individuals and employers to make prompt  
14          payment of premiums (other than the portion of the  
15          premium representing the purchasing cooperative  
16          administrative fee under section 21415).

17          “(c) FORWARDING OF PREMIUMS.—

18                 “(1) IN GENERAL.—The purchasing cooperative  
19                 shall forward to a certified standard health plan the  
20                 amount of any premiums collected by such coopera-  
21                 tive on behalf of such plan.

22                 “(2) PAYMENTS.—Payments shall be made by  
23                 the purchasing cooperative under this subsection  
24                 within a period of days (specified by the Secretary

1 and not to exceed 7 days) after receipt of the pre-  
2 mium.

3 **“SEC. 21414. PROVISION OF INFORMATION.**

4 “Each purchasing cooperative for a community rat-  
5 ing area shall make available to each employer (other than  
6 an experience-rated employer) located in the community  
7 rating area and each community-rated individual residing  
8 in such area—

9 “(1) enrollment information, including informa-  
10 tion provided to the purchasing cooperative under  
11 section 21013 by the participating State in which  
12 such cooperative is located, and

13 “(2) the opportunity to enter into an agreement  
14 with the cooperative for the purchase of a certified  
15 standard health plan.

16 The provision of information described in paragraph (1)  
17 may also be made at designated public access sites, includ-  
18 ing public libraries and local government offices.

19 **“SEC. 21415. ADMINISTRATIVE FEES.**

20 “(a) IN GENERAL.—A purchasing cooperative may  
21 impose an administrative fee with respect to a community-  
22 rated individual enrolled under a certified standard health  
23 plan offered through the purchasing cooperative.

1       “(b) FEE.—The Secretary shall establish criteria for  
2 determining the administrative fees charged by coopera-  
3 tives under subsection (a).

4           **“Subpart B—Organization and Operation of**  
5                   **Purchasing Cooperatives**

6       **“SEC. 21417. ESTABLISHMENT.**

7       “(a) ESTABLISHMENT OF COOPERATIVES.—

8           “(1) IN GENERAL.—Any person meeting the re-  
9 quirements of this part may establish a purchasing  
10 cooperative.

11          “(2) STATE SPONSORSHIP.—If a not-for-profit  
12 purchasing cooperative has not been organized in a  
13 community rating area in a participating State, the  
14 State shall, on or before January 1, 1996, establish  
15 or sponsor, by legislation or otherwise, at least one  
16 not-for-profit purchasing cooperative to serve in such  
17 community rating area.

18       “(b) RULES OF CONSTRUCTION.—

19          “(1) NONEXCLUSIVE.—Nothing in this section  
20 shall be construed as requiring that there be only  
21 one purchasing cooperative serving a community rat-  
22 ing area.

23          “(2) SINGLE ORGANIZATION SERVING MUL-  
24 TIPLE COMMUNITY RATING AREAS.—

1           “(A) IN GENERAL.—Nothing in this sec-  
2           tion shall be construed as preventing a single  
3           not-for-profit corporation from being a purchas-  
4           ing cooperative for more than one community  
5           rating area.

6           “(B) REPORTING.—If a purchasing coop-  
7           erative serves more than one community rating  
8           area and such community rating areas are lo-  
9           cated in more than one State, the purchasing  
10          cooperative shall separately report to each State  
11          with respect to the residents of such State.

12          “(3) ROLE OF INSURERS.—An insurer may not  
13          form or underwrite a purchasing cooperative, but  
14          may administer such a cooperative.

15          “(4) ROLE OF GOVERNMENTAL UNITS.—Units  
16          of State or local governments may form purchasing  
17          cooperatives.

18       **“SEC. 21418. BOARD OF DIRECTORS.**

19          “(a) IN GENERAL.—A purchasing cooperative shall  
20          be governed by a Board of Directors (in this part, referred  
21          to as the ‘Board’), appointed consistent with the provi-  
22          sions of this section. All powers vested in a purchasing  
23          cooperative under this title shall be vested in the Board.

24          “(b) MEMBERSHIP.—

1           “(1) IN GENERAL.—The Board shall consist  
2 of—

3           “(A) members who represent individuals  
4 who purchase coverage through the cooperative,  
5 including employees who purchase such cov-  
6 erage; and

7           “(B) members who represent employers  
8 who purchase coverage through a cooperative.

9           “(2) EQUAL REPRESENTATION OF EMPLOYERS  
10 AND CONSUMERS.—The number of members of the  
11 Board described under subparagraph (A) of para-  
12 graph (1) shall be the same as the number of mem-  
13 bers described in subparagraph (B) of such para-  
14 graph.

15           “(c) NO CONFLICT OF INTEREST PERMITTED.—An  
16 individual may not serve as a member of the Board if the  
17 individual is one of the following (or an immediate family  
18 member of one of the following):

19           “(1) A health care provider.

20           “(2) An individual who is an employee or mem-  
21 ber of the board of directors of, has a substantial  
22 ownership interest in, or derives substantial income  
23 from, a health care provider, health plan, pharma-  
24 ceutical company, or a supplier of medical equip-  
25 ment, devices, or services.



1       “(b) REQUIREMENTS FOR STANDARDS.—The stand-  
2 ards of conduct referred to in subsection (a) shall set  
3 forth—

4           “(1) the types of investment interests, owner-  
5 ship interests, affiliations, or other employment that  
6 would be improper for an individual described in  
7 subsection (a) to hold during the time of the individ-  
8 ual’s service or employment with the purchasing co-  
9 operative; and

10          “(2) the circumstances that will constitute im-  
11 permissible conflicts of interest or self-dealing by  
12 such employees in performing their official duties  
13 and functions for a purchasing cooperative.

14       “(c) SPECIFIC PROHIBITIONS.—No individual de-  
15 scribed in subsection (a) shall, directly or indirectly—

16           “(1) operate, represent, be employed by, or be  
17 affiliated with a health plan participating in the  
18 same community rating area; and

19           “(2) use any of the information acquired  
20 through the relationship of such person or entity  
21 with the purchasing cooperative for purposes unre-  
22 lated to such person’s or entity’s duties with such  
23 cooperative.

1 **“SEC. 21420. COORDINATION AMONG PURCHASING CO-**  
2 **OPERATIVES.**

3 “The State shall establish rules for coordination  
4 among purchasing cooperatives in cases in which employ-  
5 ers are located in one community rating area and their  
6 employees who are community-rated individuals reside in  
7 a different community rating area.

8 **“PART III—ACCESS THROUGH ASSOCIATION**  
9 **PLANS**

10 **“Subpart A—Qualified Association Plans**

11 **“SEC. 21431. TREATMENT OF QUALIFIED ASSOCIATION**  
12 **PLANS.**

13 “(a) GENERAL RULE.—For purposes of this title, in  
14 the case of a qualified association plan—

15 “(1) except as otherwise provided in this sub-  
16 part, the plan shall be required to meet all applicable  
17 requirements of this title for certified standard  
18 health plans providing the standard benefit package  
19 under subtitle C which are offered by experience-  
20 rated employers,

21 “(2) if such plan is certified as meeting such  
22 requirements, such plan shall be treated as a plan  
23 established and maintained by an experienced-rated  
24 employer and individuals enrolled in such plan shall  
25 be treated as experience-rated individuals, and

1           “(3) any individual who is a member of the as-  
2           sociation not enrolling in the plan shall not be treat-  
3           ed as an experience-rated individual solely by reason  
4           of membership in such association.

5           “(b) ELECTION TO BE TREATED AS PURCHASING  
6 COOPERATIVE.—Subsection (a) shall not apply to a quali-  
7 fied association plan if—

8           “(1) the health plan sponsor makes an irrev-  
9           ocable election to be treated as a purchasing cooper-  
10          ative for purposes of this title, and

11          “(2) such sponsor meets all requirements of  
12          this title applicable to a purchasing cooperative.

13   **“SEC. 21432. MODIFICATIONS OF STANDARDS APPLICABLE**  
14                           **TO QUALIFIED ASSOCIATION PLANS.**

15          “(a) CERTIFYING AUTHORITY.—For purposes of this  
16 title, the Secretary of Labor shall be the appropriate cer-  
17 tifying authority with respect to a qualified association  
18 plan.

19          “(b) CAPITAL REQUIREMENTS.—

20           “(1) IN GENERAL.—The solvency requirements  
21 established under the regulations under paragraph  
22 (2) shall, on and after the effective date of such reg-  
23 ulations, apply in lieu of the requirements under sec-  
24 tion 21122.

25           “(2) SOLVENCY REQUIREMENTS.—

1           “(A) IN GENERAL.—The Secretary of  
2 Labor shall prescribe by regulation—

3           “(i) solvency standards for qualified  
4 association plans which will ensure that  
5 benefits under such plans will be provided  
6 in full when due, and

7           “(ii) rules for monitoring and enforc-  
8 ing compliance with such standards.

9 Such regulations may provide procedures under  
10 which the Secretary may enter into an agreement  
11 with a State to have the State enforce the Federal  
12 standards or State standards not inconsistent with  
13 the Federal standards.

14           “(B) ASSETS HELD IN TRUST.—For pur-  
15 poses of complying with regulations prescribing  
16 solvency standards pursuant to subparagraph  
17 (A), the plan sponsor of each qualified associa-  
18 tion plan shall, in accordance with such regula-  
19 tions, take such steps as are necessary to en-  
20 sure that plan assets held for the purpose of  
21 complying with such solvency standards are  
22 held in trust under the plan and are available  
23 solely for such purpose.

24           “(c) AVAILABILITY.—Except in the case of a quali-  
25 fied association plan with respect to which an election is

1 in effect under section 21431(b), a qualified association  
2 plan may only include in coverage any individual who is  
3 a member of the association establishing or maintaining  
4 the plan, an employee of such member, or a spouse or de-  
5 pendent of either.

6 “(d) LIMITATION ON GROWTH.—The number of par-  
7 ticipants enrolled in a qualified association plan for any  
8 year shall not exceed 110 percent of the number of partici-  
9 pants enrolled in the plan during the preceding year.

10 **“SEC. 21433. QUALIFIED ASSOCIATION PLAN DEFINED.**

11 “(a) IN GENERAL.—The term ‘qualified association  
12 plan’ means a health plan which—

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

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

17 “(b) EXISTING PLAN.—For purposes of this section,  
18 a health plan is an existing plan if such plan—

19 “(1) was in existence and operating at all times  
20 as a multiple employer welfare arrangement (or  
21 rural electric cooperative or rural telephone coopera-  
22 tive association plan) during the 3-year period end-  
23 ing on the date of the enactment of the Health Se-  
24 curity Act, and

1           “(2) covered at least 500 participants in the  
2           United States on June 1, 1994.

3           “(c) QUALIFIED ASSOCIATION.—For purposes of this  
4           section, the term ‘qualified association’ means any organi-  
5           zation which—

6           “(1) is organized and maintained in good faith  
7           by a trade association, an industry association, a  
8           professional association, a chamber of commerce, a  
9           religious organization, or public entity association,

10           “(2) is organized and maintained for substan-  
11           tial purposes other than to provide a health plan,

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

14           “(4) receives the active support of its members,  
15           and

16           “(5) has been in operation continuously during  
17           the 3-year period ending on the date of the enact-  
18           ment of the Health Security Act.

19           “(d) SPECIAL RULE FOR CERTAIN ARRANGE-  
20           MENTS.—

21           “(1) IN GENERAL.—If, as of June 1, 1994, a  
22           multiple employer welfare arrangement had been in  
23           existence at least 18 months and an application with  
24           the State insurance commissioner for a certificate of  
25           operation as a health plan had been approved or was

1 pending, the requirements of subsections (a)(2) and  
2 (b)(1) shall not apply to such arrangement.

3 “(2) DISQUALIFICATION OF CERTAIN ARRANGE-  
4 MENTS.—A multiple employer welfare arrangement  
5 shall not be treated as meeting the requirements of  
6 paragraph (1) if a State demonstrates that—

7 “(A) fraudulent or material misrepresenta-  
8 tions have been made by the sponsor in the ap-  
9 plication,

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

13 “(C) a financial impairment exists with re-  
14 spect to the applicant that is sufficient to dem-  
15 onstrate the applicant’s inability to continue its  
16 operations.

17 “(e) COORDINATION WITH SUBPART B.—The term  
18 ‘qualified association plan’ shall not include a plan to  
19 which subpart B applies.

20 “(f) DEFINITIONS.—For purposes of this subchapter,  
21 the terms ‘multiple employer welfare arrangement’, ‘rural  
22 electric cooperative’, and ‘rural telephone cooperative asso-  
23 ciation’ have the meanings given such terms by section  
24 3(40) of the Employee Retirement Income Security Act

1 of 1974 (as in effect before the date of the enactment of  
2 the Health Security Act).

3           **“Subpart B—Special Rule for Church and**  
4                           **Multiemployer Plans**

5           **“SEC. 21435. SPECIAL RULE FOR CHURCH AND MULTIEM-**  
6                           **PLOYER PLANS.**

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

9                   “(1) except as otherwise provided in this part,  
10 the plan shall be required to meet all applicable re-  
11 quirements of this title for certified standard health  
12 plans providing the standard benefit package under  
13 subtitle C which are offered by experience-rated em-  
14 ployers,

15                   “(2) if such plan is certified as meeting such  
16 requirements, such plan shall be treated as a plan  
17 established and maintained by an experience-rated  
18 employer and individuals enrolled in such plan shall  
19 be treated as experience-rated individuals, and

20                   “(3) any individual eligible to enroll in the plan  
21 who does not enroll in the plan shall not be treated  
22 as an experience-rated individual solely by reason of  
23 being eligible to enroll in the plan.

24           “(b) MODIFIED STANDARDS.—

1           “(1) CERTIFYING AUTHORITY.—For purposes  
2 of this title, the Secretary of Labor shall be the ap-  
3 propriate certifying authority with respect to a plan  
4 to which this section applies.

5           “(2) SOLVENCY AND AVAILABILITY.—Rules  
6 similar to the rules of subsections (b) and (c) of sec-  
7 tion 21432 shall apply to a plan to which this sec-  
8 tion applies.

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

14           “(c) PLANS TO WHICH SECTION APPLIES.—This sec-  
15 tion shall apply to a health plan which—

16           “(1) is a church plan (as defined in section  
17 414(e) of the Internal Revenue Code of 1986) which  
18 has 100 or more participants in the United States,  
19 or

20           “(2) is a multiemployer plan (as defined in sec-  
21 tion 3(37) of the Employee Retirement Income Se-  
22 curity Act of 1974) which is maintained by a health  
23 plan sponsor described in section 3(16)(B)(iii) of  
24 such Act but only if such plan (or a predecessor  
25 plan)—

1           “(A) offered health benefits as of June 1,  
2           1994, and

3           “(B) as of June 1, 1994—

4           “(i) covered at least 500 participants  
5           in the United States, or

6           “(ii) was maintained by one or more  
7           affiliates of the same labor organization, or  
8           one or more affiliates of labor organiza-  
9           tions representing employees in the same  
10          industry, covering at least 500 employees  
11          in the United States.

12   **“Subtitle E—Implementation of**  
13    **Consumer Information Pro-**  
14    **grams and Quality Research**

15   **“SEC. 21501. CONSUMER INFORMATION PROGRAMS.**

16          “(a) IN GENERAL.—To support the consumer infor-  
17          mation program established by each participating State  
18          under section 21013, the Secretary, in consultation with  
19          the National Health Plan Standards and Quality Advisory  
20          Committee (established under section 21101(c)), shall—

21               “(1) develop a set of national measures of qual-  
22               ity performance under subsection (b);

23               “(2) determine a national standard survey de-  
24               sign and sampling strategy;

1           “(3) determine a standard format for compara-  
2           tive value information;

3           “(4) determine appropriate case-mix adjust-  
4           ments for data comparisons;

5           “(5) approve interstate geographic areas with  
6           respect to which comparative value information may  
7           be prepared;

8           “(6) establish standards for the distribution of  
9           such information; and

10          “(7) provide technical assistance and training.

11          “(b) NATIONAL MEASURES OF QUALITY PERFORM-  
12          ANCE.—

13                 “(1) IN GENERAL.—The Secretary shall develop  
14                 a set of national measures of quality performance in  
15                 accordance with paragraph (2), which shall be  
16                 used—

17                         “(A) to provide comparative value informa-  
18                         tion for consumers under section 21013, and

19                         “(B) to assess the provision of health care  
20                         services and access to such services.

21                 “(2) SUBJECT OF MEASURES.—National meas-  
22                 ures of quality performance shall be developed in ac-  
23                 cordance with criteria to be determined by the Sec-  
24                 retary and shall measure information on the follow-  
25                 ing subjects:

1           “(A) Access to health care services by con-  
2           sumers.

3           “(B) Appropriateness of health care serv-  
4           ices provided to consumers.

5           “(C) Outcomes of health care services and  
6           procedures.

7           “(D) Health promotion.

8           “(E) Prevention of diseases, disorders, and  
9           other health conditions.

10          “(F) Consumer satisfaction with care.

11          “(G) Risk assessment factors.

12          “(H) Population health status.

13          “(3) MODIFICATIONS TO PERFORMANCE MEAS-  
14          URES.—The Secretary shall update the set of na-  
15          tional measures of quality performance developed  
16          under paragraph (1) as the Secretary determines ap-  
17          propriate.

18          “(c) POPULATION HEALTH STATUS.—The Secretary,  
19          in consultation with public health experts and the National  
20          Health Plan Standards and Quality Advisory Committee  
21          (established under section 21101(c)), shall develop and de-  
22          fine methods to measure population health status, includ-  
23          ing risk factor assessment. The Secretary shall use the  
24          methods developed for measuring population health status  
25          as the basis for developing consumer-focused quality im-

1 improvement goals and the health plan standards in section  
2 21124.

3 **“SEC. 21502. HEALTH SERVICES AND QUALITY IMPROVE-**  
4 **MENT RESEARCH.**

5 “(a) HEALTH SERVICES RESEARCH.—

6 “(1) IN GENERAL.—The Secretary shall direct  
7 the Agency for Health Care Policy and Research  
8 and the Health Care Financing Administration to  
9 support and conduct research on the effects of  
10 health care reform on health care delivery systems  
11 and methods for risk adjustment.

12 “(2) QUALITY RESEARCH.—The Agency for  
13 Health Care Policy and Research shall conduct and  
14 support research on medical effectiveness includ-  
15 ing—

16 “(A) outcomes research;

17 “(B) clinical practice guidelines;

18 “(C) technology assessment; and

19 “(D) dissemination and implementation  
20 techniques.

21 “(b) AUTHORIZATION OF APPROPRIATIONS.—In ad-  
22 dition to any other amounts appropriated to carry out the  
23 provisions of this section from the Biomedical and Behav-  
24 ioral Research Trust Fund under section 9553 of the In-  
25 ternal Revenue Code of 1986, there are authorized to be

1 appropriated \$150,000,000 for fiscal year 1995,  
2 \$400,000,000 for fiscal year 1996, \$500,000,000 for fis-  
3 cal year 1997, and \$600,000,000 for the fiscal years 1998  
4 through 2004.

5 **“SEC. 21503. IMPLEMENTING QUALITY IMPROVEMENT RE-**  
6 **SEARCH.**

7 “(a) IN GENERAL.—The Secretary shall award  
8 grants to States or community-based, independent, not-  
9 for-profit organizations that have submitted applications  
10 in accordance with subsection (b) to establish demonstra-  
11 tion projects that provide certified standard health plans  
12 with the technical assistance to implement the results of  
13 quality improvement research into medical practice.

14 “(b) APPLICATION.—For purposes of subsection (a),  
15 an application is in accordance with this subsection if the  
16 applicant submits the application to the Secretary at such  
17 time, in such manner, and containing such information  
18 and assurances as the Secretary may reasonably require.

19 “(c) AVAILABILITY OF TRUST FUND AMOUNTS.—  
20 There shall be available \$50,000,000 in each of the fiscal  
21 years 1996 through 2004 from the Health Security Trust  
22 Fund established under section 9551 of the Internal Reve-  
23 nue Code of 1986 to make grants under subsection (a).

1 **“SEC. 21504. ANNUAL REPORTS.**

2 “The Secretary shall provide an annual report to  
3 Congress which—

4 “(1) reviews the results of the quality improve-  
5 ment research grants under section 21503;

6 “(2) evaluates consumer information programs  
7 established by participating States;

8 “(3) tracks the evolution of national perform-  
9 ance measures and other research; and

10 “(4) evaluates State, regional, and national  
11 trends on quality of health care.

12 **“Subtitle F—Programs to Improve**  
13 **Access To Underserved Areas**

14 **“PART I—GRANTS FOR THE DEVELOPMENT AND**  
15 **OPERATION OF COMMUNITY HEALTH**  
16 **GROUPS AND FOR CAPITAL ASSISTANCE**

17 **“SEC. 21601. DESIGNATION OF RURAL AND URBAN UNDER-**  
18 **SERVED AREAS.**

19 “(a) STATE DESIGNATION.—

20 “(1) IN GENERAL.—Subject to paragraph (2), a  
21 participating State may designate areas within the  
22 State as rural or urban underserved areas in accord-  
23 ance with the criteria developed by the Secretary  
24 under subsection (c).

25 “(2) SECRETARIAL APPROVAL OF STATE DES-  
26 IGNATION.—A State designation of an area within

1 the State as a rural or urban underserved area is  
2 subject to approval by the Secretary.

3 “(b) DESIGNATION BY THE SECRETARY.—In addi-  
4 tion to rural and urban underserved areas designated by  
5 a participating State under subsection (a)(1) and ap-  
6 proved by the Secretary under subsection (a)(2), the Sec-  
7 retary may designate additional areas within participating  
8 States as rural or urban underserved areas in accordance  
9 with the criteria developed by the Secretary under sub-  
10 section (c).

11 “(c) CRITERIA.—The Secretary shall develop criteria  
12 for designating an area as a rural or underserved area.  
13 Such criteria shall take into account—

14 “(1) whether the area is—

15 “(A) an area in an urban or rural area  
16 (which need not conform to the geographic  
17 boundaries of a political subdivision and which  
18 is a rational area for the delivery of health serv-  
19 ices) which the Secretary determines has a  
20 health manpower shortage,

21 “(B) a population group which the Sec-  
22 retary determines has such a shortage, or

23 “(C) a public or nonprofit private medical  
24 facility or other public facility which the Sec-  
25 retary determines has such a shortage,

1       except that the Secretary shall not remove an area  
2       from an area determined to be an area described in  
3       subparagraph (A) until the Secretary has afforded  
4       interested persons and groups in such area an op-  
5       portunity to provide data and information in support  
6       of the designation as such an area or a population  
7       group described in subparagraph (B) or a facility  
8       described in subparagraph (C), and has made a de-  
9       termination on the basis of the data and information  
10      submitted by such persons and groups and other  
11      data and information available to the Secretary;

12           “(2) whether a significant number of individ-  
13      uals who are furnished health care services in the  
14      area are members of a population of an urban or  
15      rural area designated by the Secretary as an area  
16      with a shortage of personal health services or are a  
17      population group designated by the Secretary as  
18      having a shortage of such services;

19           “(3) the financial and geographic access to cer-  
20      tified standard health plans;

21           “(4) the availability, adequacy, and quality of  
22      health care providers and health care facilities; and

23           “(5) the health status of residents of the area.

1 **“SEC. 21602. COMMUNITY HEALTH GROUP; CERTIFIED COM-**  
2 **MUNITY HEALTH PLAN; COMMUNITY HEALTH**  
3 **NETWORK; ELIGIBLE ENTITIES; ISOLATED**  
4 **RURAL FACILITIES.**

5 “(a) **COMMUNITY HEALTH GROUP.**—For purposes of  
6 this part, the term ‘community health group’ means a cer-  
7 tified community health plan or a community health net-  
8 work.

9 “(b) **COMMUNITY HEALTH NETWORK.**—For pur-  
10 poses of this part, the term ‘community health network’  
11 means a consortium of health care providers that—

12 “(1) is a public or non-profit private entity;

13 “(2) furnishes at least a portion of the services  
14 included in the standard benefit package either di-  
15 rectly or indirectly through affiliations with other  
16 entities;

17 “(3) has an agreement with one or more cer-  
18 tified standard health plans;

19 “(4) has a written agreement with each of the  
20 health care providers in the consortium governing  
21 the participation of the providers;

22 “(5) has as participating members of the con-  
23 sortium two or more of the categories of eligible en-  
24 tities described in subsection (d);

1           “(6) ensures that the health care services fur-  
2           nished by the consortium are available and accessible  
3           to each client with reasonable promptness; and

4           “(7) furnishes a significant volume of health  
5           care services in a rural or urban underserved area  
6           designated by the State and approved by the Sec-  
7           retary under section 21601(a), or designated by the  
8           Secretary under subsection (b) of such section.

9           “(c) CERTIFIED COMMUNITY HEALTH PLAN.—For  
10          purposes of this part, the term ‘certified community health  
11          plan’ means a health plan that—

12           “(1) is a public or nonprofit private entity;

13           “(2) furnishes a significant volume of health  
14          care services in a rural or urban underserved area  
15          designated by the State and approved by the Sec-  
16          retary under section 21601(a), or designated by the  
17          Secretary under subsection (b) of such section;

18           “(3) has two or more of the categories of eligi-  
19          ble entities described in subsection (d) furnishing  
20          health services through the health plan;

21           “(4) ensures that each individual enrolled with  
22          the plan has a primary care provider; and

23           “(5) meets all other criteria required of a cer-  
24          tified standard health plan, including the offering of  
25          a standard benefits package under subtitle C.

1       “(d) ELIGIBLE ENTITIES.—For purposes of this  
2 part, the term ‘eligible entities’ means the following cat-  
3 egories of entities:

4           “(1) Physicians, other health professionals, or  
5 health care institutions, including public hospitals,  
6 that provide a significant amount of health care  
7 services in a rural or urban underserved area des-  
8 ignated by the State and approved by the Secretary  
9 under section 21601(a) or designated by the Sec-  
10 retary under subsection (b) of such section.

11           “(2) Entities providing health services under  
12 grants under sections 329 and 330 of the Public  
13 Health Service Act.

14           “(3) Entities providing health services under  
15 grants under sections 340 and 340A of such Act.

16           “(4) Entities providing health services under  
17 grants under section 1001 or title XXVI of such  
18 Act.

19           “(5) Entities providing health services under  
20 title V of the Social Security Act.

21           “(6) Entities providing health services through  
22 rural health clinics (as defined in section  
23 1861(aa)(2)) and other federally qualified health  
24 centers (as defined in 1861(aa)(4)).

1           “(7) Entities providing health services in urban  
2           areas through programs under title V of the Indian  
3           Health Care Improvement Act, and entities provid-  
4           ing outpatient health services through programs  
5           under the Indian Self-Determination Act.

6           “(8) Programs providing personal health serv-  
7           ices and operating through State or local public  
8           health agencies.

9           “(9) Isolated rural facilities (as defined in sub-  
10          section (e)).

11          “(e) ISOLATED RURAL FACILITIES.—The term ‘iso-  
12          lated rural facility’ means a facility providing health serv-  
13          ices that is located in a county (or equivalent unit of local  
14          government) with fewer than 6 residents per square mile.

15           **“Subpart A—Grants for the Development and**  
16           **Operation of Community Health Groups**

17           **“SEC. 21611. GRANTS AND CONTRACTS FOR DEVELOPMENT**  
18           **OF PLANS AND NETWORKS.**

19           “(a) IN GENERAL.—In the case of a public or private  
20          non-profit consortium of eligible entities that submits an  
21          application in accordance with subsection (b), the Sec-  
22          retary may make grants to and enter into contracts with  
23          such consortium for the development of community health  
24          groups.

1       “(b) APPLICATION.—For purposes of subsection (a),  
2 an application is in accordance with this subsection if—

3           “(1) the applicant submits an application to the  
4 Secretary at such time and in such manner as the  
5 Secretary may reasonably require;

6           “(2) the application is accompanied by an as-  
7 sessment of need of the population or populations  
8 proposed to be served by the applicant;

9           “(3) the application is accompanied by the fol-  
10 lowing information:

11           “(A) A description of how the applicant  
12 will design the proposed community health  
13 group (including the service sites involved) for  
14 such populations based on the assessment of  
15 need.

16           “(B) A description of efforts to secure,  
17 within the proposed service area of such com-  
18 munity health group (including the service sites  
19 involved), financial and professional assistance  
20 and support for the project.

21           “(C) Evidence of significant community in-  
22 volvement in the initiation, development and on-  
23 going operation of the project;

24           “(4) the application is accompanied by the as-  
25 surances described in subsection (c); and

1           “(5) the application is accompanied by such ad-  
2           ditional assurances, agreements and other informa-  
3           tion as the Secretary may reasonably require.

4           “(c) ASSURANCES DESCRIBED.—The assurances de-  
5           scribed in this subsection are the following:

6           “(1) GUARANTEED ACCESS AND CONTINUED  
7           DELIVERY OF HEALTH CARE SERVICES IN A DES-  
8           IGNATED AREA.—An assurance that the applicant  
9           involved will furnish—

10           “(A) a significant volume of health care  
11           services within a rural or urban underserved  
12           area designated by the State and approved by  
13           the Secretary under section 21601(a) or des-  
14           ignated by the Secretary under subsection (b)  
15           of such section, and

16           “(B) health care services without regard to  
17           the financial or insurance status of an individ-  
18           ual.

19           “(2) ACCESSIBILITY OF SERVICES.—

20           “(A) SERVICES FOR CERTAIN INDIVID-  
21           UALS.—An assurance that the applicant will en-  
22           sure that the services of the applicant will be  
23           accessible directly or through formal contrac-  
24           tual arrangements with its participating provid-  
25           ers regardless of whether individuals who seek

1 care from the applicant are eligible individuals  
2 (as such term is defined in section 1958(3)).

3 “(B) USE OF THIRD-PARTY PAYORS.—An  
4 assurance that the applicant will ensure that  
5 the health care providers of the group are all  
6 approved by the Secretary as providers under  
7 title XVIII and by the appropriate State agency  
8 as providers under title XIX, and the applicant  
9 has made or will make every reasonable effort  
10 to collect appropriate reimbursement for its  
11 costs in providing health services to individuals  
12 who are enrolled in a private health insurance  
13 program or certified standard health plan, or  
14 who are entitled to insurance benefits under  
15 title XVIII, medical assistance under a State  
16 plan approved under title XIX, or to assistance  
17 for medical expenses under any other public as-  
18 sistance program.

19 “(C) SCHEDULE OF FEES.—An assurance  
20 that the applicant will—

21 “(i) prepare a schedule of fees or pay-  
22 ments for the provision of all health care  
23 services furnished by the applicant that is  
24 consistent with locally prevailing rates or  
25 charges and designed to cover its reason-

1           able costs of operation and has prepared a  
2           corresponding schedule of discounts to be  
3           applied to the payment of such fees or pay-  
4           ments (or payments of cost sharing  
5           amounts owed in the case of covered bene-  
6           fits), which discounts are applied on the  
7           basis of the patient’s ability to pay; and

8           “(ii) make every reasonable effort to  
9           secure from patients payment in accord-  
10          ance with such schedules, and to collect re-  
11          imbursement for services to persons enti-  
12          tled to public or private insurance benefits  
13          or other medical assistance on the basis of  
14          full fees without application of discounts,  
15          except that the applicant will ensure that  
16          no person is denied service based on the  
17          person’s inability to pay therefor.

18          “(D) BARRIERS WITHIN SERVICE AREA.—

19          An assurance that the applicant will ensure  
20          that the following conditions are met:

21                  “(i) In the service area of the group,  
22                  the applicant will ensure that—

23                                  “(I) the services of the applicant  
24                                  are accessible to all residents; and

1                   “(II) to the maximum extent pos-  
2                   sible, barriers to access to the services  
3                   of the applicant are eliminated, in-  
4                   cluding barriers resulting from the  
5                   area’s physical characteristics, its resi-  
6                   dential patterns, its economic, social  
7                   and cultural groupings, its available  
8                   transportation, and the ability of the  
9                   area’s residents to speak the English  
10                  language.

11                  “(ii) The applicant will periodically  
12                  conduct reviews within the service area of  
13                  the group to determine whether the condi-  
14                  tions described in clause (i) are being met.

15                  “(3) QUALITY CONTROL SYSTEM.—An assur-  
16                  ance that the applicant will maintain a community-  
17                  oriented, patient responsive, quality control system  
18                  under which the group, in accordance with regula-  
19                  tions prescribed by the Secretary—

20                         “(A) conducts an ongoing quality assur-  
21                         ance program for the health services delivered  
22                         by participating provider entities;

23                         “(B) maintains a continuous community  
24                         health status improvement process; and

1           “(C) maintains a system for development,  
2           compilation, evaluation, and reporting of infor-  
3           mation to the public regarding the costs of op-  
4           eration, service utilization patterns, availability,  
5           accessibility and acceptability of services, devel-  
6           opments in the health status of the populations  
7           served, uniform health and clinical performance  
8           measures and financial performance of the ap-  
9           plicant.

10           “(4) USE OF EXISTING RESOURCES.—An assur-  
11           ance that the applicant will, in developing the com-  
12           munity health group involved, utilize existing re-  
13           sources to the maximum extent practicable.

14           “(d) DEVELOPMENT GRANTS.—

15           “(1) PREFERENCE.—In making a grant or en-  
16           tering into a contract under subsection (a), the Sec-  
17           retary shall give a greater degree of preference to  
18           applicants—

19           “(A) according to the extent to which a  
20           greater number of categories of eligible entities  
21           described in section 21602(d) are members of  
22           the consortium, except in areas such as rural  
23           areas, where providers are severely limited in  
24           number, and

1           “(B) in which the population to be served  
2           by the consortium has a higher degree of unmet  
3           need.

4           “(2) USE OF FINANCIAL ASSISTANCE.—A con-  
5           sortium of eligible entities receiving financial assist-  
6           ance under a grant or contract pursuant to sub-  
7           section (a) may use such assistance for activities re-  
8           lating to the development of a community health  
9           group, including—

10           “(A) planning such group, including enter-  
11           ing into contracts between the recipient of the  
12           award and health care providers who are to  
13           participate in the group;

14           “(B) recruitment, compensation, training,  
15           and retention of health care professionals and  
16           administrative staff;

17           “(C) acquisition and development of infor-  
18           mation, billing, and reporting systems;

19           “(D) providing linkages between providers,  
20           including through the use of information sys-  
21           tems;

22           “(E) in the case of a consortium receiving  
23           a grant or contract pursuant to subsection (a)  
24           for the development of a certified community  
25           health plan, the establishment of reserves re-

1           required for furnishing services on a prepaid or  
2           capitated basis; and

3           “(F) such other expenditures as the Sec-  
4           retary determines to be appropriate to support  
5           other activities related to the development of  
6           community groups.

7           “(e) REPORTS AND AUDITS.—A public or private  
8           non-profit consortium of eligible entities that receives a  
9           grant or contract under subsection (a) shall—

10           “(1) provide such reports and information on  
11           activities carried out under this section in a manner  
12           and form required by the Secretary; and

13           “(2) provide an annual organizationwide audit  
14           that meets applicable standards of the Secretary.

15           “(f) AVAILABILITY OF FUNDS FROM TRUST  
16           FUND.—Except as provided in part III, the following  
17           amounts shall be available for a calendar year for making  
18           payments under subsection (a) from the Infrastructure  
19           Development Account in the Health Security Trust Fund  
20           established under section 9551 of the Internal Revenue  
21           Code of 1986:

22           “(1) In the case of calendar year 1995,  
23           \$250,000,000.

24           “(2) In the case of calendar year 1996,  
25           \$300,000,000.

1           “(3) In the case of calendar year 1997,  
2           \$300,000,000.

3           “(4) In the case of calendar year 1998,  
4           \$300,000,000.

5           “(5) In the case of calendar year 1999,  
6           \$200,000,000.

7           “(6) In the case of subsequent calendar years,  
8           the amount made available under this subsection for  
9           the previous calendar year (without regard to any  
10          reduction in such amount under part III), updated  
11          through the midpoint of the year by the estimated  
12          percentage change in the Consumer Price Index for  
13          All Urban Consumers (United States city average)  
14          during the 12-month period ending at that midpoint,  
15          with appropriate adjustments to reflect previous  
16          underestimations or overestimations under this para-  
17          graph in the projected percentage change in such  
18          Consumer Price Index.

19   **“SEC. 21612. GRANTS AND CONTRACTS FOR OPERATION OF**  
20                           **PLANS AND NETWORKS.**

21          “(a) IN GENERAL.—In the case of a community  
22          health group that submits an application in accordance  
23          with subsection (b), the Secretary may make grants to and  
24          enter into contracts with such groups for the operation  
25          of such groups.

1       “(b) APPLICATION.—For purposes of subsection (a),  
2 an application is in accordance with this subsection if—

3           “(1) the applicant submits an application to the  
4 Secretary at such time and in such manner as the  
5 Secretary may reasonably require;

6           “(2) the application is accompanied by an as-  
7 sessment of need of the population or populations  
8 served by the applicant;

9           “(3) the application provides evidence of signifi-  
10 cant community involvement in the ongoing oper-  
11 ation of the community health group;

12           “(4) the application is accompanied by the as-  
13 surances described in section 21611(c); and

14           “(5) the application is accompanied by such ad-  
15 ditional assurances, agreements, and other informa-  
16 tion as the Secretary may reasonably require.

17       “(c) OPERATION GRANTS.—

18           “(1) PREFERENCE.—In making a grant or en-  
19 tering into a contract under subsection (a), the Sec-  
20 retary shall give a greater degree of preference to  
21 applicants in accordance with subparagraphs (A)  
22 and (B) of section 21611(d)(1).

23           “(2) USE OF FINANCIAL ASSISTANCE.—A com-  
24 munity health group receiving financial assistance  
25 for the operation of the group under a grant or con-

1 tract pursuant to subsection (a) may use such as-  
2 sistance to address geographic, financial, and other  
3 barriers to access health care services including—

4 “(A) transportation, including rural and  
5 frontier emergency transportation systems;

6 “(B) patient outreach;

7 “(C) patient education;

8 “(D) translation services;

9 “(E) consumer information that would im-  
10 prove access to care; and

11 “(F) other services related to the provision  
12 of health care services.

13 “(d) REPORTS AND AUDITS.—A community health  
14 group that receives a grant or contract under subsection  
15 (a) shall—

16 “(1) provide such reports and information on  
17 activities carried out under this section in a manner  
18 and form required by the Secretary; and

19 “(2) provide an annual organization-wide audit  
20 that meets applicable standards of the Secretary.

21 “(e) AVAILABILITY OF FUNDS FROM TRUST  
22 FUND.—Except as provided in part III, the following  
23 amounts shall be available for a calendar year for making  
24 payments under subsection (a) from the Infrastructure  
25 Development Account in the Health Security Trust Fund

1 established under section 9551 of the Internal Revenue  
2 Code of 1986:

3           “(1) In the case of calendar year 1995,  
4           \$230,000,000.

5           “(2) In the case of calendar year 1996,  
6           \$380,000,000.

7           “(3) In the case of calendar year 1997,  
8           \$380,000,000.

9           “(4) In the case of calendar year 1998,  
10          \$400,000,000.

11          “(5) In the case of calendar year 1999,  
12          \$400,000,000.

13          “(6) In the case of subsequent calendar years,  
14          the amount made available under this subsection for  
15          the previous calendar year (without regard to any  
16          reduction in such amount under part III), updated  
17          through the midpoint of the year by the estimated  
18          percentage change in the Consumer Price Index for  
19          All Urban Consumers (United States city average)  
20          during the 12-month period ending at that midpoint,  
21          with appropriate adjustments to reflect previous  
22          underestimations or overestimations under this para-  
23          graph in the projected percentage change in such  
24          Consumer Price Index.

1                   **“Subpart B—Capital Assistance**

2   **“SEC. 21613. LOANS, LOAN GUARANTEES, AND GRANTS FOR**  
3                   **CAPITAL INVESTMENT.**

4           “(a) IN GENERAL.—In the case of a community  
5 health group or isolated rural facility that submits an ap-  
6 plication in accordance with subsection (b), the Secretary  
7 may make the financial assistance described in subsection  
8 (c) available to such group or facility for the provision of  
9 capital assistance.

10          “(b) APPLICATION.—For purposes of subsection (a),  
11 an application is in accordance with this subsection if—

12                   “(1) the applicant submits an application to the  
13 Secretary at such time and in such manner as the  
14 Secretary may reasonably require;

15                   “(2) in the case of an isolated rural facility,  
16 such facility submits its application prior to January  
17 1, 1999;

18                   “(3) in the case of a project for construction,  
19 conversion, expansion or modernization of a facility,  
20 the applicant submits to the Secretary the following:

21                           “(A) A description of the site.

22                           “(B) Plans and specifications which meet  
23 requirements prescribed by the Secretary.

24                           “(C) Information reasonably demonstrat-  
25 ing that title to such site is vested in one or  
26 more of the entities filing the application (un-

1           less the agreement described in paragraph  
2           (4)(A) is made).

3           “(D) A specification of the type of finan-  
4           cial assistance being requested under subsection  
5           (a);

6           “(4) in the case of a project for construction,  
7           conversion, expansion or modernization of a facility,  
8           the application is accompanied by the following  
9           agreements:

10           “(A) Title to such site will be vested in one  
11           or more of the entities filing the application  
12           (unless the assurance described in paragraph  
13           (3)(C) has been submitted under such para-  
14           graph).

15           “(B) Adequate financial support will be  
16           available for completion of the project and for  
17           its maintenance and operation when completed.

18           “(C) The facility will be made available to  
19           all persons seeking service regardless of their  
20           ability to pay;

21           “(5) the application is accompanied by the as-  
22           surances described in paragraphs section 21611(c)  
23           to the same extent and in the same manner as such  
24           provisions apply to awards of grants and contracts  
25           under such paragraphs, except that if the applicant

1 is an isolated rural facility described in section  
2 21602(d)(9) only the assurances described in para-  
3 graph (1) and subparagraphs (A), (B), (C), and (D)  
4 (if translation services are appropriate) of paragraph  
5 (2) of section 21611(c) shall apply; and

6 “(6) the application is accompanied by such ad-  
7 ditional assurances, agreements and other informa-  
8 tion as the Secretary may reasonably require.

9 “(c) FINANCIAL ASSISTANCE DESCRIBED.—The fi-  
10 nancial assistance that the Secretary may provide under  
11 subsection (a) consists of—

12 “(1) loans;

13 “(2) guarantees on the payment of principal  
14 and interest to Federal and non-Federal lenders on  
15 behalf of community health groups and isolated  
16 rural facilities; and

17 “(3) grants for urgent capital needs (in accord-  
18 ance with criteria for determining such needs to be  
19 developed by the Secretary).

20 “(d) PRIORITIES REGARDING AVAILABILITY OF FI-  
21 NANCIAL ASSISTANCE.—

22 “(1) AMOUNTS RESERVED FOR FACILITIES IN  
23 RURAL DESIGNATED AREAS.—At least 10 percent of  
24 the dollar value of financial assistance made under  
25 subsection (a) during any given year shall be allo-

1 cated to entities described in subsection (a) that  
2 serve rural underserved areas designated by the  
3 State and approved by the Secretary under section  
4 21601(a) or designated by the Secretary under sub-  
5 section (b) of such section, to the extent the Sec-  
6 retary receives a sufficient number of qualified appli-  
7 cations made by such entities.

8 “(2) PREFERENCES.—In making financial as-  
9 sistance available under subsection (a), the Secretary  
10 shall give a greater degree of preference to appli-  
11 cants proposing to use such assistance—

12 “(A) for projects for the renovation and  
13 modernization of medical facilities necessary to  
14 prevent or eliminate safety hazards;

15 “(B) to avoid noncompliance with licensure  
16 or accreditation standards; or

17 “(C) to provide essential services.

18 “(3) LIMITATION.—The Secretary may author-  
19 ize the use of amounts under subsection (a) for the  
20 construction of new buildings only if—

21 “(A) the Secretary determines that appro-  
22 priate facilities are not available through ac-  
23 quiring, modernizing, expanding or converting  
24 existing buildings, or that construction of new  
25 buildings will cost less; and

1           “(B) the applicant demonstrates that it  
2           has secured assurances of State, local, or other  
3           non-Federal support of the project.

4           “(e) AMOUNT OF ASSISTANCE.—The principal  
5 amount of loans or loan guarantees under subsection (a)  
6 may, when added to any other assistance under this sec-  
7 tion, cover up to 100 percent of the costs involved.

8           “(f) USE OF ASSISTANCE.—

9           “(1) IN GENERAL.—An entity described in sub-  
10 section (a) shall use the financial assistance de-  
11 scribed in such subsection for—

12           “(A) the acquisition, modernization, con-  
13 version, and expansion of facilities that will en-  
14 hance the provision and accessibility of health  
15 care; and

16           “(B) except as provided in paragraph (2),  
17 for the purchase of major equipment, including  
18 hardware for information systems.

19           “(2) ISOLATED RURAL FACILITIES.—In the  
20 case of an isolated rural facility that receives finan-  
21 cial assistance to purchase major equipment for the  
22 furnishing of telemedicine services, such facility may  
23 not use such assistance to purchase high-cost  
24 telemedicine technologies that—

1           “(A) incur high cost per minute of usage  
2 charges; or

3           “(B) require consultants to be available at  
4 the same time as the patient and the referring  
5 physician.

6           “(g) TERMS AND CONDITIONS.—

7           “(1) LOANS.—Any loan made under subsection  
8 (a) shall, subject to the Federal Credit Reform Act  
9 of 1990, meet such terms and conditions (including  
10 provisions for recovery in case of default) as the Sec-  
11 retary, in consultation with the Secretary of the  
12 Treasury, determines to be necessary to carry out  
13 the purposes of such section while protecting the fi-  
14 nancial interests of the United States. Terms and  
15 conditions for such loans shall include provisions re-  
16 garding the following:

17           “(A) Security.

18           “(B) Maturity date.

19           “(C) Amount and frequency of install-  
20 ments.

21           “(D) Rate of interest, which shall be at a  
22 rate comparable to the rate of interest prevail-  
23 ing on the date the loan is made.

24 Notwithstanding the provisions of subparagraph  
25 (D), the Secretary shall have the discretion to pro-

1       vide for a rate of interest that is lesser than the rate  
2       of interest described in such subparagraph.

3           “(2) LOAN GUARANTEES.—The Secretary may  
4       not approve a loan guarantee under this section un-  
5       less the Secretary determines that the terms, condi-  
6       tions, security (if any), and schedule and amount of  
7       repayments with respect to the loan are sufficient to  
8       protect the financial interests of the United States  
9       and are otherwise reasonable. Such loan guarantees  
10      shall be subject to such further terms and conditions  
11      as the Secretary determines, in consultation with the  
12      Secretary of the Treasury, and subject to the Fed-  
13      eral Credit Reform Act of 1990, to be necessary to  
14      ensure that the purposes of this section will be  
15      achieved.

16      “(h) DEFAULTS; RIGHT OF RECOVERY.—

17           “(1) DEFAULTS.—

18           “(A) IN GENERAL.—The Secretary may  
19       take such action as may be necessary to prevent  
20       a default on loans or loan guarantees under this  
21       section including the waiver of regulatory condi-  
22       tions, deferral of loan payments, renegotiation  
23       of loans, and the expenditure of funds for tech-  
24       nical and consultative assistance, for the tem-

1           porary payment of the interest and principal on  
2           such a loan, and for other purposes.

3           “(B) FORECLOSURE.—The Secretary may  
4           take such action, consistent with State law re-  
5           specting foreclosure procedures, as the Sec-  
6           retary deems appropriate to protect the interest  
7           of the United States in the event of a default  
8           on a loan made pursuant to this section, includ-  
9           ing selling real property pledged as security for  
10          such a loan or loan guarantee and for a reason-  
11          able period of time taking possession of, hold-  
12          ing, and using real property pledged as security  
13          for such a loan or loan guarantee.

14          “(C) WAIVERS.—The Secretary may, for  
15          good cause, but with due regard to the financial  
16          interests of the United States, waive any right  
17          of recovery which the Secretary has by reason  
18          of the failure of a borrower to make payments  
19          of principal of and interest on a loan made pur-  
20          suant to this section except that if such loan is  
21          sold and guaranteed, any such waiver shall have  
22          no effect upon the Secretary’s guarantee of  
23          timely payment of principal and interest.

24          “(2) TWENTY-YEAR OBLIGATION; RIGHT OF RE-  
25          COVERY.—

1           “(A) IN GENERAL.—

2                   “(i) LOANS AND LOAN GUARAN-  
3           TEES.—With respect to a facility for which  
4           a loan, or loan guarantee is to be made  
5           pursuant to this section, the Secretary may  
6           provide the loan or loan guarantee only if  
7           the applicant involved agrees that the ap-  
8           plicant will be liable to the United States  
9           for the amount of the loan or loan guaran-  
10          tee, together with an amount representing  
11          interest, if at any time during the 20-year  
12          period beginning on the date of completion  
13          of the activities involved, the facility—

14                   “(I) ceases to be a facility uti-  
15                  lized by a community health group, or  
16                  by another public or nonprofit private  
17                  entity that provides health services in  
18                  one or more areas that are rural or  
19                  urban underserved areas designated  
20                  by the State and approved by the Sec-  
21                  retary under section 21601(a), or des-  
22                  ignated by the Secretary under sub-  
23                  section (b) of such section; or

24                   “(II) is sold or transferred to any  
25                  entity other than an entity that is—

1           “(aa) a community health  
2           group or other entity described in  
3           subclause (I); and

4           “(bb) approved by the Sec-  
5           retary as a purchaser or trans-  
6           feree regarding the facility.

7           “(ii) DIRECT GRANTS.—With respect  
8           to a facility for which substantial capital  
9           costs are to be paid from a grant made  
10          pursuant to this section, an assurance that  
11          the applicant will be liable to the United  
12          States for the amount of the award ex-  
13          pended for such costs, together with an  
14          amount representing interest, if at any  
15          time during the 20-year period beginning  
16          on the date of completion of the activities  
17          involved, the facility—

18               “(I) ceases to be a facility uti-  
19               lized by a community health group,  
20               isolated rural facility, or by another  
21               public or nonprofit private entity that  
22               provides health services in one or  
23               more rural or urban underserved  
24               areas designated by the State and ap-  
25               proved by the Secretary under section

1           21601(a) or designated by the Sec-  
2           retary under subsection (b) of such  
3           section; or

4                   “(II) is sold or transferred to any  
5           entity other than an entity that is—

6                           “(aa) a community health  
7                           group or other entity described in  
8                           clause (i); and

9                           “(bb) approved by the Sec-  
10                          retary as a purchaser or trans-  
11                          feree regarding the facility.

12                   “(B) SUBORDINATION; WAIVERS.—The  
13           Secretary may subordinate or waive the right of  
14           recovery under clause (i) or (ii) of subpara-  
15           graph (A), and any other Federal interest that  
16           may be derived by virtue of a loan, loan guaran-  
17           tee, or grant under subsection (a), if the Sec-  
18           retary determines that subordination or waiver  
19           will further the objectives of this section.

20           “(i) REPORTS AND AUDITS.—A community health  
21           group or isolated rural facility that receives a loan, loan  
22           guarantee, or grant under subsection (a) shall—

23                   “(1) provide such reports and information on  
24                   activities carried out under this section in a manner  
25                   and form required by the Secretary; and

1           “(2) provide an annual organization-wide audit  
2           that meets applicable standards of the Secretary.

3           “(j) AVAILABILITY OF FUNDS FROM TRUST FUND.—

4           Except as provided in part III, the following amounts shall  
5           be available for a calendar year for making payments  
6           under subsection (a) from the Infrastructure Development  
7           Account in the Health Security Trust Fund established  
8           under section 9551 of the Internal Revenue Code of 1986:

9           “(1) In the case of calendar year 1995,  
10          \$500,000,000.

11          “(2) In the case of calendar year 1996,  
12          \$700,000,000.

13          “(3) In the case of calendar year 1997,  
14          \$700,000,000.

15          “(4) In the case of calendar year 1998,  
16          \$700,000,000.

17          “(5) In the case of calendar year 1999,  
18          \$700,000,000.

19          “(6) In the case of subsequent calendar years,  
20          the amount made available under this subsection for  
21          the previous calendar year (without regard to any  
22          reduction in such amount under part III), updated  
23          through the midpoint of the year by the estimated  
24          percentage change in the Consumer Price Index for  
25          All Urban Consumers (United States city average)

1 during the 12-month period ending at that midpoint,  
2 with appropriate adjustments to reflect previous  
3 underestimations or overestimations under this para-  
4 graph in the projected percentage change in such  
5 Consumer Price Index.

6 “(k) ADMINISTRATION OF PROGRAMS.—This sub-  
7 part, and any other program of the Secretary that pro-  
8 vides loans or loan guarantees, shall be carried out by a  
9 centralized loan unit established within the Department  
10 of Health and Human Services.

11 **“PART II—DEMONSTRATION PROJECTS TO PRO-**  
12 **MOTE TELEMEDICINE AND OTHER USES OF**  
13 **THE TELECOMMUNICATIONS NETWORK IN**  
14 **RURAL AREAS**

15 **“SEC. 21621. DEMONSTRATION PROJECTS TO PROMOTE**  
16 **TELEMEDICINE AND OTHER USES OF THE**  
17 **NETWORK.**

18 “(a) DEFINITIONS.—For purposes of this section:

19 “(1) RURAL HEALTH CARE PROVIDER.—The  
20 term ‘rural health care provider’ means any health  
21 care provider located in a rural area (as defined in  
22 section 1886(d)(2)(D)), including a rural referral  
23 center, rural clinic, area health center, migrant  
24 health center, rural community health center, local

1 health department, and isolated rural facility (as de-  
2 fined in section 21602(e)).

3 “(2) HEALTH RESOURCE PARTNER.—The term  
4 ‘health resource partner’ means a tertiary care cen-  
5 ter that is available for consultations 24-hours a day  
6 and for follow up care.

7 “(3) NONHEALTH CARE ENTITY.—The term  
8 ‘nonhealth care entity’ means any entity that is not  
9 involved in the provision of health care, including a  
10 business, educational institution, library, and prison.

11 “(b) ESTABLISHMENT.—The Secretary shall award  
12 grants to eligible entities to establish demonstration  
13 projects under which an eligible entity establishes a rural-  
14 based consortium that enables members of the consortium  
15 to utilize the telecommunications network—

16 “(1) to strengthen the delivery of health care  
17 services in the rural area through the use of  
18 telemedicine;

19 “(2) to provide for consultations involving  
20 transmissions of detailed data about the patient that  
21 serves as a reasonable substitute for face-to-face  
22 interaction between the patient and consultant; and

23 “(3) to make outside resources or business  
24 interaction more available to the rural area.

1       “(c) ELIGIBLE ENTITY.—An entity eligible to receive  
2 a grant under this section shall include as members at  
3 least—

4               “(1) one rural health care provider and a health  
5 resource partner; and

6               “(2) one nonhealth care entity located in the  
7 same rural area as the rural health care provider de-  
8 scribed in paragraph (1) and one other nonhealth  
9 care entity.

10 The Secretary may waive the membership requirement  
11 under paragraph (2) if the members described in para-  
12 graph (1) are unable to locate a nonhealth care entity lo-  
13 cated in the same rural area to participate in the dem-  
14 onstration project.

15       “(d) PREFERENCES.—The Secretary shall give great-  
16 er preference in awarding grants under this section to—

17               “(1) applicants that are seeking to serve rural  
18 underserved areas designated by the State and ap-  
19 proved by the Secretary under section 21601(a) or  
20 designated by the Secretary under subsection (b) of  
21 such section;

22               “(2) applicants that have integrated health care  
23 resources or plan to integrate such resources within  
24 the rural area to the maximum extent practicable in  
25 order to avoid redundancy of scarce technology; and

1           “(3) applicants that have coordinated usage of  
2           the telecommunications infrastructure with other po-  
3           tential telecommunications users in the area to take  
4           advantage of economies-of-scale pricing of tele-  
5           communications services.

6           “(e) APPLICATION.—To be eligible to receive a grant  
7           under this section, an eligible entity described in sub-  
8           section (c) shall prepare and submit to the Secretary an  
9           application at such time, in such manner, and containing  
10          such information as the Secretary may require, including  
11          a description of the use to which the eligible entity would  
12          apply any amounts received under such grant, the source  
13          and amount of non-Federal funds the entity would pledge  
14          for the project, and a showing of the long-term sustain-  
15          ability of the project.

16          “(f) GRANTS.—Grants under this section shall be dis-  
17          tributed in accordance with the following requirements:

18                 “(1) GRANT LIMIT.—The Secretary may not  
19                 make a grant to an eligible entity under this section  
20                 in excess of \$500,000 for each fiscal year in which  
21                 an eligible entity conducts a project under this sec-  
22                 tion.

23                 “(2) MATCHING FUNDS.—

24                         “(A) IN GENERAL.—The Secretary may  
25                         not make a grant to an eligible entity under

1           this section unless the eligible entity agrees to  
2           provide non-Federal funds in an amount equal  
3           to not less than 20 percent of the total amount  
4           to be expended by the eligible entity in any fis-  
5           cal year for the purpose of conducting the  
6           project under this section.

7           “(B) ADJUSTMENTS.—The Secretary shall  
8           make necessary adjustments to the amount that  
9           an eligible entity may receive in a subsequent  
10          fiscal year if the eligible entity does not meet  
11          the requirements of subparagraph (A) in the  
12          preceding fiscal year.

13          “(g) USE OF GRANT AMOUNTS.—

14                 “(1) IN GENERAL.—Amounts received under a  
15                 grant awarded under this section shall be utilized for  
16                 the development and operation of telemedicine sys-  
17                 tems that serve rural areas. All such grant funds  
18                 must be used to further the provision of health serv-  
19                 ices to rural areas.

20                 “(2) RULES OF USE.—

21                         “(A) PERMISSIBLE USAGES.—Grant funds  
22                         awarded under this section—

23                                 “(i) shall primarily be used to support  
24                                 the costs of establishing and operating a

1 telemedicine system that provides specialty  
2 consultations to rural communities;

3 “(ii) may be used to demonstrate the  
4 application of telemedicine for preceptor-  
5 ship of medical students, residents, and  
6 other health professions students in rural  
7 training sites;

8 “(iii) may be used for transmission  
9 costs, salaries, maintenance of equipment,  
10 and compensation of specialists and refer-  
11 ring practitioners; and

12 “(iv) may be used to demonstrate the  
13 use of telemedicine to facilitate collabora-  
14 tion between non-physician primary care  
15 practitioners (including physician assist-  
16 ants, nurse practitioners, certified nurse-  
17 midwives, and clinical nurse specialists)  
18 and physicians.

19 “(B) PROHIBITED USE OF FUNDS.—Grant  
20 funds shall not be used by members of a rural-  
21 based consortium for any of the following:

22 “(i) Expenditures to purchase or lease  
23 equipment to the extent the expenditures  
24 would exceed more than 40 percent of the  
25 total grant funds.

1           “(ii) In the case of a member of a  
2 consortium that is an isolated rural facility  
3 (as defined in section 21602(e)), purchase  
4 of high-cost telecommunications tech-  
5 nologies for the furnishing of telemedicine  
6 services that—

7                   “(I) incur high cost per minute  
8 of usage charges; or

9                   “(II) require consultants to be  
10 available at the same time as the pa-  
11 tient and the referring physician.

12           “(iii) Purchase or installation of  
13 transmission equipment or establishment  
14 or operation of a telecommunications com-  
15 mon carrier network.

16           “(iv) Expenditures for indirect costs  
17 (as determined by the Secretary) to the ex-  
18 tent the expenditures would exceed more  
19 than 20 percent of the total grant funds.

20           “(v) Construction (except for minor  
21 renovations related to the installation of  
22 equipment), or the acquisition or building  
23 of real property.

24           “(h) REIMBURSEMENT FOR TELEMEDICINE SERV-  
25 ICES UNDER THE MEDICARE PROGRAM.—

1           “(1) IN GENERAL.—In consultation with the  
2 Office of Rural Health Policy, the Secretary shall  
3 designate 4 demonstration projects that have been  
4 awarded grants under subsection (b) as projects in  
5 which the Health Care Financing Administration  
6 shall, in accordance with paragraph (2), reimburse  
7 providers for telemedicine services furnished to—

8           “(A) individuals who are eligible for bene-  
9 fits under part A of title XVIII; and

10           “(B) individuals who are eligible for bene-  
11 fits under part A and enrolled under part B of  
12 title XVIII.

13           “(2) DEVELOPMENT OF PAYMENT METHODOLO-  
14 GY AND PAYMENT PROVIDED.—

15           “(A) IN GENERAL.—For purposes of para-  
16 graph (1), the Health Care Financing Adminis-  
17 tration shall reimburse a provider of  
18 telemedicine services from funds made available  
19 under subsection (k) in accordance with one or  
20 more methodologies to be developed by the  
21 Secretary.

22           “(B) CRITERIA FOR DEVELOPING PAY-  
23 MENT METHODOLOGIES.—In developing pay-  
24 ment methodologies under subparagraph (A),  
25 the Secretary shall—

1           “(i) limit payment to services that  
2           would otherwise be paid for under the  
3           medicare program under title XVIII if  
4           such services were not telemedicine  
5           services;

6           “(ii) have the discretion to develop  
7           conditions for payment that protect the  
8           health and safety of the individuals de-  
9           scribed in paragraph (1), including limiting  
10          payment for services that cannot be fur-  
11          nished safely as telemedicine services;

12          “(iii) have the discretion to include  
13          appropriate payments for transmission  
14          costs in the payment methodology; and

15          “(iv) limit payment for telemedicine  
16          consultation services to consultation serv-  
17          ices specified by the Secretary that would  
18          otherwise be paid for under the medicare  
19          program under title XVIII if the patient  
20          and practitioner had a face-to-face con-  
21          sultation.

22          “(i) MAINTENANCE OF EFFORT.—Any funds avail-  
23          able for the activities covered by a demonstration project  
24          conducted under this section shall supplement, and shall

1 not supplant, funds that are expended for similar purposes  
2 under any State, regional, or local program.

3 “(j) EVALUATIONS.—Each eligible entity that con-  
4 ducts a demonstration project under this section shall sub-  
5 mit to the Secretary such information and interim evalua-  
6 tions as the Secretary may require. The Secretary shall  
7 provide the Interagency Task Force on Rural  
8 Telemedicine with such evaluations and information sub-  
9 mitted under the previous sentence as the Task Force may  
10 require to carry out its duties under section 21622(b).

11 “(k) AVAILABILITY OF FUNDS FROM TRUST  
12 FUND.—Except as provided in part III, \$20,000,000 in  
13 each of the calendar years 1995 through 1997 shall be  
14 available for making payments under subsection (a) from  
15 the Infrastructure Development Account in the Health Se-  
16 curity Trust Fund established under section 9551 of the  
17 Internal Revenue Code of 1986.

18 **“SEC. 21622. FEDERAL INTERAGENCY TASK FORCE.**

19 “(a) ESTABLISHMENT.—Not later than 90 days after  
20 the date of the enactment of this section, the Secretary  
21 of Health and Human Services shall establish a Federal  
22 interagency task force to be known as the ‘Interagency  
23 Task Force on Rural Telemedicine’ (hereafter in this sec-  
24 tion referred to as the ‘Task Force’).

25 “(b) DUTIES.—

1 “(1) IN GENERAL.—The Task Force shall—

2 “(A) identify specific uses for telemedicine  
3 that have been proven to be effective to be used  
4 in the evaluation of applications for federally  
5 funded telemedicine demonstration projects, in-  
6 cluding any application submitted under this  
7 part;

8 “(B) review and coordinate evaluations of  
9 all federally funded telemedicine and tele-  
10 communications infrastructure demonstration  
11 projects, including any demonstration project  
12 established under this part;

13 “(C) establish mechanisms to facilitate a  
14 local area needs assessment and consortium de-  
15 velopment process to assist entities conducting  
16 federally funded telemedicine demonstration  
17 projects, including demonstration projects  
18 under this part; and

19 “(D) review the policy of the Health Care  
20 Financing Administration relating to reimburse-  
21 ment for telemedicine services under the dem-  
22 onstration projects established under section  
23 21622(b) and designated under subsection  
24 (g)(1) of such section.

1           “(2) PUBLICATION OF RESULTS.—Not later  
2 than 3 years after the Task Force is established,  
3 and every 3 years thereafter, the Task Force shall  
4 analyze and publish a report of its findings under  
5 subparagraphs (A) through (D) of paragraph (1)  
6 and shall make such publications available to the  
7 Congress and the general public.

8           “(c) MEMBERSHIP.—

9           “(1) IN GENERAL.—The Task Force shall con-  
10 sist of representatives of—

11                   “(A) the Department of Health and  
12 Human Services;

13                   “(B) the Rural Electrification Administra-  
14 tion;

15                   “(C) the National Telecommunications In-  
16 formation Agency;

17                   “(D) the National Institutes of Health;  
18 and

19                   “(E) other agencies and departments that  
20 have responsibility for overseeing telemedicine  
21 projects.

22           “(2) CHAIRPERSON.—A representative of the  
23 Department of Health and Human Services shall  
24 serve as the chairperson of the Task Force.



1 **“Subtitle G—Automobile Insurance**  
2 **Coordination**

3 **“SEC. 21701. DEFINITIONS.**

4 “In this subtitle:

5 “(1) INJURED INDIVIDUAL.—The term ‘injured  
6 individual’ means an individual who has a bodily in-  
7 jury or illness sustained in an automobile accident  
8 and who is entitled to receive automobile insurance  
9 medical services from a certified standard health  
10 plan.

11 “(2) AUTOMOBILE INSURANCE MEDICAL SERV-  
12 ICES.—The term ‘automobile insurance medical serv-  
13 ices’ means services and items covered by automobile  
14 insurance that are medically necessary or appro-  
15 priate for treatment of bodily injuries or illnesses  
16 sustained in automobile accidents and that are with-  
17 in the scope of the benefits to which an injured indi-  
18 vidual who is enrolled in a certified standard health  
19 plan is entitled under such health plan.

20 “(3) AUTOMOBILE INSURANCE CARRIER.—The  
21 term ‘automobile insurance carrier’ means an insur-  
22 ance company, employer, or fund that is liable for  
23 payment for automobile insurance medical services  
24 based either on a direct contractual obligation to an  
25 injured individual or an obligation on behalf of a

1 person responsible for causation of an injured indi-  
2 vidual's bodily injury or illness.

3 “(4) CERTIFIED STANDARD HEALTH PLAN.—  
4 The term ‘certified standard health plan’ has the  
5 meaning given to such term by section 21111(a)(2).

6 **“PART I—REQUIREMENTS RELATING TO**

7 **AUTOMOBILE INSURANCE MEDICAL SERVICES**

8 **“SEC. 21711. PROVISION OF AUTOMOBILE INSURANCE MED-**  
9 **ICAL SERVICES THROUGH HEALTH PLANS.**

10 “(a) IN GENERAL.—

11 “(1) HEALTH PLANS.—An individual enrolled  
12 in a certified standard health plan shall receive auto-  
13 mobile insurance medical services under the terms  
14 generally applicable to the provision (or arrangement  
15 for the provision) of such services by such health  
16 plan.

17 “(2) MEDICARE AND MEDICAID.—Paragraph  
18 (1) shall not prevent a participating State from re-  
19 quiring automobile insurance carriers to make direct  
20 payment to health care providers for automobile in-  
21 surance medical services that are covered both by (i)  
22 medicare under title XVIII or a State medicaid pro-  
23 gram under title XIX, and (ii) an automobile insur-  
24 ance contract that is required by law and provides  
25 for direct payment of medical services regardless of

1 fault. Payment for automobile insurance medical  
2 services in such circumstances shall be made to the  
3 extent of the automobile insurance carrier's liability  
4 under the applicable contract.

5 “(b) ALTERNATIVE PERMITTED.—Subsection (a)  
6 shall not prevent an individual and an automobile insur-  
7 ance carrier from agreeing that treatment for bodily injury  
8 or illness sustained in an automobile accident shall be pro-  
9 vided other than by or through the certified standard  
10 health plan in which the individual is enrolled.

11 **“SEC. 21712. PAYMENT FOR AUTOMOBILE INSURANCE MED-**  
12 **ICAL SERVICES.**

13 “(a) PAYMENT TO HEALTH PLANS.—Each auto-  
14 mobile insurance carrier that is liable for payment for  
15 automobile insurance medical services provided to an in-  
16 jured individual by a certified standard health plan shall  
17 make payment to such health plan for such services to  
18 the extent of its obligations under the applicable auto-  
19 mobile insurance contract.

20 “(b) REIMBURSEMENT FOR COST-SHARING.—Each  
21 automobile insurance carrier shall be liable for the reim-  
22 bursement or payment of any deductibles, copayments, or  
23 coinsurance paid or owed by an injured individual for  
24 automobile insurance medical services to the extent of the  
25 applicable automobile insurance contract.

1       “(c) LIMITATION OF LIABILITY.—Except as provided  
2 in subsections (a) and (b), nothing in this subtitle or any  
3 other provision of law shall require an automobile insur-  
4 ance carrier or any person insured by such a carrier to  
5 make any payment to a health plan, health care provider,  
6 or any other person for (1) automobile insurance medical  
7 services, or (2) other health care services or items used  
8 to treat an injury or illness sustained in an automobile  
9 accident that are not medically necessary or appropriate.

10       “(d) USE OF FEE SCHEDULES.—

11               “(1) IN GENERAL.—Irrespective of the type of  
12 health plan providing automobile insurance medical  
13 services, payment by automobile insurance carriers  
14 for such services shall be made to the plan exclu-  
15 sively in accordance with any fee schedule or sched-  
16 ules established by the plan or the participating  
17 State for health care services generally.

18               “(2) MEDICARE FEE SCHEDULES.—If the in-  
19 jured individual is a medicare beneficiary under title  
20 XVIII, an automobile insurance carrier may use the  
21 appropriate fee schedule for health care services es-  
22 tablished under such title.

23               “(3) ALTERNATIVE PAYMENT METHODOLO-  
24 GIES.—Fee schedules shall not be required in any  
25 case in which an automobile insurance carrier and a

1 health plan have agreed on an alternative payment  
2 arrangement.

3 “(e) REIMBURSEMENT FOR PAYMENTS MADE.—  
4 Nothing in this subtitle or any other provision of law shall  
5 impair the right of a certified standard health plan or  
6 automobile insurance carrier to seek reimbursement from  
7 any individual liable for a bodily injury or illness sustained  
8 in an automobile accident for payments made for auto-  
9 mobile insurance medical services to treat such injury or  
10 illness.

11 “(f) RIGHTS TO COVERAGE FOR ADDITIONAL TREAT-  
12 MENT.—Subject to the provisions of subsection (c), noth-  
13 ing in this subtitle shall impair any rights with respect  
14 to medically necessary or appropriate services and items  
15 to which an individual injured in an automobile accident  
16 is entitled that are not automobile insurance medical serv-  
17 ices as defined in this subtitle.

18 **“PART II—ADMINISTRATION**

19 **“SEC. 21721. PAYMENT FACILITATION.**

20 “(a) IN GENERAL.—Each participating State shall  
21 establish a system for payment of automobile insurance  
22 medical services by automobile insurance carriers to cer-  
23 tified standard health plans, including mechanisms for  
24 prompt resolution of any issues or disputes that may arise  
25 in connection with such payment. Such systems shall re-

1 quire that automobile insurance carriers have an affirma-  
 2 tive obligation to identify to such health plans the auto-  
 3 mobile insurance carrier or carriers liable for payment for  
 4 automobile insurance medical services, through the use of  
 5 computer data programs where appropriate and cost effec-  
 6 tive.

7 “(b) SANCTIONS.—Each participating State shall au-  
 8 thorize appropriate sanctions for the failure of a health  
 9 plan, automobile insurance carrier, or any other person  
 10 to comply with the requirements established pursuant to  
 11 subsection (a).

## 12 **“Subtitle H—Remedies and** 13 **Enforcement**

### 14 **“PART I—REVIEW OF BENEFIT DETERMINATIONS** 15 **FOR ENROLLED INDIVIDUALS**

#### 16 **“Subpart A—General Rules**

#### 17 **“SEC. 21801. HEALTH PLAN CLAIMS PROCEDURE.**

18 “(a) DEFINITIONS.—For purposes of this section:

19 “(1) CLAIM.—The term ‘claim’ means a claim  
 20 for payment or provision of benefits under a health  
 21 plan, a request for preauthorization of items or serv-  
 22 ices which is submitted to a health plan prior to re-  
 23 ceipt of the items or services, or the denial, reduc-  
 24 tion, or termination of any service or request for a  
 25 referral or reimbursement.

1           “(2) INDIVIDUAL CLAIMANT.—The term ‘indi-  
2           vidual claimant’ means, with respect to a claim, any  
3           individual who submits the claim to a health plan in  
4           connection with the individual’s enrollment under  
5           the plan, or on whose behalf the claim is submitted  
6           to the plan by a provider.

7           “(3) PROVIDER CLAIMANT.—The term ‘provider  
8           claimant’ means, with respect to a claim, any pro-  
9           vider who submits the claim to a health plan with  
10          respect to items or services provided to an individual  
11          enrolled under the plan.

12          “(b) GENERAL RULES GOVERNING TREATMENT OF  
13          CLAIMS.—

14                 “(1) ADEQUATE NOTICE OF DISPOSITION OF  
15          CLAIM.—

16                         “(A) IN GENERAL.—In any case in which  
17                         a claim is submitted in complete form to a  
18                         health plan, the plan shall provide to the indi-  
19                         vidual claimant and any provider claimant with  
20                         respect to the claim a written notice of the  
21                         plan’s approval or denial of the claim within 15  
22                         days after the date of the submission of the  
23                         claim. The notice to the individual claimant  
24                         shall be written in plain and easily understood  
25                         language.

1           “(B) DENIALS.—In the case of a denial of  
2           the claim, the notice shall—

3                   “(i) be provided within 5 days after  
4                   the date of the determination to deny the  
5                   claim;

6                   “(ii) set forth the specific reasons for  
7                   the denial, including an explanation of  
8                   such reasons and the facts underlying the  
9                   decision to reduce or fail to provide serv-  
10                  ices or pay the claim; and

11                  “(iii) clearly explain the right to ap-  
12                  peal the denial under paragraph (2) and  
13                  contain a description of the process for ap-  
14                  pealing such decision sufficient to allow the  
15                  claimant to initiate an appeal and submit  
16                  evidence to the decision maker in support  
17                  of the position of the claimant.

18           “(C) FAILURE TO DENY TREATED AS AP-  
19           PROVAL.—Failure by any plan to comply with  
20           the requirements of this paragraph with respect  
21           to any claim submitted to the plan shall be  
22           treated as approval by the plan of the claim.

23           “(2) PLAN’S DUTY TO REVIEW DENIALS UPON  
24           TIMELY REQUEST.—The plan shall review its denial  
25           of the claim if an individual claimant or provider

1 claimant with respect to the claim submits to the  
2 plan a written request for reconsideration of the  
3 claim after receipt of written notice from the plan of  
4 the denial. The plan shall allow any such claimant  
5 not less than 60 days, after receipt of written notice  
6 from the plan of the denial, to submit the claimant's  
7 request for reconsideration of the claim.

8 “(3) TIME LIMIT FOR REVIEW.—The plan shall  
9 complete any review required under paragraph (2),  
10 and shall provide the individual claimant and any  
11 provider claimant with respect to the claim written  
12 notice of the plan's decision on the claim after re-  
13 consideration pursuant to the review, within 30 days  
14 after the date of the receipt of the request for recon-  
15 sideration.

16 “(4) DE NOVO REVIEWS.—Any review required  
17 under paragraph (2)—

18 “(A) shall be de novo,

19 “(B) shall be conducted by an individual  
20 who did not make the initial decision denying  
21 the claim and who is authorized to approve the  
22 claim, and

23 “(C) shall include review by a qualified  
24 physician in the same speciality as the treating

1           physician if the resolution of any issues involved  
2           requires medical expertise.

3           “(c) TREATMENT OF URGENT REQUESTS TO PLANS  
4 FOR PREAUTHORIZATION.—

5           “(1) IN GENERAL.—This subsection applies in  
6           the case of any claim submitted by an individual  
7           claimant or a provider claimant consisting of a re-  
8           quest for preauthorization of items or services which  
9           is accompanied by an attestation that—

10                   “(A) failure to immediately provide the  
11                   items or services could reasonably be expected  
12                   to result in—

13                           “(i) placing the health of the individ-  
14                           ual claimant (or, with respect to an indi-  
15                           vidual claimant who is a pregnant woman,  
16                           the health of the woman or her unborn  
17                           child) in serious jeopardy,

18                           “(ii) serious impairment to bodily  
19                           functions, or

20                           “(iii) serious dysfunction of any bodily  
21                           organ or part,

22           or

23                   “(B) immediate provision of the items or  
24                   services is necessary because the individual  
25                   claimant has made or is at serious risk of mak-

1           ing an attempt to harm such individual claim-  
2           ant or another individual.

3           “(2) SHORTENED TIME LIMIT FOR CONSIDER-  
4           ATION OF REQUESTS FOR PREAUTHORIZATION.—  
5           Notwithstanding subsection (b)(1), a health plan  
6           shall approve or deny any claim described in para-  
7           graph (1) within 12 hours after submission of the  
8           claim to the plan. Failure by the plan to comply with  
9           the requirements of this paragraph with respect to  
10          the claim shall be treated as approval by the plan of  
11          the claim.

12          “(3) EXPEDITED EXHAUSTION OF PLAN REM-  
13          EDIES.—Any claim described in paragraph (1) which  
14          is denied by the plan shall be treated as a claim with  
15          respect to which all remedies under the plan pro-  
16          vided pursuant to this section are exhausted, irre-  
17          spective of any review provided under subsection  
18          (b)(2).

19          “(4) DENIAL OF PREVIOUSLY AUTHORIZED  
20          CLAIMS NOT PERMITTED.—In any case in which a  
21          health plan approves a claim described in paragraph  
22          (1)—

23                  “(A) the plan may not subsequently deny  
24                  payment or provision of benefits pursuant to  
25                  the claim, unless the plan makes a showing of

1 an intentional misrepresentation of a material  
2 fact by the individual claimant, and

3 “(B) in the case of a violation of subpara-  
4 graph (A) in connection with the claim, all rem-  
5 edies under the plan provided pursuant to this  
6 section with respect to the claim shall be treat-  
7 ed as exhausted.

8 “(d) TIME LIMIT FOR DETERMINATION OF INCOM-  
9 PLETENESS OF CLAIM.—For purposes of this section—

10 “(1) any claim submitted by an individual  
11 claimant and accepted by a provider serving under  
12 contract with a health plan and any claim described  
13 in subsection (b)(1) shall be treated with respect to  
14 the individual claimant as submitted in complete  
15 form, and

16 “(2) any other claim for benefits under the plan  
17 shall be treated as filed in complete form as of 10  
18 days after the date of the submission of the claim,  
19 unless the plan provides to the individual claimant  
20 and any provider claimant, within such period, a  
21 written notice of any required matter remaining to  
22 be filed in order to complete the claim.

23 Any filing by the individual claimant or the provider claim-  
24 ant of additional matter requested by the plan pursuant

1 to paragraph (2) shall be treated for purposes of this sec-  
2 tion as an initial filing of the claim.

3 “(e) ADDITIONAL NOTICE AND DISCLOSURE RE-  
4 QUIREMENTS FOR HEALTH PLANS.—In the case of a de-  
5 nial of a claim for benefits under a health plan, the plan  
6 shall include, together with the specific reasons provided  
7 to the individual claimant and any provider claimant  
8 under subsection (b)(1)—

9 “(1) if the denial is based in whole or in part  
10 on a determination that the claim is for an item or  
11 service which is not covered by a benefits package  
12 established under subtitle C or exceeds payment  
13 rates under the plan, the factual basis for the deter-  
14 mination,

15 “(2) if the denial is based in whole or in part  
16 on exclusion of coverage with respect to services be-  
17 cause the services are determined to comprise an ex-  
18 perimental treatment or investigatory procedure, the  
19 medical basis for the determination and a descrip-  
20 tion of the process used in making the determina-  
21 tion, and

22 “(3) if the denial is based in whole or in part  
23 on a determination that the treatment is not medi-  
24 cally necessary or appropriate or is inconsistent with  
25 the plan’s practice guidelines, the medical basis for

1 the determination, the guidelines used in making the  
2 determination, and a description of the process used  
3 in making the determination.

4 “(f) WAIVER OF RIGHTS PROHIBITED.—A health  
5 plan may not require any party to waive any right under  
6 the plan or this title as a condition for approval of any  
7 claim under the plan, except to the extent otherwise speci-  
8 fied in a formal settlement agreement.

9 **“SEC. 21802. REVIEW IN AREA COMPLAINT REVIEW OFFICES**  
10 **OF GRIEVANCES BASED ON ACTS OR PRAC-**  
11 **TICES BY HEALTH PLANS.**

12 “(a) COMPLAINT REVIEW OFFICES.—

13 “(1) IN GENERAL.—Except as provided in para-  
14 graph (2), in accordance with rules which shall be  
15 prescribed by the Secretary, each participating State  
16 shall establish and maintain a complaint review of-  
17 fice for each community rating area established by  
18 such State to serve all enrollees of health plans serv-  
19 ing such area.

20 “(2) MULTISTATE PLANS.—Under regulations  
21 of the Secretary of Labor, in consultation with the  
22 Secretary, the complaint review office for a commu-  
23 nity rating area established by such State shall also  
24 serve as the complaint review office for multistate  
25 self-insured health plans operating in the State with

1       respect to individuals who are enrolled under such  
2       plans and who reside within the community rating  
3       area.

4       “(b) FILINGS OF COMPLAINTS BY AGGRIEVED PER-  
5       SONS.—In the case of any person who is aggrieved by any  
6       act or practice engaged in by any health plan which con-  
7       sists of, or results in, denial of payment or provision of  
8       benefits under the plan or delay in the payment or provi-  
9       sion of benefits, if the denial or delay is alleged to consist  
10      of a failure to comply with the terms of the plan (including  
11      the provision of benefits in full when due in accordance  
12      with the terms of the plan), or with the applicable require-  
13      ments of this title, such person may file a complaint with  
14      the appropriate complaint review office.

15      “(c) EXHAUSTION OF PLAN REMEDIES.—Any com-  
16      plaint to which this section applies, including a claim to  
17      which section 21801 applies, may not be filed until the  
18      complainant has exhausted all remedies provided under  
19      the plan with respect to the claim.

20      “(d) FORM OF COMPLAINT.—Any complaint to which  
21      this section applies shall be in writing under oath or affir-  
22      mation, shall set forth the complaint in a manner cal-  
23      culated to give notice of the nature of the complaint, and  
24      shall contain such information as may be prescribed in  
25      regulations of the Secretary.



1           “(2) To submit the complaint as a dispute  
2           under the Early Resolution Program established  
3           under subpart B and thereby suspend further review  
4           proceedings under this section pending termination  
5           of proceedings under the Program.

6           “(3) In any case in which an election under  
7           paragraph (1) or (2) is not made, or an election  
8           under paragraph (2) was made but resolution of all  
9           matters in the complaint was not obtained upon ter-  
10          mination of proceedings pursuant to the election by  
11          settlement agreement or otherwise, to proceed, with  
12          the consent of the plan, with the complaint to a  
13          hearing in the complaint review office under section  
14          21804 regarding the unresolved matters.

15          “(b) DUTY OF COMPLAINT REVIEW OFFICE.—The  
16          complaint review office shall provide (in a linguistically  
17          and culturally appropriate manner) an explanation to com-  
18          plainants bringing complaints to the office concerning the  
19          legal and other ramifications of each option available  
20          under this section.

21          “(c) EFFECT OF PARTICIPATION IN EARLY RESOLU-  
22          TION PROGRAM.—Any matter in a complaint brought to  
23          the complaint review office which is included in a dispute  
24          which is timely submitted to the Early Resolution Pro-  
25          gram established under subpart B shall not be assigned

1 to a hearing under section 21804 unless the proceedings  
2 under the Program with respect to the dispute are termi-  
3 nated without settlement or resolution of the dispute with  
4 respect to such matter. Upon termination of any proceed-  
5 ings regarding a dispute submitted to the Program, the  
6 applicability of this section to any matter in a complaint  
7 which was included in the dispute shall not be affected  
8 by participation in the proceedings, except to the extent  
9 otherwise required under the terms of any settlement  
10 agreement or other formal resolution obtained in the pro-  
11 ceedings.

12 **“SEC. 21804. HEARINGS BEFORE HEARING OFFICERS IN**  
13 **COMPLAINT REVIEW OFFICES.**

14 “(a) HEARING PROCESS.—

15 “(1) ASSIGNMENT OF COMPLAINTS TO HEARING  
16 OFFICERS AND NOTICE TO PARTIES.—

17 “(A) IN GENERAL.—In the case of an elec-  
18 tion under section 21803(a)(3)—

19 “(i) the complaint review office shall  
20 assign the complaint, and each motion in  
21 connection with the complaint, to a hearing  
22 officer employed by the participating State  
23 in the office; and

24 “(ii) the hearing officer shall have the  
25 power to issue and cause to be served upon

1           the plan named in the complaint a copy of  
2           the complaint and a notice of hearing be-  
3           fore the hearing officer at a place fixed in  
4           the notice, not less than 5 days after the  
5           serving of the complaint.

6           “(B) QUALIFICATIONS FOR HEARING OFFI-  
7           CERS.—No individual may serve in a complaint  
8           review office as a hearing officer unless the in-  
9           dividual meets standards which shall be pre-  
10          scribed by the Secretary. Such standards shall  
11          include experience, training, ability to commu-  
12          nicate with the enrollee, affiliations, diligence,  
13          absence of actual or potential conflicts of inter-  
14          est, and other qualifications deemed relevant by  
15          the Secretary. At no time shall a hearing officer  
16          have any official, financial, or personal conflict  
17          of interest with respect to issues in controversy  
18          before the hearing officer.

19          “(2) AMENDMENT OF COMPLAINTS.—Upon the  
20          motion of the complainant, any complaint may, at  
21          the discretion of the hearing officer conducting the  
22          hearing, be amended at any time prior to the issu-  
23          ance of an order based thereon.

24          “(3) ANSWERS.—The party against whom the  
25          complaint is filed shall have the right to file an an-

1 swer to the original or amended complaint and to  
2 appear in person or otherwise and give testimony at  
3 the place and time fixed in the complaint.

4 “(b) ADDITIONAL PARTIES.—In the discretion of the  
5 hearing officer conducting the hearing, any other person  
6 may be allowed to intervene in the proceeding and to  
7 present testimony.

8 “(c) HEARINGS.—

9 “(1) DE NOVO HEARING.—Each hearing officer  
10 shall hear complaints and motions de novo.

11 “(2) TESTIMONY.—The testimony taken by the  
12 hearing officer shall be reduced to writing. There-  
13 after, the hearing officer, in the officer’s discretion,  
14 may (after notice to the parties) provide for the tak-  
15 ing of further testimony or the hearing of argu-  
16 ments.

17 “(3) AUTHORITY OF HEARING OFFICERS.—

18 “(A) IN GENERAL.—The hearing officer  
19 may compel by subpoena the attendance of wit-  
20 nesses and the production of evidence at any  
21 designated place or hearing. In case of contu-  
22 macy or refusal to obey a subpoena lawfully is-  
23 sued under this paragraph and upon application  
24 of the hearing officer, an appropriate district  
25 court of the United States may issue an order

1           requiring compliance with the subpoena and  
2           any failure to obey the order may be punished  
3           by the court as a contempt thereof. The hearing  
4           officer may also seek enforcement of the sub-  
5           poena in a State court of competent jurisdic-  
6           tion.

7           “(B) EXPERT WITNESSES.—The hearing  
8           officer may use independent medical experts.

9           “(4) RULES OF EVIDENCE.—Formal rules of  
10          evidence shall apply to any hearing under this sec-  
11          tion.

12          “(5) EXPEDITED HEARINGS.—Notwithstanding  
13          section 21803 and the preceding provisions of this  
14          section, upon receipt of a complaint containing a  
15          claim described in section 21801(c)(1), the com-  
16          plaint review office shall promptly provide the com-  
17          plainant with the opportunity to make an election  
18          under section 21803(a)(3) and assignment to a  
19          hearing on the complaint before a hearing officer.  
20          The complaint review office shall ensure that such a  
21          hearing commences not later than 24 hours after re-  
22          ceipt of the complaint by the complaint hearing of-  
23          fice and not later than 3 days after the receipt of  
24          a complaint, the complaint review office shall provide  
25          a decision.

1 “(d) DECISION OF HEARING OFFICER.—

2 “(1) IN GENERAL.—Except as provided in sub-  
3 section (c)(4), not later than 120 days after the date  
4 on which a complaint is assigned under this section,  
5 the hearing officer shall decide if the preponderance  
6 of the evidence justifies the denial of services and  
7 whether to decide in favor of the complainant with  
8 respect to each alleged act or practice. Each such  
9 decision—

10 “(A) shall include the hearing officer’s  
11 findings of fact, and

12 “(B) shall constitute the hearing officer’s  
13 final disposition of the proceedings.

14 “(2) DECISIONS FINDING IN FAVOR OF COM-  
15 PLAINANT.—If the hearing officer’s decision includes  
16 a determination that any party named in the com-  
17 plaint has engaged in or is engaged in an act or  
18 practice which consists of, or results in, a denial or  
19 delay described in section 21802(b), the hearing offi-  
20 cer shall issue and cause to be served on such party  
21 an order which requires such party—

22 “(A) to cease and desist from such act or  
23 practice,

24 “(B) to provide the benefits due under the  
25 terms of the plan and to otherwise comply with

1 the terms of the plan and the applicable re-  
2 quirements of this title,

3 “(C) to pay to the complainant prejudg-  
4 ment interest on the actual costs incurred in  
5 obtaining the items and services at issue in the  
6 complaint,

7 “(D) to pay to the prevailing complainant  
8 a reasonable attorney’s fee, reasonable expert  
9 witness fees, and other reasonable costs and ex-  
10 penses relating to the hearing on the charges on  
11 which the complainant prevails, and

12 “(E) to provide other appropriate relief.

13 “(3) DECISIONS NOT IN FAVOR OF COMPLAIN-  
14 ANT.—If the hearing officer’s decision includes a de-  
15 termination that the party named in the complaint  
16 has not engaged in or is not engaged in an act or  
17 practice referred to in section 21802(b), the hearing  
18 officer—

19 “(A) shall include in the decision a dismis-  
20 sal of the charge in the complaint relating to  
21 the act or practice, and

22 “(B) upon a finding that such charge is  
23 frivolous, shall issue and cause to be served on  
24 the complainant an order which requires the  
25 complainant to pay to such party a reasonable

1 attorney's fee, reasonable expert witness fees,  
2 and other reasonable costs and expenses relat-  
3 ing to the proceedings on such charge.

4 “(4) SUBMISSION AND SERVICE OF DECI-  
5 SIONS.—The hearing officer shall submit each deci-  
6 sion to the complaint review office at the conclusion  
7 of the proceedings and the office shall cause a copy  
8 of the decision to be served on the parties to the  
9 proceedings.

10 “(e) REVIEW.—

11 “(1) IN GENERAL.—The decision of the hearing  
12 officer shall be final and binding upon all parties.  
13 Except as provided in paragraph (2), any party to  
14 the complaint may, within 30 days after service of  
15 the decision by the complaint review office, file an  
16 appeal of the decision with the State Health Plan  
17 Review Board established under section 21805 in  
18 such form and manner as may be prescribed by such  
19 Board.

20 “(2) EXCEPTION.—A decision in favor of the  
21 complainant in the case of an expedited hearing  
22 under subsection (c)(4) shall not be subject to re-  
23 view.

24 “(f) COURT ENFORCEMENT OF ORDERS.—

1           “(1) IN GENERAL.—If a decision of the hearing  
2 officer in favor of the complainant is not appealed  
3 under section 21805, the complainant may petition  
4 any court of competent jurisdiction for enforcement  
5 of the order. In any such proceeding, the order of  
6 the hearing officer shall not be subject to review.

7           “(2) AWARDING OF COSTS.—In any action for  
8 court enforcement under this subsection, a prevailing  
9 complainant shall be entitled to a reasonable attor-  
10 ney’s fee, reasonable expert witness fees, and other  
11 reasonable costs and expenses relating to such ac-  
12 tion.

13 **“SEC. 21805. REVIEW BY STATE HEALTH PLAN REVIEW**  
14 **BOARD.**

15           “(a) ESTABLISHMENT AND MEMBERSHIP.—Each  
16 participating State shall establish a State Health Plan Re-  
17 view Board (hereafter in this subtitle referred to as the  
18 ‘Review Board’). The Review Board shall be composed of  
19 individuals who by reason of training, education, or experi-  
20 ence are qualified to carry out the functions of the Review  
21 Board under this subtitle, and who fairly represent all in-  
22 terested parties. The State shall prescribe such rules as  
23 are necessary for the orderly transaction of proceedings  
24 by the Review Board. Every official act of the Review  
25 Board shall be entered of record, and its hearings and

1 records shall be open to the public consistent with State  
2 law regarding individual privacy rights and the confiden-  
3 tiality of medical records subject to the proceedings.

4       “(b) REVIEW PROCESS.—The Review Board shall en-  
5 sure that reasonable notice is provided for each appeal be-  
6 fore the Review Board of a hearing officer’s decision under  
7 section 21804, and shall provide for the orderly consider-  
8 ation of arguments by any party to the hearing upon  
9 which the hearing officer’s decision is based. In the discre-  
10 tion of the Review Board, any other person may be allowed  
11 to intervene in the proceeding and to present written argu-  
12 ment. The Secretary (or in the case of multistate self-in-  
13 sured health plans, the Secretary of Labor) may intervene  
14 in the proceeding as a matter of right.

15       “(c) SCOPE OF REVIEW.—The Review Board shall re-  
16 view the decision of the hearing officer from which the  
17 appeal is made, except that the review shall be only for  
18 the purposes of determining—

19               “(1) whether the determination is supported by  
20               substantial evidence on the record considered as a  
21               whole,

22               “(2) in the case of any interpretation by the  
23               hearing officer of contractual terms (irrespective of  
24               the extent to which extrinsic evidence was consid-

1       ered), whether the determination is supported by a  
2       preponderance of the evidence,

3           “(3) whether the determination is in excess of  
4       statutory jurisdiction, authority, or limitations, or is  
5       in violation of a statutory right, or

6           “(4) whether the determination is without ob-  
7       servance of procedure required by law.

8       “(d) DECISION OF REVIEW BOARD.—The decision of  
9       the hearing officer as affirmed or modified by the Review  
10      Board (or any reversal by the Review Board of the hearing  
11      officer’s final disposition of the proceedings) shall become  
12      the final order of the Review Board and binding on all  
13      parties, subject to review under subsection (e). The Review  
14      Board shall cause a copy of its decision to be served on  
15      the parties to the proceedings not later than 5 days after  
16      the date of the decision.

17      “(e) REVIEW OF FINAL ORDERS.—

18           “(1) IN GENERAL.—Not later than 60 days  
19      after the entry of the final order, any person ag-  
20      grieved by any such final order may seek a review  
21      of the order under State procedures.

22           “(2) ENFORCEMENT DECREE IN ORIGINAL RE-  
23      VIEW.—If, upon appeal of an order under paragraph  
24      (1), the order is not reversed, the court shall have

1 the jurisdiction to make and enter a decree enforcing  
2 the order of the Review Board.

3 “(f) AWARDING OF ATTORNEYS’ FEES AND OTHER  
4 COSTS AND EXPENSES.—In any proceeding before the Re-  
5 view Board under this section or any judicial proceeding  
6 under subsection (e), the Review Board or the court (as  
7 the case may be) shall award to a prevailing complainant  
8 a reasonable attorney’s fee, reasonable expert witness fees,  
9 and other reasonable costs and expenses relating to the  
10 causes on which the complainant prevails.

11 **“SEC. 21806. CIVIL MONEY PENALTIES.**

12 “(a) DENIAL OR DELAY IN PAYMENT OR PROVISION  
13 OF BENEFITS.—The Secretary (or in the case of a  
14 multistate self-insured health plan, the Secretary of  
15 Labor) may assess a civil penalty against any health plan  
16 for unreasonable denial or delay in the payment or provi-  
17 sion of benefits thereunder, in an amount not to exceed—

18 “(1) \$25,000 per violation, or \$75,000 per vio-  
19 lation in the case of a finding of bad faith on the  
20 part of the plan, and

21 “(2) in the case of a finding of a pattern or  
22 practice of such violations engaged in by the plan,  
23 \$1,000,000 in addition to the total amount of pen-  
24 alties assessed under paragraph (1) with respect to  
25 such violations.

1 For purposes of paragraph (1), each violation with respect  
2 to any single individual shall be treated as a separate vio-  
3 lation.

4 “(b) CIVIL ACTION TO ENFORCE CIVIL PENALTY.—  
5 The Secretary may commence a civil action in any court  
6 of competent jurisdiction to enforce a civil penalty as-  
7 sessed under subsection (a).

8 “(c) SUPPLEMENTAL PLANS.—Nothing in this sec-  
9 tion shall be construed to limit the rights and remedies  
10 available under State law with respect to supplemental  
11 health benefits plans.

12 **“Subpart B—Early Resolution Programs**

13 **“SEC. 21811. ESTABLISHMENT OF EARLY RESOLUTION PRO-**  
14 **GRAMS IN COMPLAINT REVIEW OFFICES.**

15 “(a) ESTABLISHMENT OF PROGRAMS.—Each partici-  
16 pating State shall establish and maintain an Early Resolu-  
17 tion Program in each complaint review office in such  
18 State. The Program shall include—

19 “(1) the establishment and maintenance of fo-  
20 rums for mediation of disputes in accordance with  
21 this subpart, and

22 “(2) the establishment and maintenance of such  
23 forums for other forms of alternative dispute resolu-  
24 tion (including binding arbitration) as may be pre-  
25 scribed in regulations of the Secretary.

1 Each State shall ensure that the standards applied in  
2 Early Resolution Programs administered in such State  
3 which apply to any form of alternative dispute resolution  
4 described in paragraph (2), and which relate to time re-  
5 quirements, qualifications of facilitators, arbitrators, or  
6 other mediators, and confidentiality, are at least equiva-  
7 lent to the standards which apply to mediation proceedings  
8 under this subpart.

9 “(b) DUTIES OF COMPLAINT REVIEW OFFICES.—

10 Each complaint review office in a participating State—

11 “(1) shall administer its Early Resolution Pro-  
12 gram in accordance with regulations of the Sec-  
13 retary,

14 “(2) shall, pursuant to subsection (a)(1)—

15 “(A) recruit and train individuals to serve  
16 as facilitators for mediation proceedings under  
17 the Early Resolution Program from attorneys  
18 who have the requisite expertise for such serv-  
19 ice, which shall be specified in regulations of  
20 the Secretary,

21 “(B) provide meeting sites, maintain  
22 records, and provide facilitators with adminis-  
23 trative support staff, and

24 “(C) establish and maintain attorney refer-  
25 ral panels,

1           “(3) shall ensure that, upon the filing of a com-  
2           plaint with the office, the complainant is adequately  
3           apprised of the complainant’s options for review  
4           under this part, and

5           “(4) shall monitor and evaluate the Program on  
6           an ongoing basis.

7   **“SEC. 21812. INITIATION OF PARTICIPATION IN MEDIATION**  
8                           **PROCEEDINGS.**

9           “(a) ELIGIBILITY OF CASES FOR SUBMISSION TO  
10          EARLY RESOLUTION PROGRAM.—A dispute may be sub-  
11          mitted to the Early Resolution Program only if the follow-  
12          ing requirements are met with respect to the dispute:

13                  “(1) NATURE OF DISPUTE.—The dispute con-  
14                  sists of—

15                          “(A) an assertion by an individual enrolled  
16                          under a health plan of one or more claims  
17                          against the health plan for payment or provi-  
18                          sion of benefits, based on alleged coverage  
19                          under the plan; and

20                          “(B) a denial by the plan of the claims or  
21                          appropriate reimbursement based on the claims.

22                  “(2) NATURE OF DISPUTED CLAIM.—Each  
23          claim consists of—

24                          “(A) a claim for payment or provision of  
25                          benefits under the plan; or

1           “(B) a request for information or docu-  
2           ments the disclosure of which is required under  
3           this title (including claims of entitlement to dis-  
4           closure based on colorable claims to rights to  
5           benefits under the plan).

6           “(b) FILING OF ELECTION.—A complainant with a  
7           dispute which is eligible for submission to the Early Reso-  
8           lution Program may make the election under section  
9           21803(a)(2) to submit the dispute to mediation proceed-  
10          ings under the Program not later than 15 days after the  
11          date the complaint is filed with the complaint review office  
12          under section 21802(b).

13          “(c) AGREEMENT TO PARTICIPATE.—

14                 “(1) ELECTION BY CLAIMANT.—A complainant  
15                 may elect participation in the mediation proceedings  
16                 only by entering into a written participation agree-  
17                 ment (including an agreement to comply with the  
18                 rules of the Program and consent for the complaint  
19                 review office to contact the health plan regarding the  
20                 agreement), and by releasing plan records to the  
21                 Program for the exclusive use of the facilitator as-  
22                 signed to the dispute.

23                 “(2) PARTICIPATION BY PLANS OR HEALTH  
24                 BENEFITS CONTRACTORS.—Each party whose par-  
25                 ticipation in the mediation proceedings has been

1 elected by a claimant pursuant to paragraph (1)  
2 shall participate in, and cooperate fully with, the  
3 proceedings. The claims review office shall provide  
4 such party with a copy of the participation agree-  
5 ment described in paragraph (1), together with a  
6 written description of the Program. Such party shall  
7 submit the copy of the agreement, together with its  
8 authorized signature signifying receipt of notice of  
9 the agreement, to the claims review office, and shall  
10 include in the submission to the claims review office  
11 a copy of the written record of the plan claims pro-  
12 cedure completed pursuant to section 21801 with re-  
13 spect to the dispute and all relevant plan documents.  
14 The relevant documents shall include all documents  
15 under which the plan is or was administered or oper-  
16 ated, including copies of any insurance contracts  
17 under which benefits are or were provided and any  
18 fee or reimbursement schedules for health care pro-  
19 viders.

20 **“SEC. 21813. MEDIATION PROCEEDINGS.**

21 “(a) **ROLE OF FACILITATOR.**—In the course of medi-  
22 ation proceedings under the Early Resolution Program,  
23 the facilitator assigned to the dispute shall prepare the  
24 parties for a conference regarding the dispute and serve

1 as a neutral mediator at such conference, with the goal  
2 of achieving settlement of the dispute.

3 “(b) PREPARATIONS FOR CONFERENCE.—In advance  
4 of convening the conference, the facilitator shall, after  
5 identifying the necessary parties and confirming that the  
6 case is eligible for the Program, analyze the record of the  
7 claims procedure conducted pursuant to section 21801  
8 and any position papers submitted by the parties to deter-  
9 mine if further case development is needed to clarify the  
10 legal and factual issues in dispute, and whether there is  
11 any need for additional information and documents.

12 “(c) CONFERENCE.—Upon convening the conference,  
13 the facilitator shall assist the parties in identifying undis-  
14 puted issues and exploring settlement. If settlement is  
15 reached, the facilitator shall assist in the preparation of  
16 a written settlement agreement. If no settlement is  
17 reached, the facilitator shall present the facilitator’s eval-  
18 uation, including an assessment of the parties’ positions,  
19 the likely outcome of further administrative action or liti-  
20 gation, and suggestions for narrowing the issues in  
21 dispute.

22 “(d) TIME LIMIT.—The facilitator shall ensure that  
23 mediation proceedings with respect to any dispute under  
24 the Early Resolution Program shall be completed within  
25 120 days after the election to participate. The parties may

1 agree to one extension of the proceedings by not more than  
2 30 days if the proceedings are suspended to obtain an  
3 agency ruling or to reconvene the conference in a subse-  
4 quent session.

5       “(e) INAPPLICABILITY OF FORMAL RULES.—Formal  
6 rules of evidence shall not apply to mediation proceedings  
7 under the Early Resolution Program. All statements made  
8 and evidence presented in the proceedings shall be admis-  
9 sible in the proceedings. The facilitator shall be the sole  
10 judge of the proper weight to be afforded to each submis-  
11 sion. The parties to mediation proceedings under the Pro-  
12 gram shall not be required to make statements or present  
13 evidence under oath.

14       “(f) REPRESENTATION.—Parties may participate pro  
15 se or be represented by attorneys throughout the proceed-  
16 ings of the Early Resolution Program.

17       “(g) CONFIDENTIALITY.—

18               “(1) IN GENERAL.—Under regulations of the  
19 Secretary, rules similar to the rules under section  
20 574 of title 5, United States Code (relating to con-  
21 fidentiality in dispute resolution proceedings), shall  
22 apply to the mediation proceedings under the Early  
23 Resolution Program.

24               “(2) CIVIL REMEDIES.—The Secretary may as-  
25 sess a civil penalty against any person who discloses

1 information in violation of the regulations prescribed  
2 pursuant to paragraph (1) in the amount of three  
3 times the amount of the claim involved. The Sec-  
4 retary may bring a civil action to enforce such civil  
5 penalty in any court of competent jurisdiction.

6 **“SEC. 21814. LEGAL EFFECT OF PARTICIPATION IN MEDI-**  
7 **ATION PROCEEDINGS.**

8 “(a) PROCESS NONBINDING.—Findings and conclu-  
9 sions made in the mediation proceedings of the Early Res-  
10 olution Program shall be treated as advisory in nature and  
11 nonbinding. Except as provided in subsection (b), the  
12 rights of the parties under subpart A shall not be affected  
13 by participation in the Program.

14 “(b) RESOLUTION THROUGH SETTLEMENT AGREE-  
15 MENT.—If a case is settled through participation in medi-  
16 ation proceedings under the Program, the facilitator shall  
17 assist the parties in drawing up an agreement which shall  
18 constitute, upon signature of the parties, a binding con-  
19 tract between the parties which is enforceable under sec-  
20 tion 21815.

21 “(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—  
22 The settlement agreement shall not have the effect of  
23 waiving or otherwise affecting any rights to review under  
24 subpart A, or any other right under this subtitle or the

1 plan, with respect to any person who is not a party to  
2 the settlement agreement.

3 **“SEC. 21815. ENFORCEMENT OF SETTLEMENT AGREE-**  
4 **MENTS.**

5 “(a) ENFORCEMENT.—Any party to a settlement  
6 agreement entered pursuant to mediation proceedings  
7 under this subpart may petition any court of competent  
8 jurisdiction for the enforcement of the agreement, by filing  
9 in the court a written petition praying that the agreement  
10 be enforced. In such a proceeding, the order of the hearing  
11 officer shall not be subject to review.

12 “(b) COURT REVIEW.—It shall be the duty of the  
13 court to advance on the docket, and to expedite to the  
14 greatest extent possible, the disposition of any petition  
15 filed under this section, with due deference to the role of  
16 settlement agreements under this subpart in achieving  
17 prompt resolution of disputes involving health plans.

18 “(c) AWARDING OF ATTORNEY’S FEES AND OTHER  
19 COSTS AND EXPENSES.—In any action by an individual  
20 enrolled under a health plan for court enforcement under  
21 this section, a prevailing plaintiff shall be entitled to a rea-  
22 sonable attorney’s fee, reasonable expert witness fees, and  
23 other reasonable costs and expenses relating to the  
24 charges on which the plaintiff prevails.

**“Subpart C—Funding****2 “SEC. 21816. AVAILABILITY OF TRUST FUND AMOUNTS.**

3 “(a) IN GENERAL.—There shall be available  
4 \$100,000,000 in fiscal 1995, \$150,000,000 in each of the  
5 fiscal years 1996 through 1998, and \$100,000,000 in each  
6 of the fiscal years 1999 through 2004 from the Health  
7 Security Trust Fund established under section 9551 of the  
8 Internal Revenue Code of 1986 to the Secretary to sup-  
9 port participating States that have submitted applications  
10 in accordance with subsection (b) to establish and main-  
11 tain complaint review systems and early resolution pro-  
12 grams. The Secretary shall develop a formula for deter-  
13 mining the appropriate awarding of funds to participating  
14 States submitting such applications.

15 “(b) APPLICATION.—For purposes of subsection (a),  
16 an application is in accordance with this subsection if the  
17 applicant submits the application to the Secretary at such  
18 time, in such manner, and containing such information  
19 and assurances as the Secretary may reasonably require.

**20 “PART II—ADDITIONAL REMEDIES AND**  
**21 ENFORCEMENT PROVISIONS****22 “SEC. 21821. CIVIL ENFORCEMENT.**

23 “Unless otherwise provided in this title, the district  
24 courts of the United States shall have jurisdiction of civil  
25 actions brought by—

1           “(1) the Secretary to enforce any final order of  
2           such Secretary or to collect any civil monetary pen-  
3           alty assessed by such Secretary under this title; and

4           “(2) the Secretary of Labor, in consultation  
5           with the Secretary, to enforce any final order of  
6           such Secretary or to collect any civil monetary pen-  
7           alty assessed by such Secretary under this title.

8   **“SEC. 21822. FACIAL CONSTITUTIONAL CHALLENGES.**

9           “(a) JURISDICTION.—The United States District  
10          Court for the District of Columbia shall have original and  
11          exclusive jurisdiction of any civil action brought to invali-  
12          date any provision of, or amendment made by, the Health  
13          Security Act on the ground of its being repugnant to the  
14          Constitution of the United States on its face and for every  
15          purpose. In any action described in this subsection, the  
16          district court may not grant any temporary order or pre-  
17          liminary injunction restraining the enforcement, oper-  
18          ation, or execution of any provision of, or amendment  
19          made by, the Health Security Act.

20          “(b) CONVENING OF THREE-JUDGE COURT.—An ac-  
21          tion described in subsection (a) shall be heard and deter-  
22          mined by a district court of three judges in accordance  
23          with section 2284 of title 28, United States Code.

24          “(c) CONSOLIDATION.—When actions described in  
25          subsection (a) involving a common question of law or fact

1 are pending before a district court, the court shall order  
2 all the actions consolidated.

3 “(d) DIRECT APPEAL TO SUPREME COURT.—In any  
4 action described in subsection (a), an appeal may be taken  
5 directly to the Supreme Court of the United States from  
6 any final judgment, decree, or order in which the district  
7 court—

8 “(1) holds any provision of, or amendment  
9 made by, the Health Security Act invalid; and

10 “(2) makes a determination that its holding will  
11 materially undermine the application of such Act as  
12 a whole.

13 “(e) CONSTRUCTION.—This section does not limit—

14 “(1) the right of any person—

15 “(A) to litigation concerning any provision  
16 of, or amendment made by, the Health Security  
17 Act; or

18 “(B) to petition the Supreme Court for re-  
19 view of any holding of a district court by writ  
20 of certiorari at any time before the rendition of  
21 judgment in a court of appeals; or

22 “(2) the authority of the Supreme Court to  
23 grant a writ of certiorari for the review described in  
24 paragraph (1)(B).

1 **“SEC. 21823. TREATMENT OF PLANS AS PARTIES IN CIVIL**  
2 **ACTIONS.**

3 “A health plan may sue or be sued under this title  
4 as an entity.

5 **“SEC. 21824. GENERAL NONPREEMPTION OF RIGHTS AND**  
6 **REMEDIES.**

7 “Nothing in this subtitle shall be construed to deny,  
8 impair, or otherwise adversely affect a right or remedy  
9 available under law to any person, except to the extent  
10 the right or remedy is inconsistent with this subtitle.

11 **“SEC. 21825. NONDISCRIMINATION IN FEDERALLY AS-**  
12 **SISTED PROGRAMS.**

13 “Federal payments under this title shall be treated  
14 as Federal financial assistance for purposes of section 504  
15 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section  
16 303 of the Age Discrimination Act of 1975 (42 U.S.C.  
17 6102), and section 601 of the Civil Rights Act of 1964  
18 (42 U.S.C. 2000d).

19 **Subtitle B—Coordination With**  
20 **Other Provisions of Law**

21 **SEC. 111. MCCARRAN-FERGUSON REFORM.**

22 (a) IN GENERAL.—Section 3 of the Act of March 9,  
23 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson  
24 Act, is amended by adding at the end the following:

25 “(c) Notwithstanding that the business of insurance  
26 is regulated by State law, nothing in this Act shall limit

1 the applicability of the following Acts to the business of  
2 insurance to the extent that such business relates to the  
3 provision of health benefits:

4 “(1) The Sherman Act (15 U.S.C. 1 et seq.).

5 “(2) The Clayton Act (15 U.S.C. 12 et seq.).

6 “(3) Federal Trade Commission Act (15 U.S.C.  
7 41 et seq.).

8 “(4) The Act of June 19, 1936 (49 Stat. 1526;  
9 15 U.S.C. 21a et seq.), known as the Robinson-Pat-  
10 man Antidiscrimination Act.”.

11 (b) EFFECTIVE DATE.—The amendment made by  
12 subsection (a) shall take effect with respect to causes of  
13 action arising on or after January 1, 1996.

14 **SEC. 112. OFFICE OF RURAL HEALTH POLICY.**

15 (a) APPOINTMENT OF ASSISTANT SECRETARY.—

16 (1) IN GENERAL.—Section 711(a) of the Social  
17 Security Act (42 U.S.C. 912(a)) is amended—

18 (A) by striking “by a Director, who shall  
19 advise the Secretary” and inserting “by an As-  
20 sistant Secretary for Rural Health (in this sec-  
21 tion referred to as the ‘Assistant Secretary’),  
22 who shall report directly to the Secretary”;

23 (B) by adding at the end the following new  
24 sentence: “The Office shall not be a component

1           of any other office, service, or component of the  
2           Department.”.

3           (2) CONFORMING AMENDMENTS.—(A) Section  
4           711(b) of the Social Security Act (42 U.S.C. 912(b))  
5           is amended by striking “the Director” and inserting  
6           “the Assistant Secretary”.

7           (B) Section 338J(a) of the Public Health Serv-  
8           ice Act (42 U.S.C. 254r(a)) is amended by striking  
9           “Director of the Office of Rural Health Policy” and  
10          inserting “Assistant Secretary for Rural Health”.

11          (C) Section 464T(b) of the Public Health Serv-  
12          ice Act (42 U.S.C. 285p–2(b)) is amended in the  
13          matter preceding paragraph (1) by striking “Direc-  
14          tor of the Office of Rural Health Policy” and insert-  
15          ing “Assistant Secretary for Rural Health”.

16          (D) Section 6213 of the Omnibus Budget Rec-  
17          onciliation Act of 1989 (42 U.S.C. 1395x note) is  
18          amended in subsection (e)(1) by striking “Director  
19          of the Office of Rural Health Policy” and inserting  
20          “Assistant Secretary for Rural Health”.

21          (E) Section 403 of the Ryan White Comprehen-  
22          sive AIDS Resources Emergency Act of 1990 (42  
23          U.S.C. 300ff–11 note) is amended in the matter pre-  
24          ceding paragraph (1) of subsection (a) by striking

1 “Director of the Office of Rural Health Policy” and  
2 inserting “Assistant Secretary for Rural Health”.

3 (3) AMENDMENT TO THE EXECUTIVE SCHED-  
4 ULE.—Section 5315 of title 5, United States Code,  
5 is amended by striking “Assistant Secretaries of  
6 Health and Human Services (5)” and inserting “As-  
7 sistant Secretaries of Health and Human Services  
8 (6)”.

9 (b) EXPANSION OF DUTIES.—Section 711(a) of the  
10 Social Security Act (42 U.S.C. 912(a)) is amended by  
11 striking “and access to (and the quality of) health care  
12 in rural areas” and inserting “access to, and quality of,  
13 health care in rural areas, and reforms to the health care  
14 system and the implications of such reforms for rural  
15 areas”.

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall take effect on January 1, 1996.

18 **SEC. 113. AMENDMENTS TO THE EMPLOYEE RETIREMENT**

19 **INCOME SECURITY ACT OF 1974.**

20 (a) REPORTING AND DISCLOSURE REQUIREMENTS  
21 APPLICABLE TO GROUP HEALTH PLANS.—

22 (1) IN GENERAL.—Part 1 of subtitle B of title  
23 I of such Act is amended—

24 (A) in the heading for section 110, by add-  
25 ing “BY PENSION PLANS” at the end;

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

3 (C) by inserting after section 110 the fol-  
4 lowing new section:

5 “SPECIAL RULES FOR GROUP HEALTH PLANS

6 “SEC. 111. (a) IN GENERAL.—The Secretary may by  
7 regulation provide special rules for the application of this  
8 part to group health plans which are consistent with the  
9 purposes of this title and the Health Security Act and  
10 which take into account the special needs of participants,  
11 beneficiaries, and health care providers under such plans.

12 “(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—  
13 Such special rules may include rules providing for—

14 “(1) reductions in the periods of time referred  
15 to in this part,

16 “(2) increases in the frequency of reports and  
17 disclosures required under this part, and

18 “(3) such other changes in the provisions of  
19 this part as may result in more expeditious reporting  
20 and disclosure of plan terms and changes in such  
21 terms to the Secretary and to plan participants and  
22 beneficiaries,

23 to the extent that the Secretary determines that the rules  
24 described in this subsection are necessary to ensure timely  
25 reporting and disclosure of information consistent with the

1 purposes of this part and the Health Security Act as they  
2 relate to group health plans.

3 “(c) GROUP HEALTH PLAN.—For purposes of this  
4 section, the term ‘group health plan’ means an employee  
5 welfare benefit plan which provides medical care (as de-  
6 fined in section 213(d) of the Internal Revenue Code of  
7 1986) to participants or beneficiaries directly or through  
8 insurance, reimbursement, or otherwise.”

9 (2) CLERICAL AMENDMENT.—The table of con-  
10 tents in section 1 of such Act is amended by striking  
11 the items relating to sections 110 and 111 and in-  
12 serting 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.”

13 (b) COORDINATION WITH HEALTH SECURITY ACT.—

14 (1) ENFORCEMENT.—Section 502(a)(1)(B) of  
15 the Employee Retirement Income Security Act of  
16 1974 (29 U.S.C. 1132(a)(1)(B)) is amended by in-  
17 serting “except in the case of an action by any par-  
18 ticipant, beneficiary, or fiduciary to which subtitle H  
19 of title XXI of the Social Security Act applies,” be-  
20 fore “to recover”.

21 (2) PREEMPTION OF STATE LAWS.—Section  
22 514(b) of such Act (29 U.S.C. 1144(b)) is amended  
23 by adding at the end the following new paragraph:

1           “(9) Subsection (a) shall not apply to any law  
2 of any State which implements a State single-payer  
3 system under part II of subtitle A of title XXI of  
4 the Social Security Act.”

5           (c) REPEAL OF MULTIPLE EMPLOYER WELFARE AR-  
6 RANGEMENTS.—

7           (1) IN GENERAL.—Paragraph (40) of section 3  
8 of the Employee Retirement Income Security Act of  
9 1974 (29 U.S.C. 1002(40)) is repealed.

10          (2) CONFORMING AMENDMENT.—Paragraph (6)  
11 of section 514(b) of such Act (29 U.S.C.  
12 1144(b)(6)) is repealed.

13          (d) EFFECTIVE DATE.—The amendments made by  
14 this section shall take effect on January 1, 1996.

## 15                   **TITLE II—COVERAGE**

### 16   **SEC. 201. COVERAGE.**

17           The Social Security Act, as amended by section 101,  
18 is amended by adding at the end the following new title:

## 19                   **“TITLE XXII—COVERAGE**

20                                   “TABLE OF CONTENTS

“Sec. 2201. National Health Care Commission.

“Sec. 2202. Duties of Commission.

“Sec. 2203. Congressional consideration of Commission recommendations.

“Sec. 2204. Operation of the Commission.

1 **“SEC. 2201. NATIONAL HEALTH CARE COMMISSION.**

2 “There is established a commission to be known as  
3 the National Health Care Commission (in this title re-  
4 ferred to as the ‘Commission’).

5 **“SEC. 2202. DUTIES OF COMMISSION.**

6 “(a) IN GENERAL.—The general duties of the Com-  
7 mission are to monitor and respond to—

8 “(1) trends in health insurance coverage; and

9 “(2) changes in per-capita premiums and other  
10 indicators of health care inflation.

11 The Commission may be advised by individuals with exper-  
12 tise concerning the economic, demographic, and insurance  
13 market factors that affect the cost and availability of  
14 health insurance.

15 “(b) BIENNIAL REPORTS.—

16 “(1) IN GENERAL.—The Commission shall re-  
17 port to Congress biennially on January 1 (beginning  
18 in 1996) on the status of health insurance coverage  
19 in the nation and the national goal of universal cov-  
20 erage.

21 “(2) HEALTH INSURANCE COVERAGE.—For  
22 purposes of this title, the term ‘health insurance cov-  
23 erage’ means coverage under—

24 “(A) a certified standard health plan pro-  
25 viding a standard benefits package or an alter-  
26 native standard benefits package;

1           “(B) the medicare program under title  
2 XVIII;

3           “(C) the medicaid program under title  
4 XIX;

5           “(D) the health care program for active  
6 military personnel under title 10, United States  
7 Code;

8           “(E) the veterans health care program  
9 under chapter 17 of title 38, United States  
10 Code;

11           “(F) the Civilian Health and Medical Pro-  
12 gram of the Uniformed Services (CHAMPUS),  
13 as defined in section 1073(4) of title 10, United  
14 States Code;

15           “(G) the Indian health service program  
16 under the Indian Health Care Improvement Act  
17 (25 U.S.C. 1601 et seq.);

18           “(H) a State single-payer system approved  
19 by the Secretary under section 21031; or

20           “(I) any governmental health care program  
21 for institutionalized individuals.

22           “(3) CONTENTS OF REPORT.—Each biennial re-  
23 port shall include the structure and performance  
24 measures of every community rating area, including  
25 the following:

1           “(A) Demographics of the uninsured indi-  
2           viduals, and findings on why such individuals  
3           are uninsured.

4           “(B) Structure of delivery systems.

5           “(C) Number and organizational form of  
6           certified standard health plans described in  
7           paragraph (2)(A).

8           “(D) Level of enrollment in such certified  
9           standard health plans.

10          “(E) State implementation of responsibil-  
11          ities, including establishment of community rat-  
12          ing areas, under title XXI.

13          “(F) Status of insurance reforms.

14          “(G) Development of purchasing coopera-  
15          tives and other buyer reforms.

16          “(H) Success of market and other mecha-  
17          nisms of controlling health expenditures and  
18          premium costs in the community rating areas  
19          and nationally.

20          “(I) Status of medicaid-eligible individuals  
21          under the medicaid program under title XIX,  
22          the integration of such individuals into coverage  
23          by certified standard health plans providing  
24          standard benefits packages, and the transition  
25          of such program toward managed care.

1           “(J) Adequacy of subsidies for individuals  
2 under part B of title XIX.

3           “(K) Status of medicare-eligible individuals  
4 under the medicare program under title XVIII,  
5 the integration of such individuals into coverage  
6 by certified standard health plans providing  
7 standard benefits packages, and the transition  
8 of such program into medicare risk contracts.

9           “(L) Coverage progress among individuals  
10 who are employed, including status and level of  
11 voluntary employer contributions and participa-  
12 tion rates in purchasing cooperatives and  
13 among large employers.

14           “(M) Percentage of individuals who are en-  
15 rolled in certified standard health plans de-  
16 scribed in paragraph (2)(A), separated into cat-  
17 egories of medicare-eligible individuals, medic-  
18 aid-eligible individuals, employed individuals,  
19 and individuals eligible for subsidies.

20           “(N) Recommendations, specific to each  
21 community rating area, on how the area might  
22 increase coverage among the residents and fur-  
23 ther moderate growth in premiums.

24           “(4) PROHIBITED ACTIVITY.—In carrying out  
25 its duties, including the preparation of any biennial

1 report, the Commission may not address issues re-  
2 lated to defining an employee for tax purposes, in-  
3 cluding discussing such issues with the Internal Rev-  
4 enue Service or the Department of the Treasury.

5 “(c) COVERAGE TRIGGER.—

6 “(1) IN GENERAL.—In the event the Commis-  
7 sion determines that health insurance coverage of at  
8 least 95 percent of the resident population in the  
9 United States will not be attained by 2002, the  
10 Commission shall submit recommendations in its bi-  
11 ennial report to Congress on January 1, 2002.

12 “(2) RECOMMENDATION REQUIREMENTS.—

13 “(A) IN GENERAL.—The recommendations  
14 of the Commission shall include methods to  
15 reach 95 percent health insurance coverage in  
16 community rating areas that have failed to  
17 meet that target. Such recommendations shall  
18 address all relevant parties, including States,  
19 employers, employees, unemployed and low-in-  
20 come individuals, and public program partici-  
21 pants.

22 “(B) REQUIRED SEPARATE RECOMMENDA-  
23 TIONS.—In addition to any other recommenda-  
24 tions the Commission submits, the Commission



1 to implement the recommendations developed under  
2 this subsection.

3 “(d) DEFINITIONS.—For purposes of aythis title—

4 “(1) ALTERNATIVE STANDARD BENEFITS PACK-  
5 AGE.—The term ‘alternative standard benefits pack-  
6 age’ means the alternative standard benefits package  
7 established under subtitle C of title XXI.

8 “(2) CERTIFIED STANDARD HEALTH PLAN.—  
9 The term ‘certified standard health plan’ has the  
10 meaning given such term by section 21011(a)(2).

11 “(3) COMMUNITY RATING AREA.—The term  
12 ‘community rating area’ means an area established  
13 under section 21021.

14 “(4) PURCHASING COOPERATIVE.—The term  
15 ‘purchasing cooperative’ has the meaning given such  
16 term by section 21100(14).

17 “(5) RESIDENT POPULATION.—The term ‘resi-  
18 dent population’ includes any individual who is re-  
19 siding in the United States and who is—

20 “(A) a citizen or national of the United  
21 States; or

22 “(B) an alien permanently residing in the  
23 United States under color of law (as defined in  
24 section 1958(4)(C)).

1           “(6) STANDARD BENEFITS PACKAGE.—The  
2 term ‘standard benefits package’ means the stand-  
3 ard benefits package established under subtitle C of  
4 title XXI.

5           “(7) UNITED STATES.—The term ‘United  
6 States’ means the various States (as defined in sec-  
7 tion 21100(16)).

8 **“SEC. 2203. CONGRESSIONAL CONSIDERATION OF COMMIS-**  
9 **SION RECOMMENDATIONS.**

10          “(a) IN GENERAL.—An implementing qbill described  
11 in section 2202(c)(3) shall be considered by Congress  
12 under the procedures for consideration described in sub-  
13 section (b).

14          “(b) CONGRESSIONAL CONSIDERATION.—

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

18           “(A) as an exercise of the rulemaking  
19 power of the House of Representatives and the  
20 Senate, respectively, and as such is deemed a  
21 part of the rules of each House, respectively,  
22 but applicable only with respect to the proce-  
23 dure to be followed in that House in the case  
24 of an implementing bill described in subsection  
25 (a), and supersedes other rules only to the ex-

1           tent that such rules are inconsistent therewith;  
2           and

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

9           “(2) INTRODUCTION AND REFERRAL.—On the  
10          day on which the implementing bill described in sub-  
11          section (as) is transmitted to the House of Rep-  
12          resentatives and the Senate, such bill shall be intro-  
13          duced (by request) in the House of Representatives  
14          by the majority leaderyay of the House, for himself  
15          or herself, and the minority leader of the House, or  
16          by Members of the House designated by the majority  
17          leader and minority leader of the House and shall be  
18          introduced (by request) in the Senate by the major-  
19          ity leader of the Senate, for himself or herself, and  
20          the minority leader of the Senate, or by Members of  
21          the Senate designated by the majority leader and  
22          minority leader of the Senate. If either House is not  
23          in session on the day on which the implementing bill  
24          is transmitted, the bill shall be introduced in that  
25          House, as provided in the preceding sentence, on the

1 first day thereafter on which that House is in ses-  
2 sion. If the implementing bill is not introduced with-  
3 in 5 days of its transmission, any Member of the  
4 House and of the Senate may introduce such bill.  
5 The implementing bill introduced in the House of  
6 Representatives and the Senate shall be referred to  
7 the appropriate committees of each House.

8 “(3) PERIOD FOR COMMITTEE CONSIDER-  
9 ATION.—If the committee or committees of either  
10 House to which an implementing bill has been re-  
11 ferred have not reported the bill at the close of July  
12 1, 2002 (or if such House is not in session, the next  
13 day such House is in session), such committee or  
14 committees shall be automatically discharged from  
15 further consideration of the implementing bill and it  
16 shall be placed on the appropriate calendar.

17 “(4) FLOOR CONSIDERATION IN THE SEN-  
18 ATE.—

19 “(A) IN GENERAL.—Within 5 days after  
20 the implementing bill is placed on the calendar,  
21 the majority leader, at a time to be determined  
22 by the majority leader in consultation with the  
23 minority leader, shall proceed to the consider-  
24 ation of the bill. If on the sixth day after the  
25 bill is placed on the calendar, the Senate has

1 not proceeded to consideration of the bill, then  
2 the presiding officer shall automatically place  
3 the bill before the Senate for consideration. A  
4 motion in the Senate to proceed to the consider-  
5 ation of an implementing bill shall be privileged  
6 and not debatable. An amendment to the mo-  
7 tion shall not be in order, nor shall it be in  
8 order to move to reconsider the vote by which  
9 the motion is agreed to or disagreed to.

10 “(B) TIME LIMITATION ON CONSIDER-  
11 ATION OF BILL.—

12 “(i) IN GENERAL.—Debate in the  
13 Senate on an implementing bill, and all  
14 amendments and debatable motions and  
15 appeals in connection therewith, shall be  
16 limited to not more than 30 hours. The  
17 time shall be equally divided between, and  
18 controlled by, the majority leader and the  
19 minority leader or their designees.

20 “(ii) DEBATE OF AMENDMENTS, MO-  
21 TIONS, POINTS OF ORDER, AND AP-  
22 PEALS.—In the Senate, no amendment  
23 which is not relevant to the bill shall be in  
24 order. Debate in the Senate on any amend-  
25 ment, debatable motion or appeal, or point

1 of order in connection with an implement-  
2 ing bill shall be limited to—

3 “(I) not more than 2 hours for  
4 each first degree relevant amendment,

5 “(II) one hour for each second  
6 degree relevant amendment, and

7 “(III) 30 minutes for each debat-  
8 able motion or appeal, or point of  
9 order submitted to the Senate,

10 to be equally divided between, and con-  
11 trolled by, the mover and the manager of  
12 the implementing bill, except that in the  
13 event the manager of the implementing bill  
14 is in favor of any such amendment, mo-  
15 tion, appeal, or point of order, the time in  
16 opposition thereto, shall be controlled by  
17 the minority leader or designee of the mi-  
18 nority leader. The majority leader and mi-  
19 nority leader, or either of them, may, from  
20 time under their control on the passage of  
21 an implementing bill, allot additional time  
22 to any Senator during the consideration of  
23 any amendment, debatable motion or ap-  
24 peal, or point of order.

1           “(C) OTHER MOTIONS.—A motion to re-  
2           commit an implementing bill is not in order.

3           “(D) FINAL PASSAGE.—Upon the expira-  
4           tion of the 30 hours available for consideration  
5           of the implementing bill, it shall not be in order  
6           to offer or vote on any amendment to, or mo-  
7           tion with respect to, such bill. Immediately fol-  
8           lowing the conclusion of debate in the Senate  
9           on an implementing bill that was introduced in  
10          the Senate, such bill shall be deemed to have  
11          been read a third time and the vote on final  
12          passage of such bill shall occur without any in-  
13          tervening action or debate.

14          “(E) DEBATE ON DIFFERENCES BETWEEN  
15          THE HOUSES.—Debate in the Senate on mo-  
16          tions and amendments appropriate to resolve  
17          the differences between the Houses, at any par-  
18          ticular stage of the proceedings, shall be limited  
19          to not more than 5 hours.

20          “(F) DEBATE ON CONFERENCE REPORT.—  
21          Debate in the Senate on the conference report  
22          shall be limited to not more than 10 hours.

23          “(5) FLOOR CONSIDERATION IN THE HOUSE OF  
24          REPRESENTATIVES.—

1           “(A) PROCEED TO CONSIDERATION.—On  
2 the sixth day after the implementing bill is  
3 placed on the calendar, it shall be privileged for  
4 any Member to move without debate that the  
5 House resolve itself into the Committee of the  
6 Whole House on the state of the Union, for the  
7 consideration of the bill, and the first reading  
8 of the bill shall be dispensed with.

9           “(B) GENERAL DEBATE.—After general  
10 debate, which shall be confined to the imple-  
11 menting bill and which shall not exceed 4  
12 hours, to be equally divided and controlled by  
13 the chairman and ranking minority member of  
14 the Committee or Committees to which the bill  
15 had been referred, the bill shall be considered  
16 for amendment by title under the 5-minute rule  
17 and each title shall be considered as having  
18 been read. The total time for considering all  
19 amendments shall be limited to 26 hours of  
20 which the total time for debating each amend-  
21 ment under the 5-minute rule shall not exceed  
22 one hour.

23           “(C) RISE AND REPORT.—At the conclu-  
24 sion of the consideration of the implementing  
25 bill for amendment, the Committee of the

1 Whole on the state of the Union shall rise and  
2 report the bill to the House with such amend-  
3 ments as may have been adopted, and the pre-  
4 vious question shall be considered as ordered on  
5 the bill and the amendments thereto, and the  
6 House shall proceed to vote on final passage  
7 without intervening motion except one motion  
8 to recommit.

9 “(6) COMPUTATION OF DAYS.—For purposes of  
10 this subsection, in computing a number of days in  
11 either House, there shall be excluded—

12 “(A) the days on which either House is not  
13 in session because of an adjournment of more  
14 than 3 days to a day certain, or an adjourn-  
15 ment of the Congress sine die, and

16 “(B) any Saturday and Sunday not ex-  
17 cluded under subparagraph (A) when either  
18 House is not in session.

19 **“SEC. 2204. OPERATION OF THE COMMISSION.**

20 “(a) MEMBERSHIP.—

21 “(1) IN GENERAL.—The Commission shall be  
22 composed of 7 members appointed by the President  
23 and confirmed by the Senate. Members shall be ap-  
24 pointed not later than 90 days after the date of the  
25 enactment of this title.

1           “(2) CHAIRPERSON.—The President shall des-  
2           ignate 1 individual described in paragraph (1) who  
3           shall serve as Chairperson of the Commission.

4           “(b) COMPOSITION.—The membership of the Com-  
5           mission shall include individuals with national recognition  
6           for their expertise in health markets. In appointing mem-  
7           bers of the Commission, the President shall ensure that  
8           no more than 4 members of the Commission are affiliated  
9           with the same political party.

10          “(c) TERMS.—

11           “(1) IN GENERAL.—The terms of members of  
12           the Commission shall be for 6 years, except that of  
13           the members first appointed, 2 shall be appointed  
14           for an initial term of 4 years and 2 shall be ap-  
15           pointed for an initial term of 2 years.

16           “(2) CONTINUATION IN OFFICE.—Upon the ex-  
17           piration of a term of office, a member shall continue  
18           to serve until a successor is appointed and qualified.

19          “(d) VACANCIES.—

20           “(1) IN GENERAL.—A vacancy in the Commis-  
21           sion shall be filled in the same manner as the origi-  
22           nal appointment, but the individual appointed to fill  
23           the vacancy shall serve only for the unexpired por-  
24           tion of the term for which the individual’s prede-  
25           cessor was appointed.

1           “(2) NO IMPAIRMENT OF FUNCTION.—A va-  
2           cancy in the membership of the Commission does  
3           not impair the authority of the remaining members  
4           to exercise all of the powers of the Commission.

5           “(3) ACTING CHAIRPERSON.—The Commission  
6           may designate a member to act as Chairperson dur-  
7           ing any period in which there is no Chairperson des-  
8           ignated by the President.

9           “(e) MEETINGS; QUORUM.—

10           “(1) MEETINGS.—The Chairperson shall pre-  
11           side at meetings of the Commission, and in the ab-  
12           sence of the Chairperson, the Commission shall elect  
13           a member to act as Chairperson pro tempore.

14           “(2) QUORUM.—Four members of the Commis-  
15           sion shall constitute a quorum thereof.

16           “(f) ADMINISTRATIVE PROVISIONS.—

17           “(1) FACA NOT APPLICABLE.—The Federal  
18           Advisory Committee Act (5 U.S.C. App.) shall not  
19           apply to the Commission.

20           “(2) PAY AND TRAVEL EXPENSES.—

21           “(A) PAY.—Each member shall be paid at  
22           a rate equal to the daily equivalent of the mini-  
23           mum annual rate of basic pay payable for level  
24           IV of the Executive Schedule under section  
25           5315 of title 5, United States Code, for each

1 day (including travel time) during which the  
2 member is engaged in the actual performance of  
3 duties vested in the Commission.

4 “(B) TRAVEL EXPENSES.—Members shall  
5 receive travel expenses, including per diem in  
6 lieu of subsistence, in accordance with sections  
7 5702 and 5703 of title 5, United States Code.

8 “(3) EXECUTIVE DIRECTOR.—

9 “(A) IN GENERAL.—The Commission  
10 shall, without regard to section 5311(b) of title  
11 5, United States Code, appoint an Executive  
12 Director.

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

16 “(4) STAFF.—

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

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

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

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

14 “(5) OTHER AUTHORITY.—

15 “(A) CONTRACT SERVICES.—The Commis-  
16 sion may procure by contract, to the extent  
17 funds are available, the temporary or intermit-  
18 tent services of experts or consultants pursuant  
19 to section 3109 of title 5, United States Code.

20 “(B) LEASES AND PROPERTY.—The Com-  
21 mission may lease space and acquire personal  
22 property to the extent funds are available.

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
24 are authorized to be appropriated such sums as are nec-  
25 essary for the operation of the Commission.

1 **TITLE III—PREMIUM AND COST-**  
2 **SHARING ASSISTANCE**

3 **SEC. 301. PREMIUM AND COST-SHARING ASSISTANCE.**

4 (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
5 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),  
6 as amended by section 101(a), is amended—

7 (1) by striking “and” at the end of paragraph  
8 (62);

9 (2) by striking the period at the end of para-  
10 graph (63) and inserting “; and”; and

11 (3) by adding at the end the following new  
12 paragraph:

13 “(64) provide for a State program furnishing  
14 premium and cost-sharing assistance in accordance  
15 with part B.”.

16 (b) STATE PROGRAMS FOR PREMIUM AND COST-  
17 SHARING ASSISTANCE.—Title XIX of the Social Security  
18 Act (42 U.S.C. 1396 et seq.) is amended by adding at  
19 the end the following new part:

20 **“PART B—STATE PROGRAMS FOR PREMIUM AND**  
21 **COST-SHARING ASSISTANCE**

22 **“SEC. 1951. REQUIREMENT TO OPERATE STATE PROGRAM.**

23 “(a) IN GENERAL.—A State with a State plan ap-  
24 proved under part A shall have in effect a program—

1           “(1) for furnishing premium assistance under  
2 section 1952—

3           “(A) to individuals with incomes below cer-  
4 tain income thresholds described in section  
5 1952(a)(2)(A)(i) in calendar years beginning  
6 after 1996; and

7           “(B) to children and pregnant women de-  
8 scribed in section 1952(a)(2)(A)(ii) in calendar  
9 years beginning after 1995; and

10          “(2) for determining eligibility for cost-sharing  
11 assistance under section 1953 in calendar years be-  
12 ginning after 1996.

13          “(b) STATE OPTION.—A State may have in effect a  
14 program—

15          “(1) for furnishing premium assistance under  
16 section 1952 to individuals with incomes below cer-  
17 tain income thresholds described in section  
18 1952(a)(2)(A)(i) during 1996; and

19          “(2) for determining eligibility for cost-sharing  
20 assistance under section 1953 during 1996.

21          “(c) DESIGNATION OF STATE AGENCY.—A State  
22 may designate any appropriate State agency to administer  
23 the program under this part.

1 **“SEC. 1952. ASSISTANCE WITH CERTIFIED STANDARD**  
2 **HEALTH PLAN PREMIUMS.**

3 “(a) ELIGIBILITY.—

4 “(1) IN GENERAL.—An eligible individual (as  
5 defined in section 1958(3)) who has been determined  
6 by a State under section 1954 to be a premium sub-  
7 sidy eligible individual (as defined in paragraph (2))  
8 shall be entitled to premium assistance in the  
9 amount determined under subsection (b).

10 “(2) PREMIUM SUBSIDY ELIGIBLE INDIVID-  
11 UAL.—

12 “(A) IN GENERAL.—For purposes of this  
13 part, the term ‘premium subsidy eligible indi-  
14 vidual’ means any of the following individuals:

15 “(i) INDIVIDUALS WITH INCOMES  
16 BELOW CERTAIN INCOME THRESHOLDS.—  
17 An eligible individual who has a family in-  
18 come determined under section 1958(2)  
19 which does not exceed the eligibility per-  
20 centage specified in subparagraph (B) of  
21 the poverty line (as defined in section  
22 1958(5)).

23 “(ii) CHILDREN AND PREGNANT  
24 WOMEN.—An eligible individual who is a  
25 child under 18 years of age or a pregnant  
26 woman (as defined in section 1958(6)) and

1 has a family income determined under sec-  
 2 tion 1958(2) which does not exceed 240  
 3 percent of the poverty line.

4 “(iii) REDUCTION IN ELIGIBILITY  
 5 PERCENTAGES.—For requirement that the  
 6 President reduce the percentage of the  
 7 poverty line applicable to an individual’s  
 8 family income for purposes of determining  
 9 eligibility for premium assistance under  
 10 this section, see section 801 of the Health  
 11 Security Act.

12 “(B) ELIGIBILITY PERCENTAGE.—

13 “(i) IN GENERAL.—The eligibility per-  
 14 centage shall be determined under the fol-  
 15 lowing table:

<b>“Calendar year:</b>	<b>Applicable eligibility percentage:</b>
1996 .....	100
1997 .....	125
1998 .....	150
1999 .....	175
2000 .....	200

16 “(b) AMOUNT OF ASSISTANCE.—

17 “(1) IN GENERAL.—

18 “(A) DETERMINATION OF AMOUNT.—Ex-  
 19 cept as provided in paragraph (4), the amount  
 20 of premium assistance for a month for a pre-  
 21 mium subsidy eligible individual is the lesser  
 22 of—

1           “(i) the premium assistance amount  
2           determined under paragraph (2); or

3           “(ii) the amount of the premium for  
4           coverage under the certified standard  
5           health plan (as defined in section 1958(1))  
6           in which the individual is enrolled that is  
7           not paid (or offered to be paid) on behalf  
8           of such individual by an employer.

9           “(B) SPECIAL RULE FOR DETERMINING  
10          AMOUNT OF EMPLOYER PAYMENTS.—If an em-  
11          ployer makes a payment toward the premium  
12          for coverage under a certified standard health  
13          plan on behalf of a family (rather than any par-  
14          ticular individual) such contribution shall be al-  
15          located ratably among the individuals in the  
16          family.

17          “(2) PREMIUM ASSISTANCE AMOUNT DETER-  
18          MINED.—

19                 “(A) IN GENERAL.—The premium assist-  
20                 ance amount determined under this paragraph  
21                 is an amount equal to the lesser of—

22                         “(i) the subsidy percentage specified  
23                         in paragraph (3) multiplied by  $\frac{1}{12}$ th of the  
24                         annual premium for coverage under the

1 certified standard health plan in which the  
2 individual is enrolled, or

3 “(ii) the subsidy percentage specified  
4 in paragraph (3) multiplied by  $\frac{1}{12}$ th of the  
5 weighted average annual premium for the  
6 individual’s class of enrollment (determined  
7 in accordance with subparagraph (B)) for  
8 all community-rated certified standard  
9 health plans offered in the community rat-  
10 ing area in which the individual resides.

11 “(B) DETERMINATION OF WEIGHTED AV-  
12 ERAGE ANNUAL PREMIUM.—For purposes of  
13 subparagraph (A)(ii), the weighted average an-  
14 nual premium for a class of enrollment under  
15 community-rated certified standard health plans  
16 offered in a community rating area shall be  
17 based on the number of primary enrollees in  
18 such class enrolled in each of the plans.

19 “(3) SUBSIDY PERCENTAGE.—For purposes of  
20 paragraph (2)(A), the term ‘subsidy percentage’  
21 means the following:

22 “(A) INDIVIDUALS WITH INCOMES BELOW  
23 CERTAIN INCOME THRESHOLDS.—

1           “(i) PERCENTAGE DETERMINED.—  
2 For a premium subsidy eligible individual  
3 described in subsection (a)(2)(A)(i)—

4           “(I) for 1997, 100 percent re-  
5 duced (but not below zero) by the  
6 product of the applicable factor deter-  
7 mined under clause (ii) multiplied by  
8 the number of percentage points  
9 (rounded to the nearest whole num-  
10 ber) by which such individual’s family  
11 income exceeds 100 percent of the  
12 poverty line; and

13           “(II) for succeeding years, 100  
14 percent reduced (but not below zero)  
15 by 1 percentage point for each 1 per-  
16 centage point by which such individ-  
17 ual’s family income exceeds 100 per-  
18 cent of the poverty line.

19           “(ii) APPLICABLE FACTOR.—The ap-  
20 plicable factor determined under this  
21 clause for a calendar year is the number  
22 equal to the quotient of—

23           “(I) 100, divided by

24           “(II) the eligibility percentage for  
25 the year determined under subsection

1 (a)(2)(B) (expressed as a whole num-  
2 ber) minus 100.

3 “(B) CHILDREN AND PREGNANT  
4 WOMEN.—For a premium subsidy eligible indi-  
5 vidual described in subsection (a)(2)(A)(ii)—

6 “(i) 100 percent if the individual’s  
7 family income does not exceed 185 percent  
8 of the poverty line;

9 “(ii) 80 percent if the individual’s  
10 family income exceeds 185 percent of the  
11 poverty line but does not exceed 200 per-  
12 cent of the poverty line;

13 “(iii) 60 percent if the individual’s  
14 family income exceeds 200 percent of the  
15 poverty line but does not exceed 215 per-  
16 cent of the poverty line;

17 “(iv) 40 percent if the individual’s  
18 family income exceeds 215 percent of the  
19 poverty line but does not exceed 230 per-  
20 cent of the poverty line; and

21 “(v) 20 percent if the individual’s  
22 family income exceeds 230 percent of the  
23 poverty line but does not exceed 240 per-  
24 cent of the poverty line.

25 “(4) MINIMUM AMOUNT.—

1           “(A) IN GENERAL.—If the total amount  
2 determined under paragraph (1) with respect to  
3 all premium subsidy eligible individuals in a  
4 family for a year (determined as if the individ-  
5 uals were eligible for subsidies for the entire  
6 year) does not exceed the amount determined  
7 under subparagraph (B) the individuals shall  
8 not be eligible to receive premium assistance  
9 under this section.

10           “(B) AMOUNT DETERMINED.—The  
11 amount determined under this subparagraph  
12 shall be—

13           “(i) for 1996, \$150; and

14           “(ii) for 1997 and succeeding years,  
15 an amount equal to the amount determined  
16 under this subparagraph for the previous  
17 year updated through the midpoint of the  
18 year by the estimated percentage change in  
19 the medical consumer price index (as de-  
20 fined in section 1958(4)) during the 12-  
21 month period ending at that midpoint,  
22 with appropriate adjustments to reflect  
23 previous underestimations or overesti-  
24 mations under this subparagraph in the

1           projected percentage change in the medical  
2           consumer price index.

3           “(C) ROUNDING.—Any amount determined  
4           under subparagraph (B)(ii) for a year shall be  
5           rounded to the nearest multiple of \$5.

6           “(c) PAYMENTS.—

7           “(1) IN GENERAL.—The amount of the pre-  
8           mium assistance available to a premium subsidy eli-  
9           gible individual under subsection (b) shall be paid by  
10          the State in which the individual resides directly to  
11          the certified standard health plan in which the indi-  
12          vidual is enrolled. Payments under the preceding  
13          sentence shall commence in the first month during  
14          which the individual is enrolled in a certified stand-  
15          ard health plan and determined under section 1954  
16          to be a premium subsidy eligible individual.

17          “(2) ADMINISTRATIVE ERRORS.—A State is fi-  
18          nancially responsible for premium assistance paid  
19          based on an eligibility determination error to the ex-  
20          tent the State’s error rate for eligibility determina-  
21          tions exceeds a maximum permissible error rate to  
22          be specified by the Secretary.

23       **“SEC. 1953. ASSISTANCE WITH CERTIFIED STANDARD**  
24       **HEALTH PLAN COST-SHARING.**

25       “(a) ELIGIBILITY.—

1           “(1) IN GENERAL.—An eligible individual who  
2           has been determined by a State under section 1954  
3           to be a cost-sharing subsidy eligible individual (as  
4           defined in paragraph (2)) shall be eligible for cost-  
5           sharing assistance as described in subsection (b). If  
6           a State determines that an individual is a cost-shar-  
7           ing eligible individual, the State shall notify the cer-  
8           tified standard health plan in which such individual  
9           is enrolled of such determination in a timely man-  
10          ner.

11           “(2) COST-SHARING SUBSIDY ELIGIBLE INDI-  
12          VIDUAL.—For purposes of this part, the term ‘cost-  
13          sharing subsidy eligible individual’ means an eligible  
14          individual who has a family income determined  
15          under section 1958(2) which does not exceed 100  
16          percent of the poverty line.

17           “(b) COST-SHARING ASSISTANCE.—In the case of a  
18          cost-sharing subsidy eligible individual who is enrolled in  
19          a certified standard health plan, the cost-sharing assist-  
20          ance under this subsection shall consist of the plan’s re-  
21          duction in the cost-sharing otherwise imposed under the  
22          plan to amounts that are determined appropriate by the  
23          National Health Benefits Board under section 21213(d).

24           “(c) TERMINATION OF COST-SHARING ASSIST-  
25          ANCE.—An individual’s eligibility for cost-sharing assist-

1 ance under this section shall terminate the month imme-  
2 diately following a month in which the State determines  
3 that the individual is no longer a cost-sharing subsidy eli-  
4 gible individual.

5 **“SEC. 1954. ELIGIBILITY DETERMINATIONS.**

6 “(a) IN GENERAL.—The Secretary shall promulgate  
7 regulations specifying requirements for State programs  
8 under this part with respect to determining eligibility for  
9 premium and cost-sharing assistance, including require-  
10 ments with respect to—

11 “(1) application procedures;

12 “(2) information verification procedures;

13 “(3) timeliness of eligibility determinations;

14 “(4) procedures for applicants to appeal adverse  
15 decisions; and

16 “(5) any other matters determined appropriate  
17 by the Secretary.

18 “(b) SPECIFICATIONS FOR REGULATIONS.—The reg-  
19 ulations promulgated by the Secretary under subsection  
20 (a) shall include the following requirements:

21 “(1) FREQUENCY OF APPLICATIONS.—A State  
22 program shall provide that an individual may file an  
23 application for assistance with an agency designated  
24 by the State at any time, in person or by mail.

1           “(2) APPLICATION FORM.—A State program  
2 shall provide for the use of an application form de-  
3 veloped by the Secretary under subsection (c).

4           “(3) DISTRIBUTION OF APPLICATIONS.—A  
5 State program shall distribute applications for as-  
6 sistance through employers and appropriate public  
7 agencies.

8           “(4) REQUIREMENT TO SUBMIT REVISED AP-  
9 PPLICATION.—A State program shall, in accordance  
10 with regulations promulgated by the Secretary, re-  
11 quire individuals to submit revised applications dur-  
12 ing a year to reflect changes in estimated family in-  
13 comes, including changes in employment status of  
14 family members, during the year. The State shall re-  
15 vise the amount of any premium assistance based on  
16 such a revised application.

17           “(5) PRESUMPTIVE ELIGIBILITY FOR PREG-  
18 NANT WOMEN.—A State program shall, in accord-  
19 ance with regulations promulgated by the Secretary,  
20 establish a system under which pregnant women  
21 may be determined presumptively eligible for assist-  
22 ance under this part for a period determined appro-  
23 priate by the Secretary.

24           “(6) AFDC APPLICANTS.—A State program  
25 shall include a procedure under which individuals

1 applying for benefits under title IV shall have an op-  
2 portunity to apply for assistance under this part in  
3 connection with such application.

4 “(7) VERIFICATION.—A State program shall  
5 provide for verification of the information supplied  
6 in applications under this part. Such verification  
7 may include examining return information disclosed  
8 to the State for such purpose under section  
9 6103(l)(15) of the Internal Revenue Code of 1986.

10 “(c) ADMINISTRATION OF STATE PROGRAMS.—

11 “(1) IN GENERAL.—The Secretary shall estab-  
12 lish standards for States operating programs under  
13 this part which ensure that such programs are oper-  
14 ated in a uniform manner with respect to application  
15 procedures, data processing systems, and such other  
16 administrative activities as the Secretary determines  
17 to be necessary.

18 “(2) APPLICATION FORMS.—The Secretary  
19 shall develop an application form for assistance  
20 which shall—

21 “(A) be simple in form and understandable  
22 to the average individual;

23 “(B) require the provision of information  
24 necessary to make a determination as to wheth-  
25 er an individual is a premium or cost-sharing

1           subsidy eligible individual including a declara-  
2           tion of estimated income by the individual  
3           based, at the election of the individual—

4                   “(i) on multiplying by a factor of 4  
5                   the individual’s family income for the 3-  
6                   month period immediately preceding the  
7                   month in which the application is made, or

8                   “(ii) on estimated income for the en-  
9                   tire year for which the application is sub-  
10                  mitted; and

11                  “(C) require attachment of such docu-  
12                  mentation as deemed necessary by the Sec-  
13                  retary in order to ensure eligibility for assist-  
14                  ance.

15                  “(3) OUTREACH ACTIVITIES.—A State operat-  
16                  ing a program under this part shall conduct such  
17                  outreach activities as the Secretary determines ap-  
18                  propriate.

19                  “(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM  
20                  SUBSIDIES.—A determination by a State that an individ-  
21                  ual is a premium subsidy eligible individual shall be effec-  
22                  tive for the calendar year for which such determination  
23                  is made unless a revised application submitted under sub-  
24                  section (b)(4) indicates that an individual is no longer eli-  
25                  gible for premium assistance.

1       “(e) PENALTIES FOR MATERIAL MISREPRESENTA-  
2 TIONS.—

3           “(1) IN GENERAL.—Any individual who know-  
4 ingly makes a material misrepresentation of infor-  
5 mation in an application for assistance under this  
6 part shall be liable to the Federal Government for  
7 the amount any premium assistance and cost-shar-  
8 ing assistance received by individual on the basis of  
9 a misrepresentation and interest on such amount at  
10 a rate specified by the Secretary, and shall, in addi-  
11 tion, be liable to the Federal Government for \$2,000  
12 or, if greater, 3 times the amount any premium as-  
13 sistance and cost-sharing assistance received by indi-  
14 vidual on the basis of a misrepresentation.

15           “(2) COLLECTION OF PENALTY AMOUNTS.—A  
16 State which receives an application for assistance  
17 with respect to which a material misrepresentation  
18 has been made shall collect the penalty amount re-  
19 quired under paragraph (1) and submit 50 percent  
20 of such amount to the Secretary in a timely manner.

21 **“SEC. 1955. END-OF-YEAR RECONCILIATION FOR PREMIUM**  
22 **ASSISTANCE.**

23           “(a) IN GENERAL.—

24           “(1) REQUIREMENT TO FILE STATEMENT.—An  
25 individual who received premium assistance under

1 this part from a State for any month in a calendar  
2 year shall file with the State an income reconcili-  
3 ation statement to verify the individual's family in-  
4 come for the year. Such a statement shall be filed  
5 at such time, and contain such information, as the  
6 State may specify in accordance with regulations  
7 promulgated by the Secretary.

8 “(2) NOTICE OF REQUIREMENT.—A State shall  
9 provide a written notice of the requirement under  
10 paragraph (1) at the end of the year to an individual  
11 who received premium assistance under this part  
12 from such State in any month during the year.

13 “(b) RECONCILIATION OF PREMIUM ASSISTANCE  
14 BASED ON ACTUAL INCOME.—

15 “(1) IN GENERAL.—Based on and using the in-  
16 come reported in the reconciliation statement filed  
17 under subsection (a) with respect to an individual,  
18 the State shall compute the amount of premium as-  
19 sistance that should have been provided under this  
20 part with respect to the individual for the year in-  
21 volved.

22 “(2) OVERPAYMENT OF ASSISTANCE.—If the  
23 total amount of the premium assistance provided  
24 was greater than the amount computed under para-  
25 graph (1), the individual is liable to the State to pay

1 an amount equal to the amount of the excess pay-  
2 ment. Any amount collected by a State under this  
3 paragraph shall be submitted to the Secretary in a  
4 timely manner.

5 “(3) UNDERPAYMENT OF ASSISTANCE.—If the  
6 total amount of the premium assistance provided  
7 was less than the amount computed under para-  
8 graph (1), the State shall pay to the individual an  
9 amount equal to the amount of the deficit.

10 “(4) STATE OPTION.—A State may, in accord-  
11 ance with regulations promulgated by the Secretary,  
12 establish a procedure under which any overpayments  
13 or underpayments of premium assistance determined  
14 under paragraphs (2) and (3) with respect to an in-  
15 dividual for a year may be collected or paid, as ap-  
16 propriate, through adjustments to the premium as-  
17 sistance furnished to such individual in the succeed-  
18 ing year.

19 “(c) VERIFICATION.—Each State may use such infor-  
20 mation as it has available to verify income of individuals  
21 with applications filed under this part, including return  
22 information disclosed to the State for such purpose under  
23 section 6103(l)(15) of the Internal Revenue Code of 1986.

24 “(d) PENALTIES FOR FAILURE TO FILE.—In the  
25 case of an individual who is required to file a statement

1 under this section in a year who fails to file such a state-  
2 ment by such date as the Secretary shall specify in regula-  
3 tions, the entire amount of the premium assistance pro-  
4 vided in such year shall be considered an excess amount  
5 under subsection (b)(2) and such individual shall not be  
6 eligible for premium assistance under this part until such  
7 statement is filed. A State, using rules established by the  
8 Secretary, shall waive the application of this subsection  
9 if the individual establishes, to the satisfaction of the State  
10 under such rules, good cause for the failure to file the  
11 statement on a timely basis.

12 “(e) PENALTIES FOR FALSE INFORMATION.—Any in-  
13 dividual who provides false information in a statement  
14 filed under subsection (a) is subject to the same penalties  
15 as are provided under section 1954(e) for a misrepresenta-  
16 tion of material fact described in such section.

17 “(f) NO RECONCILIATION FOR COST-SHARING RE-  
18 DUCTIONS.—No reconciliation statement is required under  
19 this section with respect to cost-sharing assistance pro-  
20 vided under section 1953.

21 **“SEC. 1956. PAYMENTS TO STATES.**

22 “(a) IN GENERAL.—

23 “(1) PAYMENTS FOR PREMIUM ASSISTANCE.—A  
24 State operating a program for furnishing premium  
25 assistance under section 1952 shall be entitled to re-

1       ceive payments in an amount equal to the amount  
2       of premium assistance paid on behalf of premium  
3       subsidy eligible individuals. Such payments shall be  
4       made at such time and in such form as provided in  
5       regulations promulgated by the Secretary.

6               “(2) MATCHING PAYMENTS FOR ADMINISTRA-  
7       TIVE EXPENSES.—The Secretary shall pay to each  
8       State operating a program for furnishing premium  
9       assistance under section 1952 and determining eligi-  
10      bility for cost-sharing assistance under section 1953,  
11      for each quarter beginning with the quarter com-  
12      mencing January 1, 1996, an amount equal to 75  
13      percent of the total amount expended by the State  
14      during the quarter as found necessary by the Sec-  
15      retary for the proper and efficient administration of  
16      the program.

17              “(3) STATE ENTITLEMENT.—This subsection  
18      constitutes budget authority in advance of appro-  
19      priations Acts, and represents the obligation of the  
20      Federal Government to provide payments to States  
21      operating programs under this part in accordance  
22      with this subsection.

23              “(b) FUNDING.—The amount paid to States under  
24      subsection (a) shall be paid by the Secretary from—

1           “(1) amounts made available under the Health  
2           Security Trust Fund established under section 9551  
3           of the Internal Revenue Code of 1986, or

4           “(2) if such amounts are insufficient, out of  
5           any funds in the Treasury of the United States not  
6           otherwise appropriated.

7           “(c) AUDITS.—The Secretary shall conduct regular  
8           audits of the activities under the State programs con-  
9           ducted under this part.

10   **“SEC. 1957. GRANT PROGRAM FOR PROVIDING COST-SHAR-**  
11                           **ING ASSISTANCE FOR CERTAIN INDIVIDUALS**  
12                           **WITH INCOMES ABOVE 100 PERCENT OF THE**  
13                           **POVERTY LINE.**

14           “(a) ESTABLISHMENT.—The Secretary shall pay to  
15           a State which elects to operate a cost-sharing assistance  
16           program under this section beginning on or after January  
17           1, 1997, the amount determined under subsection (c).

18           “(b) PROGRAM DESCRIBED.—

19           “(1) IN GENERAL.—A program described in  
20           this subsection consists of a State providing cost-  
21           sharing assistance to individuals enrolled in certified  
22           standard health plans whose family income deter-  
23           mined under section 1958(2) exceeds 100 percent  
24           but does not exceed 200 percent of the poverty line.

1           “(2) ELIGIBILITY AND ADMINISTRATION.—A  
2 State operating a program under this subsection  
3 shall be responsible for administering the program,  
4 including—

5                   “(A) establishing eligibility requirements  
6 for individuals applying for assistance under the  
7 program; and

8                   “(B) with respect to an eligible individual,  
9 determining the appropriate amount of cost-  
10 sharing that will be paid by the program.

11           “(3) PAYMENTS FOR COST-SHARING.—The  
12 amount of cost-sharing assistance available to an eli-  
13 gible individual under this section (as determined in  
14 accordance with paragraph (2)(B)) shall be paid by  
15 the State directly to the certified standard health  
16 plan in which the individual is enrolled.

17           “(c) FEDERAL PAYMENT AMOUNT.—

18                   “(1) IN GENERAL.—The Secretary shall pay a  
19 State operating a program under this section during  
20 a quarter an amount equal to 50 percent of the sum  
21 of—

22                           “(A) the amount demonstrated by the  
23 State to have been expended during the quarter  
24 for furnishing cost-sharing assistance under  
25 this section to eligible individuals; and

1           “(B) the amount expended during the  
2 quarter as found necessary by the Secretary for  
3 the proper and efficient administration of the  
4 program.

5           “(2) LIMITATION ON FEDERAL PAYMENTS.—

6           “(A) IN GENERAL.—The total amount paid  
7 to a State under paragraph (1) for a fiscal year  
8 shall not exceed the amount determined under  
9 subparagraph (B).

10           “(B) AMOUNT DETERMINED.—

11           “(i) IN GENERAL.—Except as pro-  
12 vided in clause (ii), the amount determined  
13 under this subparagraph for a State for a  
14 fiscal year is the product of—

15                   “(I) \$2,000,000,000; multiplied

16                   by

17                   “(II) the ratio of the average  
18 population of the State during the fis-  
19 cal year as estimated by the Secretary  
20 to the average population of all States  
21 during the fiscal year as estimated by  
22 the Secretary.

23           “(ii) SPECIAL RULE FOR FISCAL YEAR  
24 1998.—The amount determined under this  
25 subparagraph for a State for fiscal year

1           1998 shall be an amount equal to 75 per-  
2           cent of the amount determined under  
3           clause (i) for such fiscal year.

4           “(iii) FUNDING.—The amount paid to  
5           a State under this subsection shall be paid  
6           by the Secretary from amounts made avail-  
7           able under the Health Security Trust  
8           Fund established under section 9551 of  
9           the Internal Revenue Code of 1986.

10           “(3) ADDITIONAL LIMITATION ON PAYMENTS.—  
11           For requirement that the President reduce the pay-  
12           ments to States under this subsection, see section  
13           801 of the Health Security Act.

14           “(4) AUDITS.—The Secretary shall conduct reg-  
15           ular audits of the activities under the State pro-  
16           grams conducted under this section.

17           **“SEC. 1958. DEFINITIONS AND DETERMINATIONS OF IN-**  
18           **COME.**

19           “For purposes of this part:

20           “(1) CERTIFIED STANDARD HEALTH PLAN.—  
21           The term ‘certified standard health plan’ means a  
22           certified health plan (within the meaning of section  
23           21011(a)(1)) providing the standard benefits pack-  
24           age as described in section 21201(a).

25           “(2) DETERMINATIONS OF INCOME.—

1           “(A) FAMILY INCOME.—The term ‘family  
2 income’ means, with respect to an individual  
3 who—

4           “(i) is not a dependent (as defined in  
5 subparagraph (B)) of another individual,  
6 the sum of the modified adjusted gross in-  
7 comes (as defined in subparagraph (D))  
8 for the individual, the individual’s spouse,  
9 and dependents of the individual; or

10           “(ii) is a dependent of another indi-  
11 vidual, the sum of the modified adjusted  
12 gross incomes for the other individual, the  
13 other individual’s spouse, and dependents  
14 of the other individual.

15           “(B) DEPENDENT.—The term ‘dependent’  
16 shall have the meaning given such term under  
17 paragraphs (1) or (2) of section 152(a) of the  
18 Internal Revenue Code of 1986.

19           “(C) SPECIAL RULE FOR FOSTER CHIL-  
20 DREN.—For purposes of subparagraph (A), a  
21 child who is placed in foster care by a State  
22 agency shall not be considered a dependent of  
23 another individual.

24           “(D) MODIFIED ADJUSTED GROSS IN-  
25 COME.—The term ‘modified adjusted gross in-

1           come' means adjusted gross income (as defined  
2           in section 62(a) of the Internal Revenue Code  
3           of 1986)—

4                   “(i) determined without regard to sec-  
5                   tions 135, 162(l), 911, 931, and 933 of  
6                   such Code, and

7                   “(ii) increased by—

8                           “(I) the amount of interest re-  
9                           ceived or accrued by the individual  
10                           during the taxable year which is ex-  
11                           empt from tax,

12                           “(II) the amount of the social se-  
13                           curity benefits (as defined in section  
14                           86(d) of such Code) received during  
15                           the taxable year to the extent not in-  
16                           cluded in gross income under section  
17                           86 of such Code, and

18                           “(III) the amount of aid to fami-  
19                           lies with dependent children received  
20                           during the taxable year under part A  
21                           of title IV to the extent not included  
22                           in gross income under such Code.

23           The determination under the preceding sen-  
24           tence shall be made without regard to any car-  
25           ryover or carryback.

1 “(3) ELIGIBLE INDIVIDUAL.—

2 “(A) IN GENERAL.—The term ‘eligible in-  
3 dividual’ means an individual who is residing in  
4 the United States and who is—

5 “(i) a citizen or national of the United  
6 States; or

7 “(ii) an alien permanently residing in  
8 the United States under color of law (as  
9 defined in subparagraph (C)).

10 “(B) EXCLUSION.—The term ‘eligible indi-  
11 vidual’ shall not include an individual who is an  
12 inmate of a public institution (except as a pa-  
13 tient of a medical institution).

14 “(C) ALIEN PERMANENTLY RESIDING IN  
15 THE UNITED STATES UNDER COLOR OF LAW.—  
16 The term ‘alien permanently residing in the  
17 United States under color of law’ means an  
18 alien lawfully admitted for permanent residence  
19 (within the meaning of section 101(a)(20) of  
20 the Immigration and Nationality Act), and in-  
21 cludes any of the following:

22 “(i) An alien who is admitted as a ref-  
23 ugee under section 207 of the Immigration  
24 and Nationality Act.

1           “(ii) An alien who is granted asylum  
2           under section 208 of such Act.

3           “(iii) An alien whose deportation is  
4           withheld under section 243(h) of such Act.

5           “(iv) An alien who is admitted for  
6           temporary residence under section 210,  
7           210A, or 245A of such Act.

8           “(v) An alien who has been paroled  
9           into the United States under section  
10          212(d)(5) of such Act for an indefinite pe-  
11          riod or who has been granted extended vol-  
12          untary departure as a member of a nation-  
13          ality group.

14          “(vi) An alien who is the spouse or  
15          unmarried child under 21 years of age of  
16          a citizen of the United States, or the par-  
17          ent of such a citizen if the citizen is over  
18          21 years of age, and with respect to whom  
19          an application for adjustment to lawful  
20          permanent residence is pending.

21          “(4) MEDICAL CONSUMER PRICE INDEX.—The  
22          term ‘medical consumer price index’ means the med-  
23          ical care services component of the consumer price  
24          index (for urban consumers) as determined by the  
25          Bureau of Labor Statistics.

1           “(5) POVERTY LINE.—The term ‘poverty line’  
2 means the income official poverty line (as defined by  
3 the Office of Management and Budget, and revised  
4 annually in accordance with section 673(2) of the  
5 Omnibus Budget Reconciliation Act of 1981) that—

6           “(A) in the case of a family of less than  
7 five individuals, is applicable to a family of the  
8 size involved; and

9           “(B) in the case of a family of more than  
10 four individuals, is applicable to a family of  
11 four persons.

12           “(6) PREGNANT WOMAN.—The term ‘pregnant  
13 woman’ means a woman described in section  
14 1902(l)(1)(A).

15           “(7) PREMIUM.—Any reference to the term  
16 ‘premium’ includes a reference to premium equiva-  
17 lence for self-insured plans.”.

18           (c) CONFORMING AMENDMENTS.—(1) Title XIX of  
19 the Social Security Act (42 U.S.C. 1396 et seq.) is amend-  
20 ed by striking the title and inserting the following:

1 **“TITLE XIX—MEDICAL ASSIST-**  
2 **ANCE PROGRAMS AND STATE**  
3 **PROGRAMS FOR PREMIUM**  
4 **AND COST-SHARING ASSIST-**  
5 **ANCE**

6 **“PART A—GRANTS TO STATES FOR MEDICAL**  
7 **ASSISTANCE PROGRAMS”.**

8 (2) Title XIX of the Social Security Act (42 U.S.C.  
9 1396 et seq.) is amended by striking each reference to  
10 “this title” and inserting “this part”.

11 **TITLE IV—ADMINISTRATIVE**  
12 **SIMPLIFICATION AND PRIVACY**

13 **SEC. 401. ADMINISTRATIVE SIMPLIFICATION.**

14 (a) **MEDICARE AND MEDICAID COVERAGE DATA**  
15 **BANK AND RELATED IDENTIFICATION PROCESSES.—**

16 (1) **DELAY OF EMPLOYER REPORTING RE-**  
17 **QUIREMENT.—**

18 (A) **IN GENERAL.—**Section 1144(c)(1)(A)  
19 of the Social Security Act (42 U.S.C. 1320–  
20 14(c)(1)(A)) is amended by striking “January  
21 1, 1994” and inserting “January 1, 1996”.

22 (B) **EFFECTIVE DATE.—**The amendment  
23 made by this paragraph shall be effective on the  
24 date of the enactment of this Act.

25 (2) **REPEAL OF DATA BANK.—**

1 (A) IN GENERAL.—Effective January 1,  
2 1996, section 1144 of the Social Security Act  
3 (42 U.S.C. 1320b–14) and section 101(f) of the  
4 Employee Retirement Income Security Act of  
5 1974 (29 U.S.C. 1021(f)) are repealed.

6 (B) INTERNAL REVENUE CODE PROVI-  
7 SION.—Section 6103(*l*) of the Internal Revenue  
8 Code of 1986 is amended by striking paragraph  
9 (12).

10 (C) IDENTIFICATION OF MEDICARE SEC-  
11 ONDARY PAYER SITUATIONS.—Section 1862(b)  
12 of the Social Security Act (42 U.S.C. 1395y(b))  
13 is amended by striking paragraph (5).

14 (D) CONFORMING AMENDMENTS.—(i) Sec-  
15 tion 1902(a)(25)(A)(i) of the Social Security  
16 Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended  
17 by striking “including the use of information  
18 collected by the Medicare and Medicaid Cov-  
19 erage Data Bank under section 1144 and any  
20 additional measures”.

21 (ii) Subsection (a)(8)(B) of section 552a of  
22 title 5, United States Code, is amended—

23 (I) in clause (v), by inserting “; or” at  
24 the end;

1 (II) in clause (vi), by striking “or” at  
2 the end; and

3 (III) by striking clause (vii).

4 (E) EFFECTIVE DATE.—The amendments  
5 made by this paragraph shall be effective on  
6 and after January 1, 1996.

7 (b) HEALTH INFORMATION NETWORK.—

8 (1) IN GENERAL.—Title XI of the Social Secu-  
9 rity Act (42 U.S.C. 1301 et seq.) is amended by  
10 adding at the end the following new subtitle:

11 **“Subtitle B—Administrative**  
12 **Simplification**

“TABLE OF CONTENTS OF SUBTITLE

“Subtitle B—Administrative Simplification

“PART I—PURPOSE AND DEFINITIONS

“Sec. 11701. Purpose.

“Sec. 11702. Definitions.

“PART II—STANDARDS FOR DATA ELEMENTS AND INFORMATION  
TRANSACTIONS

“Sec. 11711. General requirements on Secretary.

“Sec. 11712. Standards for data elements of health information.

“Sec. 11713. Information transaction standards.

“Sec. 11714. Timetables for adoption of standards.

“PART III—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS  
AND INFORMATION

“Sec. 11721. Requirements with respect to certain transactions and infor-  
mation.

“Sec. 11722. Timetables for compliance with requirements.

“PART IV—ACCESSING HEALTH INFORMATION

“Sec. 11731. Accessing health information for authorized purposes.

“Sec. 11732. Responding to access requests.

“Sec. 11733. Length of time information should be accessible.

“Sec. 11734. Timetables for adoption of standards and compliance.

“PART V—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

- “Sec. 11741. Standards and certification for health information network services.  
 “Sec. 11742. Ensuring availability of information.

“PART VI—PENALTIES

- “Sec. 11751. General penalty for failure to comply with requirements and standards.

“PART VII—MISCELLANEOUS PROVISIONS

- “Sec. 11761. Imposition of additional requirements.  
 “Sec. 11762. Effect on State law.  
 “Sec. 11764. Health information continuity.  
 “Sec. 11765. Protection of commercial information.  
 “Sec. 11766. Payment for health care services or health plan premiums.  
 “Sec. 11767. Health security cards.  
 “Sec. 11768. Misuse of health security card or personal health identifier.  
 “Sec. 11769. Direct billing for clinical laboratory services.  
 “Sec. 11770. Authorization of appropriations.

“PART VIII—ASSISTANCE TO THE SECRETARY

- “Sec. 11771. General requirement on Secretary.  
 “Sec. 11772. Health information advisory committee.

“PART IX—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL INFORMATION SYSTEMS

- “Sec. 11781. Grants for demonstration projects.

1           **“PART I—PURPOSE AND DEFINITIONS**

2           **“SEC. 11701. PURPOSE.**

3           “It is the purpose of this subtitle to improve the effi-  
 4           ciency and effectiveness of the health care system, includ-  
 5           ing the medicare program under title XVIII and the med-  
 6           icaid program under title XIX, by encouraging the devel-  
 7           opment of a health information network through the es-  
 8           tablishment of standards and requirements for the elec-  
 9           tronic transmission of certain health information.

10          **“SEC. 11702. DEFINITIONS.**

11          “For purposes of this subtitle:

1           “(1) CODE SET.—The term ‘code set’ means  
2 any set of codes used for encoding data elements,  
3 such as tables of terms, medical concepts, medical  
4 diagnostic codes, or medical procedure codes.

5           “(2) COORDINATION OF BENEFITS.—The term  
6 ‘coordination of benefits’ means determining and co-  
7 ordinating the financial obligations of health plans  
8 when health care benefits are payable under 2 or  
9 more health plans.

10           “(3) HEALTH CARE PROVIDER.—The term  
11 ‘health care provider’ includes a provider of services  
12 (as defined in section 1861(u)), a provider of medi-  
13 cal or other health services (as defined in section  
14 1861(s)), and any other person furnishing health  
15 care services or supplies.

16           “(4) HEALTH INFORMATION.—The term ‘health  
17 information’ means any information, whether oral or  
18 recorded in any form or medium that—

19           “(A) is created or received by a health care  
20 provider, health plan, health oversight agency  
21 (as defined in section 11802), health re-  
22 searcher, public health authority (as defined in  
23 section 11802), employer, life insurer, school or  
24 university, or health information network serv-  
25 ice certified under section 11741; and

1           “(B) relates to the past, present, or future  
2           physical or mental health or condition of an in-  
3           dividual, the provision of health care to an indi-  
4           vidual, or the past, present, or future payment  
5           for the provision of health care to an individual.

6           “(5) HEALTH INFORMATION NETWORK.—The  
7           term ‘health information network’ means the health  
8           information system that is formed through the appli-  
9           cation of the requirements and standards established  
10          under this subtitle.

11          “(6) HEALTH INFORMATION PROTECTION OR-  
12          GANIZATION.—The term ‘health information protec-  
13          tion organization’ means a private entity or an en-  
14          tity operated by a State that accesses standard data  
15          elements of health information through the health  
16          information network, processes such information  
17          into non-identifiable health information, and may  
18          store such information.

19          “(7) HEALTH INFORMATION NETWORK SERV-  
20          ICE.—The term ‘health information network serv-  
21          ice’—

22                  “(A) means a private entity or an entity  
23                  operated by a State that enters into contracts  
24                  to—

1           “(i) process or facilitate the process-  
2           ing of nonstandard data elements of health  
3           information into standard data elements;

4           “(ii) provide the means by which per-  
5           sons are connected to the health informa-  
6           tion network for purposes of meeting the  
7           requirements of this subtitle, including the  
8           holding of standard data elements of  
9           health information;

10          “(iii) provide authorized access to  
11          health information through the health in-  
12          formation network; or

13          “(iv) provide specific information  
14          processing services, such as automated co-  
15          ordination of benefits and claims trans-  
16          action routing; and

17          “(B) includes a health information protec-  
18          tion organization.

19          “(8) HEALTH PLAN.—The term ‘health plan’  
20          has the meaning given such term in section  
21          21004(a)(1) except that such term shall include sub-  
22          paragraphs (C), (D), (E), (F), and (H) of such sec-  
23          tion.

24          “(9) NON-IDENTIFIABLE HEALTH INFORMA-  
25          TION.—The term ‘non-identifiable health informa-

1       tion’ means health information that is not protected  
2       health information as defined in section 11802.

3           “(10) HEALTH RESEARCHER.—The term  
4       ‘health researcher’ shall have the meaning given  
5       such term under section 11802.

6           “(11) PATIENT MEDICAL RECORD INFORMA-  
7       TION.—The term ‘patient medical record informa-  
8       tion’ means health information derived from a clini-  
9       cal encounter that relates to the physical or mental  
10       condition of an individual.

11          “(12) STANDARD.—The term ‘standard’ when  
12       referring to an information transaction or to data  
13       elements of health information means the trans-  
14       action or data elements meet any standard adopted  
15       by the Secretary under part II that applies to such  
16       information transaction or data elements.

17       **“PART II—STANDARDS FOR DATA ELEMENTS**  
18           **AND INFORMATION TRANSACTIONS**

19       **“SEC. 11711. GENERAL REQUIREMENTS ON SECRETARY.**

20          “(a) IN GENERAL.—The Secretary shall adopt stand-  
21       ards and modifications to standards under this subtitle  
22       that are—

23           “(1) consistent with the objective of reducing  
24       the costs of providing and paying for health care;  
25       and

1           “(2) in use and generally accepted or developed  
2           or modified by the standards setting organizations  
3           accredited by the American National Standard Insti-  
4           tute (ANSI).

5           “(b) INITIAL STANDARDS.—The Secretary may de-  
6           velop an expedited process for the adoption of initial  
7           standards under this subtitle.

8           “(c) FAILSAFE.—If the Secretary is unable to adopt  
9           standards or modified standards in accordance with sub-  
10          section (a) that meet the requirements of this subtitle—

11           “(1) the Secretary may develop or modify such  
12          standards and, after providing public notice and  
13          after an adequate period for public comment, adopt  
14          such standards; and

15           “(2) if the Secretary adopts standards under  
16          paragraph (1), the Secretary shall submit a report  
17          to the appropriate committees of Congress on the  
18          actions taken by the Secretary under this subsection.

19           “(d) PAPER FORMATS.—The Secretary may develop  
20          methods by which a person may use the standards adopted  
21          by the Secretary under this subtitle with respect to health  
22          information that is in written rather than electronic form.

1 **“SEC. 11712. STANDARDS FOR DATA ELEMENTS OF HEALTH**  
2 **INFORMATION.**

3 “(a) IN GENERAL.—The Secretary shall adopt stand-  
4 ards necessary to make data elements of the following  
5 health information uniform and compatible for electronic  
6 transmission through the health information network:

7 “(1) the health information that is appropriate  
8 for transmission in connection with transactions de-  
9 scribed in subsections (a), (b), and (d) of section  
10 11721;

11 “(2) the information required to be submitted  
12 by a health plan to a State under section 21013;  
13 and

14 “(3) patient medical record information.

15 “(b) ADDITIONS.—The Secretary may make addi-  
16 tions to the sets of data elements adopted under sub-  
17 section (a) as the Secretary determines appropriate in a  
18 manner that minimizes the disruption and cost of compli-  
19 ance with such additions.

20 “(c) CERTAIN DATA ELEMENTS.—

21 “(1) UNIQUE HEALTH IDENTIFIERS.—The Sec-  
22 retary shall establish a system to provide for a  
23 standard unique health identifier for each individual,  
24 employer, health plan, and health care provider for  
25 use in the health care system. The personal health  
26 identifier for an individual shall be an encrypted

1 form of the social security account number assigned  
2 to the individual by the Secretary under section  
3 205(c)(2).

4 “(2) CODE SETS.—

5 “(A) IN GENERAL.—The Secretary, in con-  
6 sultation with experts from the private sector  
7 and Federal agencies, shall—

8 “(i) select code sets for appropriate  
9 data elements from among the code sets  
10 that have been developed by private and  
11 public entities; or

12 “(ii) establish code sets for such data  
13 elements if no code sets for the data ele-  
14 ments have been developed.

15 “(B) DISTRIBUTION.—The Secretary shall  
16 establish efficient and low-cost procedures for  
17 distribution of code sets and modifications to  
18 such code sets under section 11714(c).

19 **“SEC. 11713. INFORMATION TRANSACTION STANDARDS.**

20 “(a) IN GENERAL.—The Secretary shall adopt tech-  
21 nical standards relating to the method by which data ele-  
22 ments of health information that have been standardized  
23 under section 11712 may be transmitted electronically, in-  
24 cluding standards with respect to the format in which such  
25 data elements shall be transmitted.

1       “(b) SPECIAL RULE FOR COORDINATION OF BENE-  
2 FITS.—Any standards adopted by the Secretary under  
3 paragraph (1) that relate to coordination of benefits shall  
4 provide that a claim for reimbursement for medical serv-  
5 ices furnished is tested by an algorithm specified by the  
6 Secretary against all records of enrollment and eligibility  
7 for the individual who received such services to determine  
8 any primary and secondary obligors for payment.

9       “(c) ELECTRONIC SIGNATURE.—The Secretary, in  
10 coordination with the Secretary of Commerce, shall pro-  
11 mulgate regulations specifying procedures for the elec-  
12 tronic transmission and authentication of signatures, com-  
13 pliance with which will be deemed to satisfy State and  
14 Federal statutory requirements for written signatures with  
15 respect to information transactions required by this Act  
16 and written signatures on medical records and prescrip-  
17 tions.

18 **“SEC. 11714. TIMETABLES FOR ADOPTION OF STANDARDS.**

19       “(a) INITIAL STANDARDS FOR DATA ELEMENTS.—  
20 The Secretary shall adopt standards relating to—

21               “(1) the data elements for the information de-  
22 scribed in section 11712(a)(1) not later than 9  
23 months after the date of the enactment of this sub-  
24 title (except in the case of standards with respect to  
25 data elements for claims attachments which shall be

1 adopted not later than 24 months after the date of  
2 the enactment of this subtitle);

3 “(2) the data elements for the information de-  
4 scribed in section 11712(a)(2) not later than 9  
5 months after the date of the enactment of this sub-  
6 title;

7 “(3) data elements for patient medical record  
8 information not earlier than 24 months and not  
9 later than 7 years after the date of the enactment  
10 of this subtitle; and

11 “(4) any addition to a set of data elements, in  
12 conjunction with making such an addition.

13 “(b) INITIAL STANDARDS FOR INFORMATION TRANS-  
14 ACTIONS.—The Secretary shall adopt standards relating  
15 to information transactions under section 11713 not later  
16 than 9 months after the date of the enactment of this sub-  
17 title (except in the case of standards for claims attach-  
18 ments which shall be adopted not later than 24 months  
19 after the date of the enactment of this subtitle).

20 “(c) MODIFICATIONS TO STANDARDS.—

21 “(1) IN GENERAL.—Except as provided in para-  
22 graph (2), the Secretary shall review the standards  
23 adopted under this subtitle and shall adopt modified  
24 standards as determined appropriate, but no more  
25 frequently than once every 6 months. Any modifica-

1       tion to standards shall be completed in a manner  
2       which minimizes the disruption and cost of compli-  
3       ance.

4           “(2) SPECIAL RULES.—

5               “(A) MODIFICATIONS DURING FIRST 12-  
6               MONTH PERIOD.—Except with respect to addi-  
7               tions and modifications to code sets under sub-  
8               paragraph (B), the Secretary shall not adopt  
9               any modifications to standards adopted under  
10              this subtitle during the 12-month period begin-  
11              ning on the date such standards are adopted  
12              unless the Secretary determines that a modi-  
13              fication is necessary in order to permit compli-  
14              ance with requirements relating to the stand-  
15              ards.

16           “(B) ADDITIONS AND MODIFICATIONS TO  
17           CODE SETS.—

18               “(i) IN GENERAL.—The Secretary  
19               shall ensure that procedures exist for the  
20               routine maintenance, testing, enhancement,  
21               and expansion of code sets to accommodate  
22               changes in biomedical science and health  
23               care delivery.

24               “(ii) ADDITIONAL RULES.—If a code  
25               set is modified under this subsection, the

1 modified code set shall include instructions  
2 on how data elements that were encoded  
3 prior to the modification are to be con-  
4 verted or translated so as to preserve the  
5 value of the data elements. Any modifica-  
6 tion to a code set under this subsection  
7 shall be implemented in a manner that  
8 minimizes the disruption and cost of com-  
9 plying with such modification.

10 “(d) EVALUATION OF STANDARDS.—The Secretary  
11 may establish a process to measure or verify the consist-  
12 ency of standards adopted or modified under this subtitle.  
13 Such process may include demonstration projects and  
14 analysis of the cost of implementing such standards and  
15 modifications.

16 **“PART III—REQUIREMENTS WITH RESPECT TO**  
17 **CERTAIN TRANSACTIONS AND INFORMATION**

18 **“SEC. 11721. REQUIREMENTS WITH RESPECT TO CERTAIN**  
19 **TRANSACTIONS AND INFORMATION.**

20 “(a) REQUIREMENTS ON PLANS AND PROVIDERS RE-  
21 LATING TO FINANCIAL AND ADMINISTRATIVE TRANS-  
22 ACTIONS.—If a health care provider or a health plan con-  
23 ducts any of the following transactions, such transactions  
24 shall be standard transactions and the information trans-

1 mitted or received in connection with such transaction  
2 shall be in the form of standard data elements:

3 “(1) Claims (including coordination of benefits).

4 “(2) Claims attachments.

5 “(3) Responses to research inquiries by a health  
6 researcher.

7 “(4) Other transactions determined appropriate  
8 by the Secretary consistent with the goal of reducing  
9 administrative costs.

10 “(b) REQUIREMENT ONLY ON PLANS RELATING TO  
11 FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a  
12 person desires to conduct any of the following transactions  
13 with a health plan as a standard transaction, the health  
14 plan shall conduct such standard transaction and the in-  
15 formation transmitted or received in connection with such  
16 transaction shall be in the form of standard data elements:

17 “(1) Enrollment and disenrollment.

18 “(2) Eligibility.

19 “(3) Payment and remittance advice.

20 “(4) Premium payments.

21 “(5) First report of injury.

22 “(6) Claims status.

23 “(7) Referral certification and authorization.

1           “(8) Other transactions determined appropriate  
2           by the Secretary consistent with the goal of reducing  
3           administrative costs.

4           “(c) REQUIREMENT ON PLANS RELATING TO QUAL-  
5           ITY INFORMATION.—Any information required to be sub-  
6           mitted by a health plan to a State under section 21013  
7           shall be in the form of standard data elements and the  
8           transmission of such data shall be in the form of a stand-  
9           ard transaction.

10          “(d) REQUIREMENT ONLY ON PURCHASING CO-  
11          OPERATIVES.—If a person desires to conduct any of the  
12          following transactions with a purchasing cooperative (as  
13          defined in section 21100(14)) as a standard transaction,  
14          the cooperative shall conduct such standard transaction  
15          and the information transmitted or received in connection  
16          with such transaction shall be in the form of standard data  
17          elements:

18                 “(1) Enrollment and disenrollment.

19                 “(2) Premium payments.

20          “(e) REQUIREMENT WITH RESPECT TO DISCLOSURE  
21          OF INFORMATION.—

22                 “(1) IN GENERAL.—A health plan or health  
23          care provider shall make the standard data elements  
24          transmitted or received by such plan or provider in  
25          connection with the transactions described in sub-

1 sections (a), (b), and (c) or acquired under section  
2 11764(a) available for disclosure as authorized by  
3 this subtitle.

4 “(2) SPECIAL RULE.—In the case of a health  
5 care provider that does not file claims, such provider  
6 shall be responsible for making standard data ele-  
7 ments for encounter information available for disclo-  
8 sure as authorized by this subtitle.

9 “(f) SATISFACTION OF REQUIREMENTS.—A health  
10 care provider, health plan, or consumer purchasing cooper-  
11 ative may satisfy the requirement imposed on such pro-  
12 vider, plan, or cooperative under subsection (a), (b), (c),  
13 (d), or (e) by—

14 “(1) directly transmitting standard data ele-  
15 ments;

16 “(2) submitting nonstandard data elements to a  
17 health information network service certified under  
18 section 11741 for processing into standard data ele-  
19 ments and transmission; or

20 “(3) in the case of a provider, submitting data  
21 elements to a plan which satisfies the requirements  
22 imposed on such provider on the provider’s behalf.

23 “(g) TIMELINESS.—A health care provider or health  
24 plan shall be determined to have satisfied a requirement  
25 imposed under this section only if the action required is

1 completed in a timely manner, as determined by the Sec-  
2 retary. In setting standards for timeliness, the Secretary  
3 shall take into consideration the age and the amount of  
4 information being requested.

5 **“SEC. 11722. TIMETABLES FOR COMPLIANCE WITH RE-**  
6 **QUIREMENTS.**

7 “(a) INITIAL COMPLIANCE.—

8 “(1) IN GENERAL.—Not later than 12 months  
9 after the date on which standards are adopted under  
10 part II with respect to a type of transaction or data  
11 elements for a type of health information, a health  
12 plan, health care provider, or purchasing cooperative  
13 shall comply with the requirements of this subtitle  
14 with respect to such transaction or information.

15 “(2) ADDITIONAL DATA ELEMENTS.—Not later  
16 than 12 months after the date on which the Sec-  
17 retary adopts an addition to a set of data elements  
18 for health information under part II, a health plan,  
19 health care provider, or purchasing cooperative shall  
20 comply with the requirements of this subtitle using  
21 such data elements.

22 “(b) COMPLIANCE WITH MODIFIED STANDARDS.—

23 “(1) IN GENERAL.—If the Secretary adopts a  
24 modified standard under part II, a health plan,  
25 health care provider, or purchasing cooperative shall

1 be required to comply with the modified standard at  
2 such time as the Secretary determines appropriate  
3 taking into account the time needed to comply due  
4 to the nature and extent of the modification.

5 “(2) SPECIAL RULE.—In the case of modifica-  
6 tions to standards that do not occur within the 12-  
7 month period beginning on the date such standards  
8 are adopted, the time determined appropriate by the  
9 Secretary under paragraph (1) shall be no sooner  
10 than the last day of the 90-day period beginning on  
11 the date such modified standard is adopted and no  
12 later than the last day of the 12 month period begin-  
13 ning on the date such modified standard is adopted.

14 **“PART IV—ACCESSING HEALTH INFORMATION**

15 **“SEC. 11731. ACCESSING HEALTH INFORMATION FOR AU-**  
16 **THORIZED PURPOSES.**

17 “(a) IN GENERAL.—The Secretary shall adopt tech-  
18 nical standards for appropriate persons, including health  
19 plans, health care providers, health information network  
20 services certified under section 11741, health researchers,  
21 and Federal and State agencies, to locate and access the  
22 health information that is available through the health in-  
23 formation network due to the requirements of this subtitle.  
24 Such technical standards shall ensure that any request to

1 locate or access information shall be authorized under sub-  
2 title C.

3 “(b) PROCUREMENT RULE FOR GOVERNMENT AGEN-  
4 CIES.—

5 “(1) IN GENERAL.—Health information protec-  
6 tion organizations certified under section 11741  
7 shall make available to a Federal or State agency  
8 pursuant to a Federal Acquisition Regulation (or an  
9 equivalent State system), any non-identifiable health  
10 information that is requested by such agency.

11 “(2) CERTAIN INFORMATION AVAILABLE AT  
12 LOW COST.—If a health information protection orga-  
13 nization described in paragraph (1) needs informa-  
14 tion from a health plan or health care provider in  
15 order to comply with a request of a Federal or State  
16 agency that is necessary to comply with a require-  
17 ment under this Act, such plan or provider shall  
18 make such information available to such organiza-  
19 tion for a charge that does not exceed the reasonable  
20 cost of transmitting the information. If requested, a  
21 health information protection organization that re-  
22 ceives information under the preceding sentence  
23 must make such information available to any other  
24 such organization that is certified under section

1 11741 for a charge that does not exceed the reason-  
2 able cost of transmitting the information.

3 “(c) FUNCTIONAL SEPARATION.—The standards  
4 adopted by the Secretary under subsection (a) shall ensure  
5 that any health information disclosed under such sub-  
6 section shall not, after such disclosure, be used or released  
7 for an administrative, regulatory, or law enforcement pur-  
8 pose unless such disclosure was made for such purpose.

9 “(d) PUBLIC USE FUNCTIONS.—Nothing in this sub-  
10 title shall be construed to limit the authority of a Federal  
11 or State agency to make non-identifiable health informa-  
12 tion available for public use functions.

13 **“SEC. 11732. RESPONDING TO ACCESS REQUESTS.**

14 “(a) IN GENERAL.—The Secretary may adopt, and  
15 modify as appropriate, standards under which a health  
16 care provider or health plan shall respond to requests for  
17 access to health information consistent with this subtitle  
18 and subtitle C.

19 “(b) STANDARDS DESCRIBED.—The standards under  
20 subsection (a) shall provide—

21 “(1) for a standard format under which a pro-  
22 vider or plan will respond to each request either by  
23 satisfying the request or responding with an expla-  
24 nation of the specific restriction which results in a  
25 failure to satisfy the request; and



1 frequently than once every 6 months. Any modifica-  
2 tion to standards shall be completed in a manner  
3 which minimizes the disruption and cost of compli-  
4 ance. Any modifications to standards adopted under  
5 this part shall be effective upon adoption.

6 “(2) SPECIAL RULE.—The Secretary shall not  
7 adopt modifications to any standards adopted under  
8 this part during the 12-month period beginning on  
9 the date such standards are adopted unless the Sec-  
10 retary determines that a modification is necessary in  
11 order to permit compliance with the requirements of  
12 this part.

13 **“PART V—STANDARDS AND CERTIFICATION FOR**  
14 **HEALTH INFORMATION NETWORK**

15 **“SEC. 11741. STANDARDS AND CERTIFICATION FOR HEALTH**  
16 **INFORMATION NETWORK SERVICES.**

17 “(a) STANDARDS FOR OPERATION.—The Secretary  
18 shall establish standards with respect to the operation of  
19 health information network services, including standards  
20 ensuring that—

21 “(1) such services develop, operate, and cooper-  
22 ate with one another to form the health information  
23 network;

24 “(2) such services meet all of the requirements  
25 under subtitle C that are applicable to such services;

1           “(3) such services make public information con-  
2           cerning their performance, as measured by uniform  
3           indicators such as accessibility, transaction respon-  
4           siveness, administrative efficiency, reliability, de-  
5           pendability, and any other indicator determined ap-  
6           propriate by the Secretary;

7           “(4) such services have security procedures that  
8           are consistent with the privacy requirements under  
9           subtitle C, including secure methods of access to and  
10          transmission of data;

11          “(5) such services, if they are part of a larger  
12          organization, have policies and procedures in place  
13          which isolate their activities with respect to process-  
14          ing information in a manner that prevents access to  
15          such information by such larger organization.

16          “(b) CERTIFICATION BY THE SECRETARY.—

17          “(1) ESTABLISHMENT.—Not later than 12  
18          months after the date of the enactment of this sub-  
19          title, the Secretary shall establish a certification pro-  
20          cedure for health information network services which  
21          ensures that certified services are qualified to meet  
22          the requirements of this subtitle and the standards  
23          established by the Secretary under this section. Such  
24          certification procedure shall be implemented in a

1 manner that minimizes the costs and delays of oper-  
2 ations for such services.

3 “(2) APPLICATION.—Each entity desiring to be  
4 certified as a health information network service  
5 shall apply to the Secretary for certification in a  
6 form and manner determined appropriate by the  
7 Secretary.

8 “(3) AUDITS AND REPORTS.—The procedure  
9 established under paragraph (1) shall provide for au-  
10 dits by the Secretary and reports by an entity cer-  
11 tified under this section as the Secretary determines  
12 appropriate in order to monitor such entity’s compli-  
13 ance with the requirements of this subtitle, subtitle  
14 C, and the standards established by the Secretary  
15 under this section.

16 “(4) RECERTIFICATION.—A health information  
17 network service must be recertified under this sub-  
18 section at least every 3 years.

19 “(c) LOSS OF CERTIFICATION.—

20 “(1) MANDATORY TERMINATION.—Except as  
21 provided in paragraph (3), if a health information  
22 network service violates a requirement imposed on  
23 such service under subtitle C, its certification under  
24 this section shall be terminated unless the Secretary

1 determines that appropriate corrective action has  
2 been taken.

3 “(2) DISCRETIONARY TERMINATION.—If a  
4 health information network service violates a re-  
5 quirement or standard imposed under this subtitle  
6 and a penalty has been imposed under section  
7 11751, the Secretary shall review the certification of  
8 such service and may terminate such certification.

9 “(3) CONDITIONAL CERTIFICATION.—The Sec-  
10 retary may establish a procedure under which a  
11 health information network service may remain cer-  
12 tified on a conditional basis if the service is operat-  
13 ing consistently with a plan intended to correct any  
14 violations described in paragraphs (1) or (2). Such  
15 procedure may provide for the appointment of a  
16 trustee to continue operation of the service until the  
17 requirements for full certification are met.

18 “(d) CERTIFICATION BY PRIVATE ENTITIES.—The  
19 Secretary may designate private entities to conduct the  
20 certification procedures established by the Secretary under  
21 this section. A health information network service certified  
22 by such an entity in accordance with such designation  
23 shall be considered to be certified by the Secretary.

1 **“SEC. 11742. ENSURING AVAILABILITY OF INFORMATION.**

2 “The Secretary shall establish a procedure under  
3 which a health plan or health care provider which does  
4 not have the ability to transmit standard data elements  
5 directly or does not have access to a health information  
6 network service certified under section 11741 shall be able  
7 to make health information available for disclosure as au-  
8 thorized by this subtitle.

9 **“PART VI—PENALTIES**

10 **“SEC. 11751. GENERAL PENALTY FOR FAILURE TO COMPLY**  
11 **WITH REQUIREMENTS AND STANDARDS.**

12 “(a) IN GENERAL.—Except as provided in subsection  
13 (b), the Secretary shall impose on any person that violates  
14 a requirement or standard imposed under this subtitle a  
15 penalty of not more than \$1,000 for each violation. The  
16 provisions of section 1128A (other than subsections (a)  
17 and (b) and the second sentence of subsection (f)) shall  
18 apply to the imposition of a civil money penalty under this  
19 subsection in the same manner as such provisions apply  
20 to the imposition of a penalty under section 1128A.

21 “(b) LIMITATIONS.—

22 “(1) NONCOMPLIANCE NOT DISCOVERED EXER-  
23 CISING REASONABLE DILIGENCE.—A penalty may  
24 not be imposed under subsection (a) if it is estab-  
25 lished to the satisfaction of the Secretary that the  
26 person liable for the penalty did not know, and by

1 exercising reasonable diligence would not have  
2 known, that such person failed to comply with the  
3 requirement or standard described in subsection (a).

4 “(2) FAILURES DUE TO REASONABLE CAUSE.—

5 “(A) IN GENERAL.—Except as provided in  
6 subparagraphs (B) and (C), a penalty may not  
7 be imposed under subsection (a) if—

8 “(i) the failure to comply was due to  
9 reasonable cause and not to willful neglect;  
10 and

11 “(ii) the failure to comply is corrected  
12 during the 30-day period beginning on the  
13 1st date the person liable for the penalty  
14 knew, or by exercising reasonable diligence  
15 would have known, that the failure to com-  
16 ply occurred.

17 “(B) EXTENSION OF PERIOD.—

18 “(i) NO PENALTY.—The period re-  
19 ferred to in subparagraph (A)(ii) may be  
20 extended as determined appropriate by the  
21 Secretary based on the nature and extent  
22 of the failure to comply.

23 “(ii) ASSISTANCE.—If the Secretary  
24 determines that a health plan, health care  
25 provider, or purchasing cooperative failed

1 to comply because such person was unable  
2 to comply, the Secretary may provide tech-  
3 nical assistance to such person. Such as-  
4 sistance shall be provided in any manner  
5 determined appropriate by the Secretary.

6 “(3) REDUCTION.—In the case of a failure to  
7 comply which is due to reasonable cause and not to  
8 willful neglect, any penalty under subsection (a) that  
9 is not entirely waived under paragraph (2) may be  
10 waived to the extent that the payment of such pen-  
11 alty would be excessive relative to the compliance  
12 failure involved.

13 **“PART VII—MISCELLANEOUS PROVISIONS**

14 **“SEC. 11761. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

15 “(a) DATA ELEMENT STANDARDS.—A person may  
16 not impose a standard on another person that is in addi-  
17 tion to the standards adopted by the Secretary under sec-  
18 tion 11712 unless—

19 “(1) such person voluntarily agrees to such  
20 standard; or

21 “(2) a waiver is granted under subsection (c) to  
22 impose such standard.

23 “(b) TRANSACTIONS AND ACCESS STANDARDS.—A  
24 person may not impose a standard on another person that  
25 is in addition to the standards adopted by the Secretary

1 under section 11713 or 11731 unless such person volun-  
2 tarily agrees to such standard.

3 “(c) CONDITIONS FOR WAIVERS.—

4 “(1) IN GENERAL.—A person may request a  
5 waiver from the Secretary in order to require an-  
6 other person to comply with a standard that is in  
7 addition to the standards adopted by the Secretary  
8 under section 11712.

9 “(2) CONSIDERATION OF WAIVER REQUESTS.—

10 No waiver may be granted unless the Secretary de-  
11 termines that the value of the data to be exchanged  
12 for research or other purposes significantly out-  
13 weighs the administrative cost of the additional  
14 standard taking into consideration the burden of the  
15 timing of the imposition of the additional standard.

16 “(3) ANONYMOUS REPORTING.—If a person at-  
17 tempts to impose a standard in addition to the  
18 standards adopted by the Secretary under section  
19 11712, the person on whom such additional stand-  
20 ard is being imposed may contact the Secretary. The  
21 Secretary shall develop a procedure under which the  
22 contacting person shall remain anonymous. The Sec-  
23 retary shall notify the person imposing the addi-  
24 tional standard that the additional standard may not  
25 be imposed unless the other person voluntarily

1 agrees to such standard or a waiver is obtained  
2 under this subsection.

3 **“SEC. 11762. EFFECT ON STATE LAW.**

4 “(a) IN GENERAL.—A provision, requirement, or  
5 standard under this subtitle shall supersede any contrary  
6 provision of State law, including—

7 “(1) a provision of State law that requires med-  
8 ical or health plan records (including billing informa-  
9 tion) to be maintained or transmitted in written  
10 rather than electronic form, and

11 “(2) a provision of State law which provides for  
12 requirements or standards that are more stringent  
13 than the requirements or standards under this sub-  
14 title;

15 except where the Secretary determines that the provision  
16 is necessary to prevent fraud and abuse, with respect to  
17 controlled substances, or for other purposes.

18 “(b) PUBLIC HEALTH REPORTING.—Nothing in this  
19 subtitle shall be construed to invalidate or limit the au-  
20 thority, power, or procedures established under any law  
21 providing for the reporting of disease or injury, child  
22 abuse, birth, or death, public health surveillance, or public  
23 health investigation or intervention.

1 **“SEC. 11764. HEALTH INFORMATION CONTINUITY.**

2       “(a) INFORMATION HELD BY HEALTH PLANS AND  
3 PROVIDERS.—If a health plan or health care provider  
4 takes any action that would threaten the continued avail-  
5 ability of the standard data elements of health information  
6 held by such plan or provider, such data elements shall  
7 be obtained by the State in which such plan or provider  
8 is located. The State shall ensure that such data elements  
9 are transferred to a health plan or health care provider  
10 in accordance with procedures established by the Sec-  
11 retary.

12       “(b) INFORMATION HELD BY HEALTH INFORMATION  
13 NETWORK SERVICES.—If a health information network  
14 service certified under section 11741 loses its certified sta-  
15 tus or takes any action that would threaten the continued  
16 availability of the standard data elements of health infor-  
17 mation held by such service, such data elements shall be  
18 transferred to another health information network service  
19 certified under section 11741, as designated by the Sec-  
20 retary.

21 **“SEC. 11765. PROTECTION OF COMMERCIAL INFORMATION.**

22       “‘In adopting standards under this subtitle, the Sec-  
23 retary shall not require disclosure of trade secrets and  
24 confidential commercial information by entities operating  
25 in the health information network except as required by  
26 law.

1 **“SEC. 11766. PAYMENT FOR HEALTH CARE SERVICES OR**  
2 **HEALTH PLAN PREMIUMS.**

3 “Nothing in this subtitle shall be construed to pro-  
4 hibit payments for health care services or health plan pre-  
5 miums from being made by debit, credit, or other payment  
6 cards or numbers or other electronic payment means.

7 **“SEC. 11767. HEALTH SECURITY CARDS.**

8 “(a) IN GENERAL.—The Secretary shall establish  
9 standards relating to the form of health security cards is-  
10 sued by health plans and the information to be encoded  
11 electronically on such cards.

12 “(b) FORM DESCRIBED.—The standard form for a  
13 health security card shall be a card which—

14 “(1) is made of plastic or a similar durable ma-  
15 terial with a useful life of at least 5 years;

16 “(2) is resistant to counterfeiting;

17 “(3) can store information that can be encoded  
18 and retrieved electronically;

19 “(4) can be produced in a cost-effective manner  
20 and used in all types of health care locations; and

21 “(5) specifies on its face the social security ac-  
22 count number assigned to the individual who is the  
23 cardholder by the Secretary under section 205(c)(2).

24 “(c) INFORMATION DESCRIBED.—The information  
25 electronically encoded on a health security card shall in-  
26 clude the identity of the individual to whom the card was

1 issued, including such individual's personal health identi-  
2 fier specified under section 11712(c)(1), and may include  
3 any other information that the Secretary determines may  
4 be useful in order for the card to serve the purpose of  
5 easing access to and paying for health care services. A  
6 health plan shall make available to an individual card-  
7 holder, upon demand by such individual, a printed copy  
8 of all information electronically encoded on such individ-  
9 ual's health security card.

10 **“SEC. 11768. MISUSE OF HEALTH SECURITY CARD OR PER-**  
11 **SONAL HEALTH IDENTIFIER.**

12 “(a) HEALTH SECURITY CARD.—A person who—

13 “(1) requires the display of, requires the use of,  
14 or uses a health security card for any purpose other  
15 than obtaining or paying for health care;

16 “(2) falsely makes, forges, counterfeits or alters  
17 a health security card;

18 “(3) without lawful authority prints, photo-  
19 graphs, or makes any impression in the likeness of  
20 any health security card; or

21 “(4) sells, transfers, or otherwise delivers a  
22 false, forged, counterfeited, or altered health security  
23 card knowing that the card is false, forged, counter-  
24 feited, or altered;

1 shall be fined not more than \$25,000, imprisoned not  
2 more than 2 years, or both.

3 “(b) PERSONAL HEALTH IDENTIFIER.—A person  
4 who requires the disclosure of, requires the use of, or uses  
5 an individual’s personal health identifier for any purpose  
6 that is not authorized by the Secretary, shall be fined not  
7 more than \$25,000, imprisoned not more than 2 years,  
8 or both.

9 **“SEC. 11769. DIRECT BILLING FOR CLINICAL LABORATORY**  
10 **SERVICES.**

11 “(a) IN GENERAL.—

12 “(1) REQUIREMENT.—Except as provided in  
13 paragraph (2), in the case of a claim for payment  
14 for a clinical diagnostic laboratory test for which  
15 payment may otherwise be made, payment may be  
16 made only to the person who, or entity which, per-  
17 formed or supervised the test.

18 “(2) EXCEPTIONS.—Payment for a clinical di-  
19 agnostic laboratory test may be made to a physician  
20 with whom the physician who performed the test  
21 shares a practice.

22 “(b) ADDITIONAL EXCEPTIONS.—The Secretary  
23 may, by regulation, establish exceptions to the require-  
24 ment under subsection (a)(1) that are in addition to the

1 exceptions under subsection (a)(2). In establishing such  
2 exceptions the Secretary shall take into account—

3 “(1) circumstances in which an individual’s pri-  
4 vacy might be violated; or

5 “(2) the need for confidentiality on the part of  
6 the person furnishing the test.

7 **“SEC. 11770. AUTHORIZATION OF APPROPRIATIONS.**

8 “There are authorized to be appropriated such sums  
9 as may be necessary to carry out the purposes of this sub-  
10 title.

11 **“PART VIII—ASSISTANCE TO THE SECRETARY**

12 **“SEC. 11771. GENERAL REQUIREMENT ON SECRETARY.**

13 “In complying with any requirements imposed under  
14 this subtitle, the Secretary shall rely on recommendations  
15 of the Health Information Advisory Committee established  
16 under section 11772 and shall consult with appropriate  
17 Federal agencies.

18 **“SEC. 11772. HEALTH INFORMATION ADVISORY COMMIT-**  
19 **TEE.**

20 “(a) ESTABLISHMENT.—There is established a com-  
21 mittee to be known as the Health Care Information Advi-  
22 sory Committee.

23 “(b) DUTY.—

24 “(1) IN GENERAL.—The committee shall—

1           “(A) provide assistance to the Secretary in  
2           complying with the requirements imposed on  
3           the Secretary under this subtitle and subtitle C;

4           “(B) be generally responsible for advising  
5           the Secretary and the Congress on the status of  
6           the health information network; and

7           “(C) make recommendations to correct any  
8           problems that may occur in the network’s im-  
9           plementation and ongoing operations and to re-  
10          fine and improve the network.

11          “(2) TECHNICAL ASSISTANCE.—In performing  
12          its duties under this subsection, the committee shall  
13          receive technical assistance from appropriate Federal  
14          agencies.

15          “(c) MEMBERSHIP.—

16                 “(1) IN GENERAL.—The committee shall con-  
17                 sist of 15 members to be appointed by the President  
18                 not later than 60 days after the date of the enact-  
19                 ment of this subtitle. The President shall designate  
20                 1 member as the Chair.

21                 “(2) EXPERTISE.—The membership of the com-  
22                 mittee shall consist of individuals who are of recog-  
23                 nized standing and distinction and who possess the  
24                 demonstrated capacity to discharge the duties im-  
25                 posed on the committee.

1           “(3) TERMS.—Each member of the committee  
2 shall be appointed for a term of 5 years, except that  
3 the members first appointed shall serve staggered  
4 terms such that the terms of no more than 3 mem-  
5 bers expire at one time.

6           “(4) VACANCIES.—

7           “(A) IN GENERAL.—A vacancy on the  
8 committee shall be filled in the manner in which  
9 the original appointment was made and shall be  
10 subject to any conditions which applied with re-  
11 spect to the original appointment.

12           “(B) FILLING UNEXPIRED TERM.—An in-  
13 dividual chosen to fill a vacancy shall be ap-  
14 pointed for the unexpired term of the member  
15 replaced.

16           “(C) EXPIRATION OF TERMS.—The term  
17 of any member shall not expire before the date  
18 on which the member’s successor takes office.

19           “(5) CONFLICTS OF INTEREST.—Members of  
20 the committee shall disclose upon appointment to  
21 the committee or at any subsequent time that it may  
22 occur, conflicts of interest.

23           “(d) MEETINGS.—

1           “(1) IN GENERAL.—Except as provided in para-  
2           graph (2), the committee shall meet at the call of  
3           the Chair.

4           “(2) INITIAL MEETING.—Not later than 30  
5           days after the date on which all members of the  
6           committee have been appointed, the committee shall  
7           hold its first meeting.

8           “(3) QUORUM.—A majority of the members of  
9           the committee shall constitute a quorum, but a less-  
10          er number of members may hold hearings.

11          “(e) POWER TO HOLD HEARINGS.—The committee  
12          may hold such hearings, sit and act at such times and  
13          places, take such testimony, and receive such evidence as  
14          the committee considers advisable to carry out the pur-  
15          poses of this section.

16          “(f) OTHER ADMINISTRATIVE PROVISIONS.—Sub-  
17          paragraphs (C), (D), and (H) of section 1886(e)(6) shall  
18          apply to the committee in the same manner as they apply  
19          to the Prospective Payment Assessment Commission.

20          “(g) REPORTS.—

21                  “(1) IN GENERAL.—The committee shall annu-  
22                  ally prepare and submit to Congress and the Sec-  
23                  retary a report including at least an analysis of—

24                                  “(A) the status of the health information  
25                                  network established under this subtitle, includ-

1           ing whether the network is fulfilling the pur-  
2           pose described in section 11701;

3           “(B) the savings and costs of the network;

4           “(C) the activities of health information  
5           network services certified under section 11741,  
6           health care providers, health plans, and other  
7           entities using the network to exchange health  
8           information;

9           “(D) the extent to which entities described  
10          in subparagraph (C) are meeting the standards  
11          adopted under this subtitle and working to-  
12          gether to form an integrated network that  
13          meets the needs of its users;

14          “(E) the extent to which entities described  
15          in subparagraph (C) are meeting the privacy  
16          and security protections of subtitle C;

17          “(F) the number and types of penalties as-  
18          sessed for noncompliance with the standards  
19          adopted under this subtitle;

20          “(G) whether the Federal Government and  
21          State Governments are receiving information of  
22          sufficient quality to meet their responsibilities  
23          under the Health Security Act;

24          “(H) any problems with respect to imple-  
25          mentation of the network;

1           “(I) the extent to which timetables under  
2           this subtitle for the adoption and implementa-  
3           tion of standards are being met; and

4           “(J) any legislative recommendations relat-  
5           ed to the health information network.

6           “(2) AVAILABILITY TO THE PUBLIC.—Any in-  
7           formation in the report submitted to Congress under  
8           paragraph (1) shall be made available to the public  
9           unless such information may not be disclosed by law.

10          “(h) DURATION.—Notwithstanding section 14(a) of  
11          the Federal Advisory Committee Act, the committee shall  
12          continue in existence until otherwise provided by law.

13          “(i) AUTHORIZATION OF APPROPRIATIONS.—

14                 “(1) IN GENERAL.—There are authorized to be  
15                 appropriated such sums as may be necessary to  
16                 carry out the purposes of this section.

17                 “(2) AVAILABILITY.—Any sums appropriated  
18                 under the authorization contained in this subsection  
19                 shall remain available, without fiscal year limitation,  
20                 until expended.

1 **“PART IX—DEMONSTRATION PROJECTS FOR**  
2 **COMMUNITY-BASED CLINICAL INFORMATION**  
3 **SYSTEMS**

4 **“SEC. 11781. GRANTS FOR DEMONSTRATION PROJECTS.**

5 “(a) IN GENERAL.—The Secretary may make grants  
6 for demonstration projects to promote the development  
7 and use of electronically integrated community-based clinical  
8 information systems and computerized patient medical  
9 records.

10 “(b) APPLICATIONS.—

11 “(1) SUBMISSION.—To apply for a grant under  
12 this part for any fiscal year, an applicant shall submit  
13 an application to the Secretary in accordance  
14 with the procedures established by the Secretary.

15 “(2) CRITERIA FOR APPROVAL.—The Secretary  
16 may not approve an application submitted under  
17 paragraph (1) unless the application includes assurances  
18 satisfactory to the Secretary regarding the following:  
19

20 “(A) USE OF EXISTING TECHNOLOGY.—  
21 Funds received under this part will be used to  
22 apply telecommunications and information systems  
23 technology that is in existence on the date  
24 the application is submitted in a manner that  
25 improves the quality of health care, reduces the  
26 costs of such care, and protects the privacy and

1 confidentiality of information relating to the  
2 physical or mental condition of an individual.

3 “(B) USE OF EXISTING INFORMATION SYS-  
4 TEMS.—Funds received under this part will be  
5 used—

6 “(i) to enhance telecommunications or  
7 information systems that are operating on  
8 the date the application is submitted;

9 “(ii) to integrate telecommunications  
10 or information systems that are operating  
11 on the date the application is submitted; or

12 “(iii) to connect additional users to  
13 telecommunications or information net-  
14 works or systems that are operating on the  
15 date the application is submitted.

16 “(C) MATCHING FUNDS.—The applicant  
17 shall make available funds for the demonstra-  
18 tion project in an amount that equals at least  
19 20 percent of the cost of the project.

20 “(c) GEOGRAPHIC DIVERSITY.—In making any  
21 grants under this part, the Secretary shall, to the extent  
22 practicable, make grants to persons representing different  
23 geographic areas of the United States, including urban  
24 and rural areas.

1       “(d) REVIEW AND SANCTIONS.—The Secretary shall  
2 review at least annually the compliance of a person receiv-  
3 ing a grant under this part with the provisions of this  
4 part. The Secretary shall establish a procedure for deter-  
5 mining whether such a person has failed to comply sub-  
6 stantially within the provisions of this part and the sanc-  
7 tions to be imposed for any such noncompliance.

8       “(e) ANNUAL REPORT.—The Secretary shall submit  
9 an annual report to the President for transmittal to Con-  
10 gress containing a description of the activities carried out  
11 under this part.

12       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated such sums as may be  
14 necessary to carry out the purposes of this section.”.

15               (2) Conforming amendments.—(A) Title XI of  
16 the Social Security Act (42 U.S.C. 1301 et seq.) is  
17 amended by striking the title and inserting the fol-  
18 lowing:

1 **“TITLE XI—GENERAL PROVI-**  
 2 **SIONS, PEER REVIEW, AND**  
 3 **ADMINISTRATIVE SIM-**  
 4 **PLIFICATION**

5 **“Subtitle A—General Provisions**  
 6 **and Peer Review”**

7 (B) Title XI of the Social Security Act (42  
 8 U.S.C. 1301 et seq.) is amended by striking each  
 9 reference to “this title” and inserting “this subtitle”.

10 **SEC. 402. PRIVACY OF HEALTH INFORMATION UNDER THE**  
 11 **SOCIAL SECURITY ACT.**

12 (a) IN GENERAL.—Title XI of the Social Security Act  
 13 (42 U.S.C. 1301 et seq.), as amended by section 401, is  
 14 amended by adding at the end the following new subtitle:

15 **“Subtitle C—Privacy of Health**  
 16 **Information**

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“Subtitle C—Privacy of Health Information

“PART I—FINDINGS AND DEFINITIONS

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“Sec. 11802. Definitions.

“PART II—AUTHORIZED DISCLOSURES

“SUBPART A—GENERAL PROVISIONS

“Sec. 11811. General rules regarding disclosure.

“Sec. 11812. Authorizations for disclosure of protected health information.

“Sec. 11813. Certified health information network services.

“SUBPART B—SPECIFIC DISCLOSURES RELATING TO PATIENT

“Sec. 11821. Disclosures for treatment and financial and administrative  
 transactions.

“Sec. 11822. Next of kin and directory information.

“Sec. 11823. Emergency circumstances.

“SUBPART C—DISCLOSURE FOR OVERSIGHT, PUBLIC HEALTH, AND RESEARCH PURPOSES

“Sec. 11831. Oversight.

“Sec. 11832. Public health.

“Sec. 11833. Health research.

“SUBPART D—DISCLOSURE FOR JUDICIAL, ADMINISTRATIVE, AND LAW ENFORCEMENT PURPOSES

“Sec. 11841. Judicial and administrative purposes.

“Sec. 11842. Law enforcement.

“SUBPART E—DISCLOSURE PURSUANT TO GOVERNMENT SUBPOENA OR WARRANT

“Sec. 11851. Government subpoenas and warrants.

“Sec. 11852. Access procedures for law enforcement subpoenas and warrants.

“Sec. 11853. Challenge procedures for law enforcement warrants and subpoenas.

“SUBPART F—DISCLOSURE PURSUANT TO PRIVATE PARTY SUBPOENA

“Sec. 11854. Private party subpoenas.

“Sec. 11855. Access procedures for private party subpoenas.

“Sec. 11856. Challenge procedures for private party subpoenas.

“PART III—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

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“Sec. 11861. Establishment of safeguards.

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“Sec. 11871. Inspection of protected health information.

“Sec. 11872. Amendment of protected health information.

“Sec. 11873. Notice of information practices.

“SUBPART C—STANDARDS FOR ELECTRONIC DISCLOSURES

“Sec. 11882. Standards for electronic disclosures.

“PART IV—SANCTIONS

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“Sec. 11891. No liability for permissible disclosures.

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“SUBPART B—CIVIL SANCTIONS

“Sec. 11901. Civil penalty.

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## “SUBPART C—CRIMINAL SANCTIONS

“Sec. 11911. Wrongful disclosure of protected health information.

## “PART V—ADMINISTRATIVE PROVISIONS

“Sec. 11921. Relationship to other laws.

“Sec. 11922. Rights of incompetents.

“Sec. 11923. Exercise of rights.

1           **“PART I—FINDINGS AND DEFINITIONS**2   **“SEC. 11801. FINDINGS AND PURPOSES.**

3           “(a) FINDINGS.—The Congress finds as follows:

4                   “(1) The improper disclosure of individually  
5           identifiable health care information may cause sig-  
6           nificant harm to an individual’s interests in privacy,  
7           health care, and reputation and may unfairly affect  
8           the ability of an individual to obtain employment,  
9           education, insurance, and credit.

10                   “(2) The movement of people and health care  
11           related information across State lines, the availabil-  
12           ity of, access to, and exchange of health care related  
13           information with Federally funded health care sys-  
14           tems, the medicare program under title XVIII, and  
15           the medicaid program under title XIX, through  
16           automated data banks and networks, and the emer-  
17           gence of other multistate health care providers and  
18           payors create a need for a uniform Federal law gov-  
19           erning the disclosure of health care information.

20                   “(b) PURPOSE.—The purpose of this subtitle is to es-  
21           tablish effective mechanisms to protect the privacy of indi-

1 viduals with respect to individually identifiable health care  
2 information that is created or maintained as part of health  
3 treatment, enrollment, payment, testing, or research proc-  
4 esses.

5 **“SEC. 11802. DEFINITIONS.**

6 “(a) TERMS RELATING TO PROTECTED HEALTH IN-  
7 FORMATION.—In this subtitle:

8 “(1) PROTECTED HEALTH INFORMATION.—The  
9 term ‘protected health information’ means any infor-  
10 mation, including demographic information collected  
11 from an individual, whether oral or recorded in any  
12 form or medium, that—

13 “(A) is created or received by a health care  
14 provider, health plan, health oversight agency,  
15 health researcher, public health authority, em-  
16 ployer, life insurer, school or university, or cer-  
17 tified health information network service; and

18 “(B) relates to the past, present, or future  
19 physical or mental health or condition of an in-  
20 dividual, the provision of health care to an indi-  
21 vidual, or the past, present, or future payment  
22 for the provision of health care to an individual,  
23 and—

24 “(i) identifies an individual; or

1           “(ii) with respect to which there is a  
2           reasonable basis to believe that the infor-  
3           mation can be used to identify an individ-  
4           ual.

5           “(2) DISCLOSE.—The term ‘disclose’, when  
6           used with respect to protected health information,  
7           means to provide access to the information, but only  
8           if such access is provided to a person other than the  
9           individual who is the subject of the information.

10          “(b) TERMS RELATING TO HEALTH CARE SYSTEM  
11 PARTICIPANTS.—In this subtitle:

12           “(1) HEALTH INFORMATION TRUSTEE.—The  
13           term ‘health information trustee’ means—

14                   “(A) a health care provider, health plan,  
15                   health oversight agency, certified health infor-  
16                   mation network service, employer, life insurer,  
17                   or school or university insofar as it creates, re-  
18                   ceives, maintains, uses, or transmits protected  
19                   health information;

20                   “(B) any person who obtains protected  
21                   health information under section 11823, 11832,  
22                   11833, 11841, 11842, 11851, or 11854; and

23                   “(C) any employee or agent of a person  
24                   covered under subparagraphs (A) or (B).

25           “(2) HEALTH CARE.—The term ‘health care’—

1 “(A) means—

2 “(i) a preventative, diagnostic, thera-  
3 peutic, rehabilitative, maintenance, or pal-  
4 liative care, counseling, service, or proce-  
5 dure—

6 “(I) with respect to the physical  
7 or mental condition of an individual;  
8 or

9 “(II) affecting the structure or  
10 function of the human body or any  
11 part of the human body; or

12 “(ii) any sale or dispensing of a drug,  
13 device, equipment, or other item to an indi-  
14 vidual, or for the use of an individual, pur-  
15 suant to a prescription; but

16 “(B) does not include any item or service  
17 that is not furnished for the purpose of examin-  
18 ing, maintaining, or improving the health of an  
19 individual.

20 “(3) HEALTH CARE PROVIDER.—The term  
21 ‘health care provider’ means a person who is li-  
22 censed, certified, registered, or otherwise authorized  
23 by law to provide an item or service that constitutes  
24 health care in the ordinary course of business or  
25 practice of a profession.

1           “(4) HEALTH OVERSIGHT AGENCY.—The term  
2 ‘health oversight agency’ means a person who—

3           “(A) performs or oversees the performance  
4 of an assessment, evaluation, determination, or  
5 investigation relating to the licensing, accredita-  
6 tion, or certification of health care  
7 providers; or

8           “(B)(i) performs or oversees the perform-  
9 ance of an assessment, evaluation, determina-  
10 tion, or investigation relating to the effective-  
11 ness of, compliance with, or applicability of  
12 legal, fiscal, medical, or scientific standards or  
13 aspects of performance related to the delivery  
14 of, or payment for, health care or relating to  
15 health care fraud or fraudulent claims for pay-  
16 ment regarding health; and

17           “(ii) is a public agency, acting on behalf of  
18 a public agency, acting pursuant to a require-  
19 ment of a public agency, or carrying out activi-  
20 ties under a Federal or State law governing the  
21 assessment, evaluation, determination, or inves-  
22 tigation described in clause (i).

23           “(5) HEALTH PLAN.—The term ‘health plan’  
24 shall have the meaning given such term under sec-  
25 tion 11702.

1           “(6) HEALTH RESEARCHER.—The term ‘health  
2 researcher’ means a person who conducts a bio-  
3 medical, public health, epidemiological, health serv-  
4 ices, or health statistics research project or a re-  
5 search project on social and behavioral factors relat-  
6 ing to health.

7           “(7) INSTITUTIONAL REVIEW BOARD.—The  
8 term ‘institutional review board’ means—

9                   “(A) a board established in accordance  
10 with regulations of the Secretary under section  
11 491(a) of the Public Health Service Act;

12                   “(B) a similar board established by the  
13 Secretary for the protection of human subjects  
14 in research conducted by the Secretary; or

15                   “(C) a similar board established under reg-  
16 ulations of a Federal Government authority  
17 other than the Secretary.

18           “(8) PUBLIC HEALTH AUTHORITY.—The term  
19 ‘public health authority’ means an authority or in-  
20 strumentality of the United States, a State, or a po-  
21 litical subdivision of a State that is (A) responsible  
22 for public health matters; and (B) engaged in such  
23 activities as injury reporting, public health surveil-  
24 lance, and public health investigation or interven-  
25 tion.

1       “(c) REFERENCES TO CERTIFIED ENTITIES.—In this  
2 subtitle:

3           “(1) CERTIFIED HEALTH INFORMATION NET-  
4 WORK SERVICE.—The term ‘certified health informa-  
5 tion network service’ means a health information  
6 service (as defined under section 11702) that is cer-  
7 tified under section 11741.

8           “(2) CERTIFIED HEALTH INFORMATION PRO-  
9 TECTION ORGANIZATION.—The term ‘certified health  
10 information protection organization’ means a health  
11 information protection organization (as defined in  
12 section 11702) that is certified under section 11741.

13       “(d) OTHER TERMS.—In this subtitle:

14           “(1) INDIVIDUAL REPRESENTATIVE.—The term  
15 ‘individual representative’ means any individual le-  
16 gally empowered to make decisions concerning the  
17 provision of health care to an individual (where the  
18 individual lacks the legal capacity under State law to  
19 make such decisions) or the administrator or execu-  
20 tor of the estate of a deceased individual.

21           “(2) LAW ENFORCEMENT INQUIRY.—The term  
22 ‘law enforcement inquiry’ means an investigation or  
23 official proceeding inquiring into whether there is a  
24 violation of, or failure to comply with, any criminal

1 or civil statute or any regulation, rule, or order is-  
2 sued pursuant to such a statute.

3 “(3) PERSON.—The term ‘person’ includes an  
4 authority of the United States, a State, or a political  
5 subdivision of a State.

6 **“PART II—AUTHORIZED DISCLOSURES**

7 **“Subpart A—General Provisions**

8 **“SEC. 11811. GENERAL RULES REGARDING DISCLOSURE.**

9 “(a) GENERAL RULE.—A health information trustee  
10 may disclose protected health information only for a pur-  
11 pose that is authorized under this subtitle.

12 “(b) DISCLOSURE WITHIN A TRUSTEE.—A health in-  
13 formation trustee may disclose protected health informa-  
14 tion to an officer, employee, or agent of the trustee, but  
15 only for a purpose that is compatible with and related to  
16 the purpose for which the information was collected or re-  
17 ceived by that trustee.

18 “(c) SCOPE OF DISCLOSURE.—

19 “(1) IN GENERAL.—Every disclosure of pro-  
20 tected health information by a health information  
21 trustee shall be limited to the minimum amount of  
22 information necessary to accomplish the purpose for  
23 which the information is disclosed.

24 “(2) REGULATIONS.—The Secretary, after no-  
25 tice and opportunity for public comment, may issue

1 regulations under paragraph (1), which shall take  
2 into account the technical capabilities of the record  
3 systems used to maintain protected health informa-  
4 tion and the costs of limiting disclosure.

5 “(d) NO GENERAL REQUIREMENT TO DISCLOSE.—  
6 Nothing in this subtitle that permits a disclosure of health  
7 information shall be construed to require such disclosure.

8 “(e) USE AND REDISCLOSURE OF INFORMATION.—  
9 The protected health information received under a disclo-  
10 sure permitted by the subtitle may not be used or disclosed  
11 unless the use or disclosure is necessary to fulfill the pur-  
12 pose for which the information was obtained and is not  
13 otherwise prohibited by law. Protected health information  
14 about an individual that is disclosed under this subtitle  
15 may not be used in, or disclosed to any person for use  
16 in, any administrative, civil, or criminal action or inves-  
17 tigation directed against the individual unless specifically  
18 permitted by this subtitle.

19 “(f) IDENTIFICATION OF DISCLOSED INFORMATION  
20 AS PROTECTED INFORMATION.—

21 “(1) IN GENERAL.—Except with respect to pro-  
22 tected health information that is disclosed under sec-  
23 tion 11823 and except as provided in paragraph (2),  
24 a health information trustee may not disclose pro-  
25 tected health information unless such information is

1 clearly identified as protected health information  
2 that is subject to this subtitle.

3 “(2) ROUTINE DISCLOSURES SUBJECT TO WRIT-  
4 TEN AGREEMENT.—A health information trustee  
5 who routinely discloses protected health information  
6 to a person may satisfy the identification require-  
7 ment in paragraph (1) through a written agreement  
8 between the trustee and the person with respect to  
9 the protected health information.

10 “(g) CONSTRUCTION.—Nothing in this subtitle shall  
11 be construed to limit the ability of a health information  
12 trustee to charge a reasonable fee for the disclosure or  
13 reproduction of health information.

14 “(h) INFORMATION IN WHICH PROVIDERS ARE IDEN-  
15 TIFIED.—The Secretary, after notice and opportunity for  
16 public comment, may issue regulations protecting informa-  
17 tion identifying providers in order to promote the availabil-  
18 ity of health care services.

19 **“SEC. 11812. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**  
20 **TECTED HEALTH INFORMATION.**

21 “(a) WRITTEN AUTHORIZATIONS.—A health infor-  
22 mation trustee may disclose protected health information  
23 pursuant to an authorization executed by the individual  
24 who is the subject of the information, if each of the follow-  
25 ing requirements is met:

1           “(1) WRITING.—The authorization is in writ-  
2           ing, signed by the individual who is the subject of  
3           the information, and dated on the date of such sig-  
4           nature.

5           “(2) SEPARATE FORM.—The authorization is  
6           not on a form used to authorize or facilitate the pro-  
7           vision of, or payment for, health care.

8           “(3) TRUSTEE DESCRIBED.—The trustee is  
9           specifically named or generically described in the au-  
10          thorization as authorized to disclose such informa-  
11          tion.

12          “(4) RECIPIENT DESCRIBED.—The person to  
13          whom the information is to be disclosed is specifi-  
14          cally named or generically described in the author-  
15          ization as a person to whom such information may  
16          be disclosed.

17          “(5) STATEMENT OF INTENDED DISCLO-  
18          SURES.—The authorization contains an acknowledg-  
19          ment that the individual who is the subject of the in-  
20          formation has read a statement of the disclosures  
21          that the person to receive the protected health infor-  
22          mation intends to make, which statement shall be in  
23          writing, on a form that is distinct from the author-  
24          ization for disclosure, and which statement must be

1 received by the individual authorizing the disclosure  
2 on or before such authorization is executed.

3 “(6) INFORMATION DESCRIBED.—The informa-  
4 tion to be disclosed is described in the authorization.

5 “(7) EXPIRATION DATE SPECIFIED.—The au-  
6 thorization specifies a date or event upon which the  
7 authorization expires, which shall not exceed 2 years  
8 from the date of the execution of the authorization.

9 “(8) AUTHORIZATION TIMELY RECEIVED.—The  
10 authorization is received by the trustee during a pe-  
11 riod described in subsection (c)(1).

12 “(9) DISCLOSURE TIMELY MADE.—The disclo-  
13 sure occurs during a period described in subsection  
14 (c)(2).

15 “(b) AUTHORIZATIONS REQUESTED IN CONNECTION  
16 WITH PROVISION OF HEALTH CARE.—

17 “(1) IN GENERAL.—A health information trust-  
18 ee may not request that an individual provide to any  
19 other person an authorization described in sub-  
20 section (a) on a day on which—

21 “(A) the trustee provides health care to  
22 the individual requested to provide the author-  
23 ization; or

24 “(B) in the case of a trustee that is a  
25 health facility, the individual is admitted into

1           the facility as a resident or inpatient in order  
2           to receive health care.

3           “(2) EXCEPTION.—Paragraph (1) does not  
4           apply if a health information trustee requests that  
5           an individual provide an authorization described in  
6           subsection (a) for the purpose of assisting the indi-  
7           vidual in obtaining counseling or social services from  
8           a person other than the trustee.

9           “(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

10           “(1) RECEIPT BY TRUSTEE.—For purposes of  
11           subsection (a)(8), an authorization is timely received  
12           if it is received by the trustee during—

13                   “(A) the 1-year period beginning on the  
14                   date on which the authorization is signed under  
15                   subsection (a)(1), if the authorization permits  
16                   the disclosure of protected health information to  
17                   a person who provides health counseling or so-  
18                   cial services to individuals; or

19                   “(B) the 30-day period beginning on the  
20                   date on which the authorization is signed under  
21                   subsection (a)(1), if the authorization permits  
22                   the disclosure of protected health information to  
23                   a person other than a person described in sub-  
24                   paragraph (A).

1           “(2) DISCLOSURE BY TRUSTEE.—For purposes  
2 of subsection (a)(9), a disclosure is timely made if  
3 it occurs before the date or event specified in the au-  
4 thorization upon which the authorization expires.

5           “(d) REVOCATION OR AMENDMENT OF AUTHORIZA-  
6 TION.—

7           “(1) IN GENERAL.—An individual may in writ-  
8 ing revoke or amend an authorization described in  
9 subsection (a), in whole or in part, at any time, ex-  
10 cept when—

11                   “(A) disclosure of protected health infor-  
12 mation has been authorized to permit validation  
13 of expenditures for health care; or

14                   “(B) action has been taken in reliance on  
15 the authorization.

16           “(2) NOTICE OF REVOCATION.—A health infor-  
17 mation trustee who discloses protected health infor-  
18 mation pursuant to an authorization that has been  
19 revoked shall not be subject to any liability or pen-  
20 alty under this subtitle if—

21                   “(A) the reliance was in good faith;

22                   “(B) the trustee had no notice of the rev-  
23 ocation; and

24                   “(C) the disclosure was otherwise in ac-  
25 cordance with the requirements of this subtitle.



1 of the purpose for which such information was disclosed  
2 to the service.

3 “(b) CERTIFIED HEALTH INFORMATION PROTEC-  
4 TION ORGANIZATIONS.—A health information trustee may  
5 disclose protected health information to a certified health  
6 information protection organization for the purpose of cre-  
7 ating non-identifiable health information (as defined in  
8 section 11702).

9 **“Subpart B—Specific Disclosures Relating to Patient**  
10 **“SEC. 11821. DISCLOSURES FOR TREATMENT AND FINAN-**  
11 **CIAL AND ADMINISTRATIVE TRANSACTIONS.**

12 “(a) HEALTH CARE TREATMENT.—A health care  
13 provider, health plan, employer, or person who receives  
14 protected health information under section 11823, may  
15 disclose protected health information to a health care pro-  
16 vider for the purpose of providing health care to an indi-  
17 vidual if the individual who is the subject of the informa-  
18 tion has not previously objected in writing to the disclo-  
19 sure.

20 “(b) DISCLOSURE TO HEALTH PLANS FOR FINAN-  
21 CIAL AND ADMINISTRATIVE PURPOSES.—A health care  
22 provider or employer may disclose protected health infor-  
23 mation to a health plan for the purpose of providing for  
24 the payment for, or reviewing the payment of, health care  
25 furnished to an individual.

1       “(c) DISCLOSURE BY HEALTH PLANS FOR FINAN-  
2 CIAL AND ADMINISTRATIVE PURPOSES.—A health plan  
3 may disclose protected health information to a health care  
4 provider or a health plan for the purpose of providing for  
5 the payment for, or reviewing the payment of, health care  
6 furnished to an individual.

7       **“SEC. 11822. NEXT OF KIN AND DIRECTORY INFORMATION.**

8       “(a) NEXT OF KIN.—A health care provider or per-  
9 son who receives protected health information under sec-  
10 tion 11823 may disclose protected health information to  
11 the next of kin, an individual representative of the individ-  
12 ual who is the subject of the information, or an individual  
13 with whom that individual has a close personal relation-  
14 ship if—

15               “(1) the individual who is the subject of the in-  
16 formation—

17                       “(A) has been notified of the individual’s  
18 right to object and has not objected to the dis-  
19 closure;

20                       “(B) is not competent to be notified about  
21 the right to object; or

22                       “(C) exigent circumstances exist such that  
23 it would not be practicable to notify the individ-  
24 ual of the right to object; and

1           “(2) the information disclosed relates to health  
2           care currently being provided to that individual.

3           “(b) DIRECTORY INFORMATION.—A health care pro-  
4           vider and a person receiving protected health information  
5           under section 11823 may disclose protected health infor-  
6           mation to any person if—

7           “(1) the information does not reveal specific in-  
8           formation about the physical or mental condition of  
9           the individual who is the subject of the information  
10          or health care provided to that person;

11          “(2) the individual who is the subject of the in-  
12          formation—

13                 “(A) has been notified of the individual’s  
14                 right to object and has not objected to the dis-  
15                 closure;

16                 “(B) is not competent to be notified about  
17                 the right to object; or

18                 “(C) exigent circumstances exist such that  
19                 it would not be practicable to notify the individ-  
20                 ual of the right to object; and

21          “(3) the information consists only of 1 or more  
22          of the following items:

23                 “(A) The name of the individual who is the  
24                 subject of the information.

1           “(B) If the individual who is the subject of  
2           the information is receiving health care from a  
3           health care provider on a premises controlled by  
4           the provider—

5                   “(i) the location of the individual on  
6                   the premises; and

7                   “(ii) the general health status of the  
8                   individual, described as critical, poor, fair,  
9                   stable, or satisfactory or in terms denoting  
10                  similar conditions.

11          “(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—  
12          A health care provider, health plan, employer, or life in-  
13          surer, may disclose protected health information if nec-  
14          essary to assist in the identification of a deceased individ-  
15          ual.

16          **“SEC. 11823. EMERGENCY CIRCUMSTANCES.**

17          “(a) IN GENERAL.—A health care provider, health  
18          plan, employer, or person who receives protected health  
19          information under this section may disclose protected  
20          health information in emergency circumstances when nec-  
21          essary to protect the health or safety of an individual from  
22          imminent harm.

23          “(b) SCOPE OF DISCLOSURE.—The disclosure of pro-  
24          tected health information under this section shall be lim-

1 ited to persons who need the information to take action  
2 to protect the health or safety of the individual.

3 **“Subpart C—Disclosure for Oversight, Public Health,  
4 and Research Purposes**

5 **“SEC. 11831. OVERSIGHT.**

6 “(a) IN GENERAL.—A health information trustee  
7 may disclose protected health information to a health over-  
8 sight agency for an oversight function authorized by law.

9 “(b) USE IN ACTION AGAINST INDIVIDUALS.—Not-  
10 withstanding section 11811(e), protected health informa-  
11 tion about an individual that is disclosed under this sec-  
12 tion may be used in, or disclosed to any person for use  
13 in, any administrative, civil, or criminal action or inves-  
14 tigation directed against the individual who is the subject  
15 of the information if the action or investigation arises out  
16 of and is directly related to receipt of health care or pay-  
17 ment for health care or an action involving a fraudulent  
18 claim related to health.

19 **“SEC. 11832. PUBLIC HEALTH.**

20 “A health care provider, health plan, public health  
21 authority, employer, or person who receives protected  
22 health information under section 11823 may disclose pro-  
23 tected health information to a public health authority or  
24 other person authorized by law for use in a legally author-  
25 ized—

1 “(1) disease or injury reporting;

2 “(2) public health surveillance; or

3 “(3) public health investigation or intervention.

4 **“SEC. 11833. HEALTH RESEARCH.**

5 “(a) IN GENERAL.—A health information trustee  
6 may disclose protected health information to a health re-  
7 searcher if an institutional review board determines that  
8 the research project engaged in by the health researcher—

9 “(1) requires use of the protected health infor-  
10 mation for the effectiveness of the project; and

11 “(2) is of sufficient importance to outweigh the  
12 intrusion into the privacy of the individual who is  
13 the subject of the information that would result from  
14 the disclosure.

15 “(b) RESEARCH REQUIRING DIRECT CONTACT.—A  
16 health information trustee may disclose protected health  
17 information to a health researcher for a research project  
18 that includes direct contact with an individual who is the  
19 subject of protected health information if an institutional  
20 review board determines that—

21 “(1) the research project meets the require-  
22 ments of paragraphs (1) and (2) of subsection (a);

23 “(2) direct contact is necessary to accomplish  
24 the research purpose; and

1           “(3) the direct contact will be made in a man-  
2           ner that minimizes the risk of harm, embarrassment,  
3           or other adverse consequences to the individual.

4           “(c) USE OF HEALTH INFORMATION NETWORK.—

5           “(1) IN GENERAL.—A health information trust-  
6           ee may disclose protected health information to a  
7           health researcher using the health information net-  
8           work (as defined in section 11702) only if an institu-  
9           tional review board certified by the Secretary under  
10          paragraph (2) determines that the research project  
11          engaged in by the health researcher meets the re-  
12          quirements of this section.

13          “(2) CERTIFICATION OF INSTITUTIONAL RE-  
14          VIEW BOARDS.—

15          “(A) REGULATIONS.—The Secretary, after  
16          notice and opportunity for public comment,  
17          shall issue regulations establishing certification  
18          requirements for institutional review boards  
19          under this subtitle. Such regulations shall be  
20          based on regulations issued under section  
21          491(a) of the Public Health Service Act and  
22          shall ensure that institutional review boards  
23          certified under this paragraph have the quali-  
24          fications to access and protect the confidential-  
25          ity of research subjects.

1           “(B) CERTIFICATION.—The Secretary  
2           shall certify an institutional review board that  
3           meets the certification requirements established  
4           by the Secretary under subparagraph (A).

5           “(d) OBLIGATIONS OF RECIPIENT.—A person who  
6           receives protected health information pursuant to sub-  
7           section (a)—

8           “(1) shall remove or destroy, at the earliest op-  
9           portunity consistent with the purposes of the project,  
10          information that would enable an individual to be  
11          identified, unless—

12           “(A) an institutional review board has de-  
13          termined that there is a health or research jus-  
14          tification for retention of such identifiers; and

15           “(B) there is an adequate plan to protect  
16          the identifiers from disclosure that is inconsis-  
17          tent with this section; and

18          “(2) shall use protected health information sole-  
19          ly for purposes of the health research project for  
20          which disclosure was authorized under this section.

1 **“Subpart D—Disclosure For Judicial, Administrative,**  
2 **and Law Enforcement Purposes**

3 **“SEC. 11841. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

4 A health care provider, health plan, health oversight  
5 agency, or employer may disclose protected health infor-  
6 mation—

7 “(1) pursuant to the Federal Rules of Civil  
8 Procedure, the Federal Rules of Criminal Procedure,  
9 or comparable rules of other courts or administrative  
10 agencies in connection with litigation or proceedings  
11 to which the individual who is the subject of the in-  
12 formation is a party and in which the individual has  
13 placed the individual’s physical or mental condition  
14 in issue;

15 “(2) to a court, and to others ordered by a  
16 court, if the protected health information is devel-  
17 oped in response to a court-ordered physical or men-  
18 tal examination; or

19 “(3) pursuant to a law requiring the reporting  
20 of specific medical information to law enforcement  
21 authorities.

22 **“SEC. 11842. LAW ENFORCEMENT.**

23 “(a) IN GENERAL.—A health care provider, health  
24 plan, health oversight agency, employer, or person who re-  
25 ceives protected health information under section 11823  
26 may disclose protected health information to a law en-

1 enforcement agency (other than a health oversight agency  
2 governed by section 11831) if the information is requested  
3 for use—

4           “(1) in an investigation or prosecution of a  
5 health information trustee;

6           “(2) in the identification of a victim or witness  
7 in a law enforcement inquiry; or

8           “(3) in connection with the investigation of  
9 criminal activity committed against the trustee or on  
10 premises controlled by the trustee.

11       “(b) CERTIFICATION.—When a law enforcement  
12 agency (other than a health oversight agency) requests  
13 that a health information trustee disclose protected health  
14 information under this section, the law enforcement agen-  
15 cy shall provide the trustee with a written certification  
16 that—

17           “(1) specifies the information requested;

18           “(2) states that the information is needed for a  
19 lawful purpose under this section; and

20           “(3) is signed by a supervisory official of a rank  
21 designated by the head of the agency.

22       “(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—  
23 Notwithstanding section 11811(e), protected health infor-  
24 mation about an individual that is disclosed to a law en-  
25 forcement agency under this section may be used in, or

1 disclosed for, an administrative, civil, or criminal action  
2 or investigation against the individual if the action or in-  
3 vestigation arises out of and is directly related to the ac-  
4 tion or investigation for which the information was ob-  
5 tained.

6 **“Subpart E—Disclosure Pursuant to Government**  
7 **Subpoena or Warrant**

8 **“SEC. 11851. GOVERNMENT SUBPOENAS AND WARRANTS.**

9 “(a) IN GENERAL.—A health care provider, health  
10 plan, health oversight agency, employer, or person who re-  
11 ceives protected health information under section 11823  
12 may disclose protected health information under this sec-  
13 tion if the disclosure is pursuant to—

14 “(1) a subpoena issued under the authority of  
15 a grand jury, and the trustee is provided a written  
16 certification by the grand jury seeking the informa-  
17 tion that the grand jury has complied with the appli-  
18 cable access provisions of section 11852;

19 “(2) an administrative subpoena or a judicial  
20 subpoena or warrant, and the trustee is provided a  
21 written certification by the person seeking the infor-  
22 mation that the person has complied with the appli-  
23 cable access provisions of section 11852; or

24 “(3) an administrative subpoena or a judicial  
25 subpoena or warrant, and the disclosure otherwise

1 meets the conditions of section 11831, 11832,  
2 11841, or 11842.

3 “(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

4 “(1) ACTIONS OR INVESTIGATIONS.—Notwith-  
5 standing section 11811(c), protected health informa-  
6 tion about an individual that is received under sub-  
7 section (a) may be disclosed for, or used in, any ad-  
8 ministrative, civil, or criminal action or investigation  
9 against the individual if the action or investigation  
10 arises out of and is directly related to the inquiry for  
11 which the information was obtained.

12 “(2) SPECIAL RULE.—Protected health infor-  
13 mation about an individual that is received under  
14 subsection (a)(3) may not be disclosed by the recipi-  
15 ent unless the recipient complies with the conditions  
16 and restrictions on disclosure with which the recipi-  
17 ent would have been required to comply if the disclo-  
18 sure had been made under section 11831, 11832,  
19 11841, or 11842.

20 **“SEC. 11852. ACCESS PROCEDURES FOR LAW ENFORCE-**  
21 **MENT SUBPOENAS AND WARRANTS.**

22 “(a) PROBABLE CAUSE REQUIREMENT.—A govern-  
23 ment authority may not obtain protected health informa-  
24 tion about an individual under paragraph (1) or (2) of  
25 section 11851(a) for use in a law enforcement inquiry un-

1 less there is probable cause to believe that the information  
2 is relevant to a legitimate law enforcement inquiry being  
3 conducted by the government authority.

4       “(b) WARRANTS.—A government authority that ob-  
5 tains protected health information about an individual  
6 under circumstances described in subsection (a) and pur-  
7 suant to a warrant shall, not later than 30 days after the  
8 date the warrant was executed, serve the individual with,  
9 or mail to the last known address of the individual, a no-  
10 tice that protected health information about the individual  
11 was so obtained, together with a notice of the individual’s  
12 right to challenge the warrant in accordance with section  
13 11853.

14       “(c) SUBPOENAS.—Except as provided in subsection  
15 (d), a government authority may not obtain protected  
16 health information about an individual under cir-  
17 cumstances described in subsection (a) and pursuant to  
18 a subpoena unless a copy of the subpoena has been served  
19 on the individual on or before the date of return of the  
20 subpoena, together with a notice of the individual’s right  
21 to challenge the subpoena in accordance with section  
22 11853, and—

23               “(1) 15 days have passed since the date of serv-  
24       ice on the individual and within that time period the

1 individual has not initiated a challenge in accordance  
2 with section 11853; or

3 “(2) disclosure is ordered by a court after chal-  
4 lenge under section 11853.

5 “(d) APPLICATION FOR DELAY.—

6 “(1) IN GENERAL.—A government authority  
7 may apply ex parte and under seal to an appropriate  
8 court to delay (for an initial period of not longer  
9 than 90 days) serving a notice or copy of a subpoena  
10 required under subsection (b) or (c) with respect to  
11 a law enforcement inquiry. The government author-  
12 ity may apply to the court for extensions of the  
13 delay.

14 “(2) REASONS FOR DELAY.—An application for  
15 a delay, or extension of a delay, under this sub-  
16 section shall state, with reasonable specificity, the  
17 reasons why the delay or extension is being sought.

18 “(3) EX PARTE ORDER.—The court shall enter  
19 an ex parte order delaying or extending the delay of  
20 notice, an order prohibiting the disclosure of the re-  
21 quest for, or disclosure of, the protected health in-  
22 formation, and an order requiring the disclosure of  
23 the protected health information if the court finds  
24 that—

1           “(A) the inquiry being conducted is within  
2 the lawful jurisdiction of the government au-  
3 thority seeking the protected health informa-  
4 tion;

5           “(B) there is probable cause to believe that  
6 the protected health information being sought is  
7 relevant to a legitimate law enforcement in-  
8 quiry;

9           “(C) the government authority’s need for  
10 the information outweighs the privacy interest  
11 of the individual who is the subject of the infor-  
12 mation; and

13           “(D) there is reasonable ground to believe  
14 that receipt of notice by the individual will re-  
15 sult in—

16                   “(i) endangering the life or physical  
17 safety of any individual;

18                   “(ii) flight from prosecution;

19                   “(iii) destruction of or tampering with  
20 evidence or the information being sought;  
21 or

22                   “(iv) intimidation of potential wit-  
23 nesses.

1 **“SEC. 11853. CHALLENGE PROCEDURES FOR LAW EN-**  
2 **FORCEMENT WARRANTS AND SUBPOENAS.**

3 “(a) MOTION TO QUASH.—Within 15 days after the  
4 date of service of a notice of execution or a copy of a sub-  
5 poena of a government authority seeking protected health  
6 information about an individual under paragraph (1) or  
7 (2) of section 11851(a), the individual may file a motion  
8 to quash—

9 “(1) in the case of a State judicial warrant or  
10 subpoena, in the court which issued the warrant or  
11 subpoena;

12 “(2) in the case of a warrant or subpoena is-  
13 sued under the authority of a State that is not a  
14 State judicial warrant or subpoena, in a court of  
15 competent jurisdiction; or

16 “(3) in the case of any other warrant or sub-  
17 poena issued under the authority of a Federal court  
18 or the United States, in the United States district  
19 court for the district in which the individual resides  
20 or in which the warrant or subpoena was issued.

21 “(b) COPY.—A copy of the motion shall be served by  
22 the individual upon the government authority by reg-  
23 istered or certified mail.

24 “(c) PROCEEDINGS.—The government authority may  
25 file with the court such papers, including affidavits and  
26 other sworn documents, as sustain the validity of the war-

1 rant or subpoena. The individual may file with the court  
2 reply papers in response to the government authority's fil-  
3 ing. The court, upon the request of the individual or the  
4 government authority or both, may proceed in camera.  
5 The court may conduct such proceedings as it deems ap-  
6 propriate to rule on the motion, but shall endeavor to ex-  
7 pedite its determination.

8       “(d) STANDARD FOR DECISION.—A court may deny  
9 a motion under subsection (a) if it finds there is probable  
10 cause to believe the protected health information is rel-  
11 evant to a legitimate law enforcement inquiry being con-  
12 ducted by the government authority, unless the court finds  
13 the individual's privacy interest outweighs the government  
14 authority's need for the information. The individual shall  
15 have the burden of demonstrating that the individual's pri-  
16 vacy interest outweighs the need by the government au-  
17 thority for the information.

18       “(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
19 PRIVACY INTEREST.—In reaching its determination, the  
20 court shall consider—

21               “(1) the particular purpose for which the infor-  
22 mation was collected;

23               “(2) the degree to which disclosure of the infor-  
24 mation will embarrass, injure, or invade the privacy  
25 of the individual;

1           “(3) the effect of the disclosure on the individ-  
2           ual’s future health care;

3           “(4) the importance of the inquiry being con-  
4           ducted by the government authority, and the impor-  
5           tance of the information to that inquiry; and

6           “(5) any other factor deemed relevant by the  
7           court.

8           “(f) ATTORNEY’S FEES.—In the case of a motion  
9           brought under subsection (a) in which the individual has  
10          substantially prevailed, the court may assess against the  
11          government authority a reasonable attorney’s fee and  
12          other litigation costs (including expert’s fees) reasonably  
13          incurred.

14          “(g) NO INTERLOCUTORY APPEAL.—A ruling deny-  
15          ing a motion to quash under this section shall not be  
16          deemed to be a final order, and no interlocutory appeal  
17          may be taken therefrom by the individual. An appeal of  
18          such a ruling may be taken by the individual within such  
19          period of time as is provided by law as part of any appeal  
20          from a final order in any legal proceeding initiated against  
21          the individual arising out of or based upon the protected  
22          health information disclosed.



1 **“SEC. 11856. CHALLENGE PROCEDURES FOR PRIVATE**  
2 **PARTY SUBPOENAS.**

3 “(a) MOTION TO QUASH SUBPOENA.—Within 15  
4 days after service of a copy of the subpoena seeking pro-  
5 tected health information under section 11854, the indi-  
6 vidual who is the subject of the protected health informa-  
7 tion may file in any court of competent jurisdiction a mo-  
8 tion to quash the subpoena and serve a copy of the motion  
9 on the person seeking the information.

10 “(b) STANDARD FOR DECISION.—The court shall  
11 grant a motion under subsection (a) unless the respondent  
12 demonstrates that—

13 “(1) there is reasonable ground to believe the  
14 information is relevant to a lawsuit or other judicial  
15 or administrative proceeding; and

16 “(2) the need of the respondent for the infor-  
17 mation outweighs the privacy interest of the individ-  
18 ual.

19 “(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO  
20 PRIVACY INTEREST.—In determining under subsection  
21 (b) whether the need of the respondent for the information  
22 outweighs the privacy interest of the individual, the court  
23 shall consider—

24 “(1) the particular purpose for which the infor-  
25 mation was collected;

1           “(2) the degree to which disclosure of the infor-  
2           mation would embarrass, injure, or invade the pri-  
3           vacy of the individual;

4           “(3) the effect of the disclosure on the individ-  
5           ual’s future health care;

6           “(4) the importance of the information to the  
7           lawsuit or proceeding; and

8           “(5) any other relevant factor.

9           “(d) ATTORNEY’S FEES.—In the case of a motion  
10          brought under subsection (a) in which the individual has  
11          substantially prevailed, the court may assess against the  
12          respondent a reasonable attorney’s fee and other litigation  
13          costs and expenses (including expert’s fees) reasonably in-  
14          curred.

15          **“PART III—PROCEDURES FOR ENSURING SECUR-**  
16          **ITY OF PROTECTED HEALTH INFORMATION**

17                 **“Subpart A—Establishment of Safeguards**

18          **“SEC. 11861. ESTABLISHMENT OF SAFEGUARDS.**

19           “(a) IN GENERAL.—A health information trustee  
20          shall establish and maintain appropriate administrative,  
21          technical, and physical safeguards—

22                 “(1) to ensure the integrity and confidentiality  
23                 of protected health information created or received  
24                 by the trustee; and

1           “(2) to protect against any anticipated threats  
2           or hazards to the security or integrity of such infor-  
3           mation.

4           “(b) REGULATIONS.—The Secretary shall promul-  
5           gate regulations regarding security measures for protected  
6           health information.

7           **“SEC. 11862. ACCOUNTING FOR DISCLOSURES.**

8           “(a) IN GENERAL.—

9           “(1) REQUIREMENT TO CREATE OR MAINTAIN  
10          RECORD.—A health information trustee shall create  
11          and maintain, with respect to any protected health  
12          information disclosed in exceptional circumstances  
13          (as described in paragraph (2)), a record of—

14                 “(A) the date and purpose of the disclo-  
15                 sure;

16                 “(B) the name of the person to whom or  
17                 to which the disclosure was made;

18                 “(C) the address of the person to whom or  
19                 to which the disclosure was made or the loca-  
20                 tion to which the disclosure was made; and

21                 “(D) the information disclosed, if the re-  
22                 cording of the information disclosed is prac-  
23                 ticable, taking into account the technical capa-  
24                 bilities of the system used to maintain the  
25                 record and the costs of such maintenance.

1           “(2) EXCEPTIONAL CIRCUMSTANCES DE-  
2           SCRIBED.—For purposes of paragraph (1) protected  
3           health information is disclosed in exceptional cir-  
4           cumstances if the disclosure—

5                   “(A) is not a routine part of doing busi-  
6                   ness, as determined in accordance with guide-  
7                   lines promulgated by the Secretary; or

8                   “(B) is permitted under sections 11823  
9                   and 11832.

10           “(b) DISCLOSURE RECORD PART OF INFORMATION.—  
11           A record created and maintained under paragraph (a)  
12           shall be maintained as part of the protected health infor-  
13           mation to which the record pertains.

14           **“Subpart B—Review of Protected Health Information**  
15                   **By Subjects of the Information**

16           **“SEC. 11871. INSPECTION OF PROTECTED HEALTH INFOR-**  
17                   **MATION.**

18           “(a) IN GENERAL.—Except as provided in subsection  
19           (c), a health care provider or health plan—

20                   “(1) shall permit an individual who is the sub-  
21                   ject of protected health information to inspect any  
22                   such information that the provider or plan main-  
23                   tains;

24                   “(2) shall permit the individual to have a copy  
25                   of the information;

1           “(3) shall permit a person who has been des-  
2           ignated in writing by the individual who is the sub-  
3           ject of the information to inspect, or to have a copy  
4           of, the information on behalf of the individual or to  
5           accompany the individual during the inspection; and

6           “(4) may offer to explain or interpret informa-  
7           tion that is inspected or copied under this sub-  
8           section.

9           “(b) ADDITIONAL REQUESTS.—Except as provided in  
10          subsection (c), a health plan or health care provider shall,  
11          upon written request of an individual—

12           “(1) determine the identity of previous provid-  
13           ers to the individual; and

14           “(2) obtain protected health information re-  
15           garding the individual.

16          “(c) EXCEPTIONS.—A health care provider or health  
17          plan is not required by this section to permit inspection  
18          or copying of protected health information if any of the  
19          following conditions apply:

20           “(1) MENTAL HEALTH TREATMENT NOTES.—

21          The information consists of psychiatric, psycho-  
22          logical, or mental health treatment notes, and the  
23          provider or plan determines, based on reasonable  
24          medical judgment, that inspection or copying of the  
25          notes would cause sufficient harm to the individual

1 who is the subject of the notes so as to outweigh the  
2 desirability of permitting access, and the provider or  
3 plan has not disclosed the notes to any person not  
4 directly engaged in treating the individual, except  
5 with the authorization of the individual or under  
6 compulsion of law.

7 “(2) INFORMATION ABOUT OTHERS.—The in-  
8 formation relates to an individual other than the in-  
9 dividual seeking to inspect or have a copy of the in-  
10 formation and the provider or plan determines,  
11 based on reasonable medical judgment, that inspec-  
12 tion or copying of the information would cause suffi-  
13 cient harm to 1 or both of the individuals so as to  
14 outweigh the desirability of permitting access.

15 “(3) ENDANGERMENT TO LIFE OR SAFETY.—  
16 The provider or plan determines that disclosure of  
17 the information could reasonably be expected to en-  
18 danger the life or physical safety of any individual.

19 “(4) CONFIDENTIAL SOURCE.—The information  
20 identifies or could reasonably lead to the identifica-  
21 tion of a person (other than a health care provider)  
22 who provided information under a promise of con-  
23 fidentiality to a health care provider concerning the  
24 individual who is the subject of the information.

1           “(5) ADMINISTRATIVE PURPOSES.—The infor-  
2           mation—

3                   “(A) is used by the provider or plan solely  
4                   for administrative purposes and not in the pro-  
5                   vision of health care to the individual who is the  
6                   subject of the information; and

7                   “(B) has not been disclosed by the pro-  
8                   vider or plan to any other person.

9           “(d) INSPECTION AND COPYING OF SEGREGABLE  
10           PORTION.—A health care provider or health plan shall  
11           permit inspection and copying under subsection (a) of any  
12           reasonably segregable portion of a record after deletion of  
13           any portion that is exempt under subsection (c).

14           “(e) CONDITIONS.—A health care provider or health  
15           plan may require a written request for the inspection and  
16           copying of protected health information under this sub-  
17           section. The health care provider or health plan may re-  
18           quire a cost reimbursement for such inspection and copy-  
19           ing.

20           “(f) STATEMENT OF REASONS FOR DENIAL.—If a  
21           health care provider or health plan denies a request for  
22           inspection or copying under this section, the provider or  
23           plan shall provide the individual who made the request (or  
24           the individual’s designated representative) with a written  
25           statement of the reasons for the denial.



1           “(1) the reasons for the refusal of the provider  
2 or plan to make the correction or amendment;

3           “(2) any procedures for further review of the  
4 refusal; and

5           “(3) the individual’s right to file with the pro-  
6 vider or plan a concise statement setting forth the  
7 requested correction or amendment and the individ-  
8 ual’s reasons for disagreeing with the refusal of the  
9 provider or plan.

10       “(c) BASES FOR REQUEST TO CORRECT OR  
11 AMEND.—An individual may request correction or amend-  
12 ment of protected health information about the individual  
13 under paragraph (a) if the information is not timely, accu-  
14 rate, relevant to the system of records, or complete.

15       “(d) STATEMENT OF DISAGREEMENT.—After an in-  
16 dividual has filed a statement of disagreement under para-  
17 graph (b)(3), the provider or plan, in any subsequent dis-  
18 closure of the disputed portion of the information—

19           “(1) shall include a copy of the individual’s  
20 statement; and

21           “(2) may include a concise statement of the  
22 reasons of the provider or plan for not making the  
23 requested correction or amendment.

24       “(e) RULE OF CONSTRUCTION.—This section shall  
25 not be construed to require a health care provider or

1 health plan to conduct a formal, informal, or other hearing  
2 or proceeding concerning a request for a correction or  
3 amendment to protected health information the provider  
4 or plan maintains.

5 “(f) CORRECTION.—For purposes of paragraph (a),  
6 a correction is deemed to have been made to protected  
7 health information when information that is not timely,  
8 accurate, relevant to the system of records, or complete  
9 is clearly marked as incorrect or when supplementary cor-  
10 rect information is made part of the information.

11 **“SEC. 11873. NOTICE OF INFORMATION PRACTICES.**

12 “(a) PREPARATION OF WRITTEN NOTICE.—A health  
13 care provider or health plan shall prepare a written notice  
14 of information practices describing the following:

15 “(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—  
16 The rights under this subpart of an individual who  
17 is the subject of protected health information, in-  
18 cluding the right to inspect and copy such informa-  
19 tion and the right to seek amendments to such infor-  
20 mation, and the procedures for authorizing disclo-  
21 sures of protected health information and for revok-  
22 ing such authorizations.

23 “(2) PROCEDURES OF PROVIDER OR PLAN.—  
24 The procedures established by the provider or plan

1 for the exercise of the rights of individuals about  
2 whom protected health information is maintained.

3 “(3) AUTHORIZED DISCLOSURES.—The disclo-  
4 sures of protected health information that are au-  
5 thorized.

6 “(b) DISSEMINATION OF NOTICE.—A health care  
7 provider or health plan—

8 “(1) shall, upon request, provide any individual  
9 with a copy of the notice of information practices de-  
10 scribed in subsection (a); and

11 “(2) shall make reasonable efforts to inform in-  
12 dividuals in a clear and conspicuous manner of the  
13 existence and availability of the notice.

14 “(c) MODEL NOTICE.—The Secretary, after notice  
15 and opportunity for public comment, shall develop and dis-  
16 seminate a model notice of information practices for use  
17 by health care providers and health plans under this sec-  
18 tion.

19 **“Subpart C—Standards for Electronic Disclosures**

20 **“SEC. 11882. STANDARDS FOR ELECTRONIC DISCLOSURES.**

21 “The Secretary shall promulgate standards for dis-  
22 closing protected health information in accordance with  
23 this subtitle in electronic form. Such standards shall in-  
24 clude standards relating to the creation, transmission, re-

1 ceipt, and maintenance, of any written document required  
2 or authorized under this subtitle.

3 **“PART IV—SANCTIONS**

4 **“Subpart A—No Sanctions for Permissible Actions**

5 **“SEC. 11891. NO LIABILITY FOR PERMISSIBLE DISCLO-**  
6 **SURES.**

7 “A health information trustee who makes a disclosure  
8 of protected health information about an individual that  
9 is permitted by this subtitle shall not be liable to the indi-  
10 vidual for the disclosure under common law.

11 **“SEC. 11892. NO LIABILITY FOR INSTITUTIONAL REVIEW**  
12 **BOARD DETERMINATIONS.**

13 “If the members of an institutional review board  
14 make a determination in good faith that—

15 “(1) a health research project is of sufficient  
16 importance to outweigh the intrusion into the pri-  
17 vacy of an individual; and

18 “(2) the effectiveness of the project requires use  
19 of protected health information,

20 the members, the board, and the parent institution of the  
21 board shall not be liable to the individual as a result of  
22 the determination.

23 **“SEC. 11893. RELIANCE ON CERTIFIED ENTITY.**

24 “If a health information trustee contracts with a cer-  
25 tified health information network service to make a disclo-

1 sure of any protected health information on behalf of such  
2 trustee in accordance with this subtitle and such service  
3 makes a disclosure of such information that is in violation  
4 of this subtitle, the trustee shall not be liable for to the  
5 individual who is the subject of the information for such  
6 unlawful disclosure.

7 **“Subpart B—Civil Sanctions**

8 **“SEC. 11901. CIVIL PENALTY.**

9 “(a) VIOLATION.—Any health information trustee  
10 who the Secretary determines has substantially failed to  
11 comply with this subtitle shall be subject, in addition to  
12 any other penalties that may be prescribed by law, to a  
13 civil penalty of not more than \$10,000 for each such viola-  
14 tion.

15 “(b) PROCEDURES FOR IMPOSITION OF PEN-  
16 ALTIES.—Section 1128A, other than subsections (a) and  
17 (b) and the second sentence of subsection (f) of that sec-  
18 tion, shall apply to the imposition of a civil monetary pen-  
19 alty under this section in the same manner as such provi-  
20 sions apply with respect to the imposition of a penalty  
21 under section 1128A.

22 **“SEC. 11902. CIVIL ACTION.**

23 “(a) IN GENERAL.—An individual who is aggrieved  
24 by conduct in violation of this subtitle may bring a civil  
25 action to recover—

1           “(1) the greater of actual damages or liquidated  
2 damages of \$5,000;

3           “(2) punitive damages;

4           “(3) a reasonable attorney’s fee and expenses of  
5 litigation;

6           “(4) costs of litigation; and

7           “(5) such preliminary and equitable relief as  
8 the court determines to be appropriate.

9           “(b) LIMITATION.—No action may be commenced  
10 under this section more than 3 years after the date on  
11 which the violation was or should reasonably have been  
12 discovered.

13                   **“Subpart C—Criminal Sanctions**

14 **“SEC. 11911. WRONGFUL DISCLOSURE OF PROTECTED**  
15 **HEALTH INFORMATION.**

16           “(a) OFFENSE.—A person who knowingly—

17           “(1) obtains protected health information relat-  
18 ing to an individual in violation of this subtitle; or

19           “(2) discloses protected health information to  
20 another person in violation of this subtitle,

21 shall be punished as provided in subsection (b).

22           “(b) PENALTIES.—A person described in subsection  
23 (a) shall—

24           “(1) be fined not more than \$50,000, impris-  
25 oned not more than 1 year, or both;

1           “(2) if the offense is committed under false pre-  
2           tenses, be fined not more than \$100,000, imprisoned  
3           not more than 5 years, or both; and

4           “(3) if the offense is committed with intent to  
5           sell, transfer, or use protected health information for  
6           commercial advantage, personal gain, or malicious  
7           harm, fined not more than \$250,000, imprisoned not  
8           more than 10 years, or both.

9           **“PART V—ADMINISTRATIVE PROVISIONS**

10          **“SEC. 11921. RELATIONSHIP TO OTHER LAWS.**

11          “(a) STATE LAW.—Except as provided in subsections  
12          (b), (c), and (d), this subtitle preempts State law.

13          “(b) LAWS RELATING TO PUBLIC OR MENTAL  
14          HEALTH.—Nothing in this subtitle shall be construed to  
15          preempt or operate to the exclusion of any State law relat-  
16          ing to public health or mental health that prevents or reg-  
17          ulates disclosure of protected health information otherwise  
18          allowed under this subtitle.

19          “(c) PRIVILEGES.—Nothing in this subtitle is in-  
20          tended to preempt or modify State common or statutory  
21          law to the extent such law concerns a privilege of a witness  
22          or person in a court of the State. This subtitle does not  
23          supersede or modify Federal common or statutory law to  
24          the extent such law concerns a privilege of a witness or  
25          person in a court of the United States. Authorizations

1 pursuant to section 11812 shall not be construed as a  
2 waiver of any such privilege.

3 “(d) CERTAIN DUTIES UNDER STATE OR FEDERAL  
4 LAW.—This subtitle shall not be construed to preempt,  
5 supersede, or modify the operation of—

6 “(1) any law that provides for the reporting of  
7 vital statistics such as birth or death information;

8 “(2) any law requiring the reporting of abuse or  
9 neglect information about any individual;

10 “(3) subpart II of part E of title XXVI of the  
11 Public Health Service Act (relating to notifications  
12 of emergency response employees of possible expo-  
13 sure to infectious diseases); or

14 “(4) any Federal law or regulation governing  
15 confidentiality of alcohol and drug patient records.

16 **“SEC. 11922. RIGHTS OF INCOMPETENTS.**

17 “(a) EFFECT OF DECLARATION OF INCOM-  
18 PETENCE.—Except as provided in section 11923, if an in-  
19 dividual has been declared to be incompetent by a court  
20 of competent jurisdiction, the rights of the individual  
21 under this subtitle shall be exercised and discharged in  
22 the best interests of the individual through the individual’s  
23 representative.

24 “(b) NO COURT DECLARATION.—Except as provided  
25 in section 11923, if a health care provider determines that

1 an individual, who has not been declared to be incom-  
2 petent by a court of competent jurisdiction, suffers from  
3 a medical condition that prevents the individual from act-  
4 ing knowingly or effectively on the individual's own behalf,  
5 the right of the individual to authorize disclosure may be  
6 exercised and discharged in the best interest of the individ-  
7 ual by the individual's representative.

8 **“SEC. 11923. EXERCISE OF RIGHTS.**

9 “(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-  
10 BLE.—In the case of an individual—

11 “(1) who is 18 years of age or older, all rights  
12 of the individual shall be exercised by the individual;  
13 or

14 “(2) who, acting alone, has the legal right, as  
15 determined by State law, to apply for and obtain a  
16 type of medical examination, care, or treatment and  
17 who has sought such examination, care, or treat-  
18 ment, the individual shall exercise all rights of an in-  
19 dividual under this subtitle with respect to protected  
20 health information relating to such examination,  
21 care, or treatment.

22 “(b) INDIVIDUALS UNDER 18.—Except as provided  
23 in subsection (a)(2), in the case of an individual who is—

1           “(1) under 14 years of age, all the individual’s  
2           rights under this subtitle shall be exercised through  
3           the parent or legal guardian of the individual; or

4           “(2) 14, 15, 16, or 17 years of age, the rights  
5           of inspection and amendment, and the right to au-  
6           thorize disclosure of protected health information of  
7           the individual may be exercised either by the individ-  
8           ual or by the parent or legal guardian of the individ-  
9           ual.”.

10          (b) CONFORMING AMENDMENT.—Title XI of the So-  
11          cial Security Act (42 U.S.C. 1301 et seq.), as amended  
12          by section 401, is amended by striking the title and insert-  
13          ing the following:

14          **“TITLE XI—GENERAL PROVI-**  
15                 **SIONS, PEER REVIEW, ADMIN-**  
16                 **ISTRATIVE SIMPLIFICATION,**  
17                 **AND PRIVACY”**

18          **TITLE V—MALPRACTICE AND**  
19                 **FRAUD**

20          **Subtitle A—Federal Tort Reform**

21          **SEC. 501. FEDERAL TORT REFORM.**

22          (a) IN GENERAL.—Part A of subtitle A of title XI  
23          of the Social Security Act (42 U.S.C. 1301 et seq.), as  
24          amended by section 401, is amended by inserting after  
25          section 1128B the following new section:

1 **“SEC. 1129. FEDERAL TORT REFORM.**

2 “(a) APPLICABILITY.—

3 “(1) IN GENERAL.—Except as provided in para-  
4 graph (3), this section shall apply with respect to  
5 any medical malpractice claim or medical mal-  
6 practice liability action brought in any Federal or  
7 State court, except that this section shall not apply  
8 to a claim or action for damages arising from a vac-  
9 cine-related injury or death to the extent that title  
10 XXI of the Public Health Service Act applies to the  
11 claim or action.

12 “(2) PREEMPTION.—The provisions of this sec-  
13 tion shall preempt any State law to the extent such  
14 law is inconsistent with the limitations contained in  
15 such provisions. The provisions of this section shall  
16 not preempt any State law that provides for defenses  
17 in addition to those contained in this section, places  
18 greater limitations on the amount of attorneys’ fees  
19 that can be collected, or otherwise imposes greater  
20 restrictions on non-economic or punitive damages  
21 than those provided in this section.

22 “(3) EFFECT ON SOVEREIGN IMMUNITY AND  
23 CHOICE OF LAW OR VENUE.—Nothing in this section  
24 shall be construed to—

1           “(A) waive or affect any defense of sov-  
2           ereign immunity asserted by any State under  
3           any provision of law;

4           “(B) waive or affect any defense of sov-  
5           ereign immunity asserted by the United States;

6           “(C) affect the applicability of any provi-  
7           sion of the Foreign Sovereign Immunities Act  
8           of 1976;

9           “(D) preempt State choice-of-law rules  
10          with respect to claims brought by a foreign na-  
11          tion or a citizen of a foreign nation; or

12          “(E) affect the right of any court to trans-  
13          fer venue or to apply the law of a foreign nation  
14          or to dismiss a claim of a foreign nation or of  
15          a citizen of a foreign nation on the ground of  
16          inconvenient forum.

17          “(4) FEDERAL COURT JURISDICTION NOT ES-  
18          TABLISHED ON FEDERAL QUESTION GROUNDS.—  
19          Nothing in this section shall be construed to estab-  
20          lish any jurisdiction in the district courts of the  
21          United States over medical malpractice liability ac-  
22          tions on the basis of section 1331 or 1337 of title  
23          28, United States Code.

24          “(b) DEFINITIONS.—In this section, the following  
25          definitions apply:

1           “(1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
2           TEM; ADR.—The term ‘alternative dispute resolution  
3           system’ or ‘ADR’ means a system that provides for  
4           the resolution of medical malpractice claims in a  
5           manner other than through medical malpractice li-  
6           ability actions.

7           “(2) CLAIMANT.—The term ‘claimant’ means  
8           any person who alleges a medical malpractice claim,  
9           and any person on whose behalf such a claim is al-  
10          leged, including the decedent in the case of an action  
11          brought through or on behalf of an estate.

12          “(3) HEALTH CARE PROFESSIONAL.—The term  
13          ‘health care professional’ means any individual who  
14          provides health care services in a State and who is  
15          required by the laws or regulations of the State to  
16          be licensed or certified by the State to provide such  
17          services in the State.

18          “(4) HEALTH CARE PROVIDER.—The term  
19          ‘health care provider’ means any organization or in-  
20          stitution that is engaged in the delivery of health  
21          care services in a State and that is required by the  
22          laws or regulations of the State to be licensed or cer-  
23          tified by the State to engage in the delivery of such  
24          services in the State.

1           “(5) INJURY.—The term ‘injury’ means any ill-  
2           ness, disease, or other harm that is the subject of  
3           a medical malpractice liability action or a medical  
4           malpractice claim.

5           “(6) MEDICAL MALPRACTICE LIABILITY AC-  
6           TION.—The term ‘medical malpractice liability ac-  
7           tion’ means a civil action brought in a State or Fed-  
8           eral court against a health care provider or health  
9           care professional (regardless of the theory of liability  
10          on which the claim is based) in which the plaintiff  
11          alleges a medical malpractice claim.

12          “(7) MEDICAL MALPRACTICE CLAIM.—

13               “(A) IN GENERAL.—The term ‘medical  
14               malpractice claim’ means a claim brought  
15               against a health care provider or health care  
16               professional in which a claimant alleges that in-  
17               jury was caused by the provision of (or the fail-  
18               ure to provide) health care services, including  
19               health care services provided under a health  
20               care plan described in subparagraph (B), except  
21               that such term does not include—

22                       “(i) any claim based on an allegation  
23                       of an intentional tort; or

24                       “(ii) any claim based on an allegation  
25                       that a product is defective that is brought

1           against any individual or entity that is not  
2           a health care professional or health care  
3           provider.

4           “(B) HEALTH CARE PLAN DESCRIBED.—A  
5           health care plan described in this subparagraph  
6           includes—

7                   “(i) a certified standard or non-  
8                   standard health plan;

9                   “(ii) a certified supplemental health  
10                  benefits plan;

11                  “(iii) a certified long-term care policy;

12                  “(iv) a State health care program (as  
13                  defined in section 1128(h)); and

14                  “(v) the medicare program under title  
15                  XVIII.

16           “(8) PARTICIPATING STATE.—The term ‘par-  
17           ticipating State’ means a participating State under  
18           title XXI.

19           “(c) ALTERNATIVE DISPUTE RESOLUTION.—

20                   “(1) ADR IN PARTICIPATING STATES.—Each  
21                   participating State shall—

22                           “(A) establish an alternative dispute reso-  
23                           lution system for the determination of medical  
24                           malpractice claims (including the tolling of any

1 applicable statute of limitations during any ac-  
2 tion under such system); and

3 “(B) require that State health care pro-  
4 grams and certified standard and nonstandard  
5 health plans disclose to enrollees (and potential  
6 enrollees), in accordance with standards estab-  
7 lished by the Secretary—

8 “(i) the availability of procedures for  
9 consumer grievances under the program or  
10 plan;

11 “(ii) the alternative dispute resolution  
12 method or methods adopted by the State  
13 under this subsection for its alternative  
14 dispute resolution system and the proce-  
15 dures for filing actions under such system;

16 “(iii) the consequences of, and alter-  
17 natives to, participation in such system.

18 “(2) APPLICATION TO MEDICAL MALPRACTICE  
19 CLAIMS.—In the case of any medical malpractice  
20 claim, no medical malpractice liability action may be  
21 brought with respect to such claim in a participating  
22 State until the final resolution of the claim under  
23 the alternative dispute resolution system established  
24 by the State under paragraph (1).

1           “(3) ADOPTION OF MECHANISM BY PARTICIPAT-  
2           ING STATES.—Each participating State shall adopt  
3           at least one of the methods of alternative dispute  
4           resolution specified under paragraph (4) or (5) for  
5           the resolution of medical malpractice claims.

6           “(4) SPECIFICATION OF PERMISSIBLE ADR  
7           METHODS.—

8           “(A) IN GENERAL.—The Secretary shall,  
9           by regulation, develop alternative dispute reso-  
10          lution methods for use by participating States  
11          in resolving medical malpractice claims under  
12          paragraph (1). Such methods shall include at  
13          least the following:

14               “(i) BINDING ARBITRATION.—The use  
15               of binding arbitration.

16               “(ii) FAULT-BASED SYSTEMS.—The  
17               use of fault-based administrative systems,  
18               expedited review, and dismissal of claims  
19               when not adequately supported.

20               “(iii) EARLY OFFERS OF SETTLE-  
21               MENT.—The use of a process under which  
22               parties have the option to make early of-  
23               fers of settlement.

1           “(iv) CATASTROPHIC SYSTEMS.—The  
2           use of catastrophic injury compensation  
3           systems.

4           “(B) STANDARDS FOR ESTABLISHING  
5           METHODS.—In developing alternative dispute  
6           resolution methods under subparagraph (A),  
7           the Secretary shall assure that the methods  
8           promote the resolution of medical malpractice  
9           claims in a manner that—

10           “(i) is affordable for the parties in-  
11           volved;

12           “(ii) provides for timely resolution of  
13           claims;

14           “(iii) provides for the consistent and  
15           fair resolution of claims; and

16           “(iv) provides for reasonably conven-  
17           ient access to the alternative dispute reso-  
18           lution system for individuals enrolled in  
19           certified standard and nonstandard health  
20           plans.

21           “(5) STATE INITIATED ALTERNATIVE.—A par-  
22           ticipating State will be permitted to operate a meth-  
23           od of alternative dispute resolution (other than a  
24           method described in paragraph (4)) that otherwise  
25           complies with this section if such system—

1           “(A) is determined by the Secretary to ac-  
2           complish the purposes and otherwise meet the  
3           requirements of this section; and

4           “(B) is certified by the Secretary as an ap-  
5           propriate alternative dispute resolution method.

6           “(d) PROCEDURES FOR FILING ACTIONS.—

7           “(1) CONTESTING OF ADR DECISION.—If either  
8           party to a decision issued with respect to an alter-  
9           native dispute resolution method applied under sub-  
10          section (c) is dissatisfied with such decision, such  
11          party may (to the extent otherwise permitted by  
12          State law) contest such decision after it is issued  
13          and seek a rehearing of the medical malpractice  
14          claim involved in a court of competent jurisdiction.

15          “(2) NOTICE OF INTENT TO CONTEST DECI-  
16          SION.—Not later than 60 days after a decision is is-  
17          sued with respect to a medical malpractice claim  
18          under an alternative dispute resolution system estab-  
19          lished by a participating State under subsection (c),  
20          each party affected by the decision shall submit a  
21          sealed statement to a court of competent jurisdiction  
22          indicating whether or not the party intends to con-  
23          test the decision.

1           “(3) COURT OF COMPETENT JURISDICTION.—

2           For purposes of this subsection, the term ‘court of  
3           competent jurisdiction’ means—

4                   “(A) with respect to actions filed in a  
5           State court, the appropriate State trial court;  
6           and

7                   “(B) with respect to actions filed in a Fed-  
8           eral court, the appropriate United States dis-  
9           trict court.

10           “(4) LEGAL EFFECT OF UNCONTESTED ALTER-

11           NATIVE DISPUTE RESOLUTION SYSTEM DECISION.—

12           The decision reached under an alternative dispute  
13           resolution system shall, for purposes of enforcement  
14           by a court of competent jurisdiction, have the same  
15           status in the court as the verdict of a medical mal-  
16           practice liability action adjudicated in a State or  
17           Federal trial court. The previous sentence shall not  
18           apply to a decision that is contested by a party af-  
19           fected by the decision pursuant to paragraph (1).

20           “(e) TREATMENT OF ATTORNEYS’ FEES AND OTHER  
21           COSTS.—

22                   “(1) LIMITATION ON AMOUNT OF CONTINGENCY  
23           FEES.—

24                   “(A) IN GENERAL.—An attorney who rep-  
25           resents, on a contingency fee basis, a claimant

1 in a medical malpractice claim or medical mal-  
2 practice liability action may not charge, de-  
3 mand, receive, or collect for services rendered in  
4 connection with such claim or action in excess  
5 of the following amount recovered by judgment  
6 or settlement under such claim or action:

7 “(i)  $33\frac{1}{3}$  percent of the first  
8 \$150,000 (or portion thereof) recovered,  
9 based on after-tax recovery, plus

10 “(ii) 25 percent of any amount in ex-  
11 cess of \$150,000 recovered, based on after-  
12 tax recovery.

13 “(B) CALCULATION OF PERIODIC PAY-  
14 MENTS.—In the event that a judgment or set-  
15 tlement includes periodic or future payments of  
16 damages, the amount recovered for purposes of  
17 computing the limitation on the contingency fee  
18 under subparagraph (A) shall be based on the  
19 cost of the annuity or trust established to make  
20 the payments. In any case in which an annuity  
21 or trust is not established to make such pay-  
22 ments, such amount shall be based on the  
23 present value of the payments.

24 “(2) REQUIRING PARTY CONTESTING ADR RUL-  
25 ING TO PAY ATTORNEYS’ FEES AND OTHER COSTS.—

1           “(A) IN GENERAL.—The court in a medi-  
2 cal malpractice liability action shall require a  
3 party that (pursuant to subsection (d)(1)) con-  
4 tests the ruling of the alternative dispute reso-  
5 lution system of a participating State with re-  
6 spect to the medical malpractice claim that is  
7 the subject of the action to pay to the opposing  
8 party the costs incurred by the opposing party  
9 under the action, including attorneys’ fees, fees  
10 paid to expert witnesses, and other litigation ex-  
11 penses (but not including court costs, filing  
12 fees, or other expenses paid directly by the  
13 party to the court, or any fees or costs associ-  
14 ated with the resolution of the claim under the  
15 alternative dispute resolution system), but only  
16 if—

17           “(i) in the case of an action in which  
18 the party that contested the ruling is the  
19 claimant, the amount of damages awarded  
20 to the party under the action is less than  
21  $66\frac{2}{3}$  percent of the amount of damages  
22 awarded to the party under the alternative  
23 dispute resolution system; and

24           “(ii) in the case of an action in which  
25 the party that contested the ruling is the

1           defendant, the amount of damages as-  
2           sessed against the party under the action  
3           is greater than the amount of damages as-  
4           sessed under the alternative dispute resolu-  
5           tion system.

6           “(B) EXCEPTION.—Subparagraph (A)  
7           shall not apply if the court finds that the appli-  
8           cation of such subparagraph to a party would  
9           constitute an undue hardship, and issues an  
10          order waiving or modifying the application of  
11          such subparagraph that specifies the grounds  
12          for the court’s decision.

13          “(C) LIMIT ON ATTORNEYS’ FEES PAID.—  
14          Attorneys’ fees that are required to be paid  
15          under subparagraph (A) by the contesting party  
16          shall not exceed the amount of the attorneys’  
17          fees incurred by the contesting party in the ac-  
18          tion. If the attorneys’ fees of the contesting  
19          party are based on a contingency fee agree-  
20          ment, the amount of attorneys’ fees for pur-  
21          poses of the preceding sentence shall not exceed  
22          the reasonable value of those services.

23          “(3) CONTINGENCY FEE DEFINED.—As used in  
24          this subsection, the term ‘contingency fee’ means  
25          any fee for professional legal services which is, in

1 whole or in part, contingent upon the recovery of  
2 any amount of damages, whether through judgment  
3 or settlement.

4 “(f) SCOPE OF LIABILITY.—

5 “(1) IN GENERAL.—With respect to punitive  
6 and noneconomic damages, the liability of each de-  
7 fendant in a medical malpractice claim or medical  
8 malpractice liability action shall be several only and  
9 may not be joint. Such a defendant shall be liable  
10 only for the amount of punitive or noneconomic  
11 damages allocated to the defendant in direct propor-  
12 tion to such defendant’s percentage of fault or re-  
13 sponsibility for the injury suffered by the claimant.

14 “(2) DETERMINATION OF PERCENTAGE OF LI-  
15 ABILITY.—The trier of fact in a medical malpractice  
16 claim or medical malpractice liability action shall de-  
17 termine the extent of each defendant’s fault or re-  
18 sponsibility for injury suffered by the claimant, and  
19 shall assign a percentage of responsibility for such  
20 injury to each such defendant.

21 “(g) REFORM OF DAMAGES.—

22 “(1) LIMITATION ON NONECONOMIC DAM-  
23 AGES.—

24 “(A) IN GENERAL.—With respect to a  
25 medical malpractice claim or medical mal-

1 practice liability action brought in any forum,  
2 the total amount of damages that may be  
3 awarded to an individual and the family mem-  
4 bers of such individual for noneconomic losses  
5 resulting from an injury alleged under such  
6 claim or action may not exceed the amount de-  
7 termined under subparagraph (B), regardless of  
8 the number of health care professionals, health  
9 care providers, and other defendants against  
10 whom the action is brought or the number of  
11 actions brought with respect to the injury. With  
12 respect to actions heard by a jury, the jury may  
13 not be informed of the limitation contained in  
14 this paragraph. If the jury's damage award ex-  
15 ceeds such limitation, a reduction in such award  
16 shall be made by the court.

17 “(B) LIMITATION AMOUNT.—The amount  
18 determined under this subparagraph shall be  
19 equal to—

20 “(i) in 1995, \$250,000; and

21 “(ii) in subsequent years, the amount  
22 determined under this subparagraph in the  
23 previous year, updated by the estimated  
24 percentage change in the Consumer Price  
25 Index for All Urban Consumers (United

1 States city average) during the previous  
2 calendar year, adjusted by any previous  
3 over estimations or under estimations  
4 under this subparagraph.

5 “(2) PUNITIVE DAMAGES.—

6 “(A) FUND.—Each participating State  
7 shall establish a health care safety and policy  
8 program, to be approved by the Secretary, and  
9 a fund consisting of such amounts as are trans-  
10 ferred to the fund under subparagraph (B).

11 “(B) TRANSFER OF AMOUNTS.—Each par-  
12 ticipating State shall require that 75 percent of  
13 all awards of punitive damages resulting from  
14 all medical malpractice claims or medical mal-  
15 practice liability actions in that State be trans-  
16 ferred to the fund established under subpara-  
17 graph (A) in the State.

18 “(C) OBLIGATIONS FROM FUND.—The  
19 chief executive officer of a participating State  
20 shall obligate such sums as are available in the  
21 fund established in that State under subpara-  
22 graph (A) to—

23 “(i) license and certify health care  
24 professionals in the State;

1           “(ii) implement health care quality as-  
2           surance programs;

3           “(iii) carry out public education pro-  
4           grams to increase awareness of the avail-  
5           ability of comparative value information on  
6           certified standard health plans distributed  
7           in accordance with the State consumer in-  
8           formation program established under sec-  
9           tion 21025; and

10           “(iv) carry out programs to reduce  
11           malpractice-related costs for health care  
12           providers volunteering to provide health  
13           care services in medically underserved  
14           areas.

15           “(h) NO-FAULT LIABILITY DEMONSTRATION  
16           PROJECTS.—

17           “(1) IN GENERAL.—The Secretary may provide  
18           funds (in such amount as the Secretary considers  
19           appropriate) to one or more eligible participating  
20           States to establish no-fault medical liability system  
21           demonstration projects to replace the common law  
22           tort liability system for medical injuries.

23           “(2) ELIGIBILITY OF STATE.—A participating  
24           State is eligible to participate in the demonstration  
25           project established under paragraph (1) if the State

1 submits an application to the Secretary at such  
2 time, in such manner, and containing such informa-  
3 tion and assurances as the Secretary may require.

4 “(3) WAIVERS.—The Secretary may waive any  
5 provision of this section that the Secretary deter-  
6 mines is necessary for a State to conduct a dem-  
7 onstration project established under paragraph (1).

8 “(4) AUTHORIZATION OF APPROPRIATIONS.—  
9 There are authorized to be appropriated such sums  
10 as may be necessary to carry out the demonstration  
11 projects under this subsection.”.

12 (b) EFFECTIVE DATE.—The amendment made by  
13 subsection (a) shall apply to medical malpractice claims  
14 arising on or after January 1, 1995.

15 **Subtitle B—Expanded Efforts To**  
16 **Control Health Care Fraud and**  
17 **Abuse Affecting Federal Outlay**  
18 **Programs**

19 **PART I—IMPROVED ENFORCEMENT**

20 **SEC. 511. HEALTH CARE FRAUD AND ABUSE AFFECTING**  
21 **FEDERAL OUTLAY PROGRAMS.**

22 (a) IN GENERAL.—Part A of subtitle A of title XI  
23 of the Social Security Act, as amended by section 501,  
24 is amended by inserting after section 1128B (42 U.S.C.  
25 1320a-7b) the following new sections:

1 “HEALTH CARE FRAUD AND ABUSE AFFECTING FEDERAL  
2 OUTLAY PROGRAMS

3 “SEC. 1128C. (a) IN GENERAL.—Not later than Jan-  
4 uary 1, 1996, the Secretary and the Attorney General of  
5 the United States shall establish a joint program—

6 “(1) to coordinate Federal, State, and local law  
7 enforcement programs to control fraud and abuse af-  
8 fecting Federal outlay programs,

9 “(2) to prosecute health care matters (through  
10 criminal, civil, and administrative proceedings);

11 “(3) to conduct investigations (including  
12 consumer complaint investigations), audits, evalua-  
13 tions, and inspections relating to the delivery of and  
14 payment for health care in the United States,

15 “(4) to conduct financial and performance au-  
16 dits of health care programs and operations;

17 “(5) to conduct inspections and other evalua-  
18 tions;

19 “(6) to provide rewards paid under section  
20 1128F;

21 “(7) to facilitate the enforcement of sections  
22 1128 through 1128G and other statutes applicable  
23 to health care fraud and abuse.

24 “(8) to provide health care provider and  
25 consumer education (including the provision of advi-

1 sory opinions) regarding compliance with the provi-  
2 sions of sections 1128 through 1128G.

3 Not more than 20 percent of the amounts available in the  
4 Federal Outlay Program Fraud and Abuse Control Ac-  
5 count for any fiscal year shall be used for the purposes  
6 described in paragraph (8).

7 “(b) COORDINATION WITH LAW ENFORCEMENT  
8 AGENCIES.—In carrying out the program under sub-  
9 section (a), the Secretary and the Attorney General shall  
10 consult with, and arrange for the sharing of data and re-  
11 sources with, Federal, State, and local law enforcement  
12 agencies, State Medicaid Fraud Control Units, and State  
13 agencies responsible for the licensing and certification of  
14 health care providers.

15 “(c) COORDINATION WITH PURCHASING COOPERA-  
16 TIVES AND CERTIFIED HEALTH PLANS.—In carrying out  
17 the program under subsection (a), the Secretary and the  
18 Attorney General shall consult with, and arrange for the  
19 sharing of data with representatives of purchasing co-  
20 operatives and certified health plans.

21 “(d) AUTHORITIES OF ATTORNEY GENERAL AND  
22 SECRETARY.—In carrying out duties under subsection (a),  
23 the Attorney General and the Secretary are authorized—

24 “(1) to conduct, supervise, and coordinate au-  
25 dits, civil and criminal investigations, inspections,

1 and evaluations relating to the program established  
2 under such subsection;

3 “(2) to have access (including on-line access as  
4 requested and available) to all records available to  
5 purchasing cooperatives and certified health plans  
6 relating to the activities described in paragraph (1)  
7 (subject to restrictions based on the confidentiality  
8 of certain information under part II of subtitle B of  
9 this title); and

10 “(3) to issue advisory opinions, fraud alerts,  
11 and other appropriate educational material to assist  
12 in compliance with the provisions of sections 1128  
13 through 1128G.

14 “(e) QUALIFIED IMMUNITY FOR PROVIDING INFOR-  
15 MATION.—The provisions of section 1157(a) (relating to  
16 limitation on liability) shall apply to a person providing  
17 information or communications to the Secretary or the At-  
18 torney General in conjunction with their performance of  
19 duties under this section, in the same manner as such sec-  
20 tion applies to information provided to organizations with  
21 a contract under part B of this subtitle.

22 “(f) USE OF POWERS UNDER INSPECTOR GENERAL  
23 ACT OF 1978.—In carrying out duties and responsibilities  
24 under the program established under subsection (a), the  
25 Inspector General is authorized to exercise all powers

1 granted under the Inspector General Act of 1978 to the  
2 same manner and extent as provided in that Act.

3 “(g) DEFINITIONS.—In this subtitle:

4 “(1) CERTIFIED HEALTH PLANS; PURCHASING  
5 COOPERATIVES.—The terms ‘certified health plan’  
6 and ‘purchasing cooperative’ have the meanings  
7 given such terms by sections 21011(a)(1) and  
8 21100(14), respectively.

9 “(2) FEDERAL OUTLAY PROGRAMS.—The term  
10 ‘Federal outlay programs’ means—

11 “(A) any program under title XVIII, and

12 “(B) any State health care program (as  
13 defined in section 1128(h).

14 “(3) INSPECTOR GENERAL.—The term ‘Inspec-  
15 tor General’ means the Inspector General of the De-  
16 partment of Health and Human Services.”.

17 (b) STATE HEALTH CARE PROGRAM DEFINED.—  
18 Section 1128(h) of the Social Security Act (42 U.S.C.  
19 1320a-7(h)) is amended by redesignating paragraphs (2)  
20 and (3) as paragraphs (3) and (4), respectively, and by  
21 inserting after paragraph (1) the following new paragraph:

22 “(2) any participating State program approved  
23 under title XXI (including any program established  
24 by the Secretary of Labor with respect to multistate  
25 self-insured health plans) and any standard or non-

1 standard health plan, supplemental health benefits  
2 plan, or long-term care policy certified under such  
3 program.”.

4 **SEC. 512. DEFINITION OF FEDERAL HEALTH CARE OF-**  
5 **FENSE.**

6 Subtitle A of title XI of the Social Security Act, as  
7 amended by section 511, is amended by inserting after  
8 section 1128C the following new section:

9 “FEDERAL HEALTH CARE OFFENSE DEFINED

10 “SEC. 1128D. For purposes of this title, the term  
11 ‘Federal health care offense’ means a violation of, or a  
12 criminal conspiracy to violate—

13 “(1) sections 226, 668, 1033, or 1347 of title  
14 18, United States Code;

15 “(2) section 1128B;

16 “(3) sections 287, 371, 664, 666, 1001, 1027,  
17 1341, 1343, or 1954 of title 18, United States Code,  
18 if the violation or conspiracy relates to health care  
19 fraud;

20 “(4) sections 501 or 511 of the Employee Re-  
21 tirement Income Security Act of 1974, if the viola-  
22 tion or conspiracy relates to health care fraud; or

23 “(5) sections 301, 303(a)(2), or 303 (b) or (e)  
24 of the Federal Food Drug and Cosmetic Act, if the  
25 violation or conspiracy relates to health care fraud.”.

1 **SEC. 513. USE OF FUNDS BY INSPECTOR GENERAL.**

2 Subtitle A of title XI of the Social Security Act, as  
3 amended by section 512, is amended by inserting after  
4 section 1128D the following new section:

5 “USE OF FUNDS BY INSPECTOR GENERAL

6 “SEC. 1128E. (a) REIMBURSEMENTS FOR INVES-  
7 TIGATIONS.—

8 “(1) IN GENERAL.—The Inspector General is  
9 authorized to receive and retain for current use re-  
10 imbursement for the costs of conducting investiga-  
11 tions, when such restitution is ordered by a court,  
12 voluntarily agreed to by the payer, or otherwise.

13 “(2) CREDITING.—Funds received by the In-  
14 spector General as reimbursement for costs of con-  
15 ducting investigations shall be deposited to the cred-  
16 it of the appropriation from which initially paid, or  
17 to appropriations for similar purposes currently  
18 available at the time of deposit, and shall remain  
19 available for obligation for 1 year from the date of  
20 their deposit.

21 “(3) EXCEPTION FOR FORFEITURES.—This  
22 subsection does not apply to investigative costs paid  
23 to the Inspector General from the Department of  
24 Justice Asset Forfeiture Fund, which monies shall  
25 be deposited and expended in accordance with sub-  
26 section (b).



1 a Federal health care offense (as defined in section  
2 1128D).

3 “(b) INELIGIBLE PERSONS.—A person is not eligible  
4 for a payment under subsection (a) if—

5 “(1) the person is a current or former officer  
6 or employee of a Federal or State government agen-  
7 cy or instrumentality who furnishes information dis-  
8 covered or gathered in the course of government em-  
9 ployment;

10 “(2) the person knowingly participated in the  
11 offense;

12 “(3) the information furnished by the person  
13 consists of allegations or transactions that have been  
14 disclosed to the public—

15 “(A) in a criminal, civil, or administrative  
16 proceeding;

17 “(B) in a congressional, administrative, or  
18 General Accounting Office report, hearing,  
19 audit, or investigation; or

20 “(C) by the news media, unless the person  
21 is the original source of the information; or

22 “(4) when, in the judgment of the Attorney  
23 General, it appears that a person whose illegal ac-  
24 tivities are being prosecuted or investigated could  
25 benefit from the award.



1 the remainder of the amounts recovered shall be deposited  
2 in the Federal Outlays Program Fraud and Abuse Control  
3 Account established under section 9551 of the Internal  
4 Revenue Code of 1986.”.

5 (b) ADDITIONAL OFFENSES.—

6 (1) IN GENERAL.—Section 1128A(a) of the So-  
7 cial Security Act (42 U.S.C. 1320a–7a(a)) is amend-  
8 ed—

9 (A) by striking “or” at the end of para-  
10 graphs (1) and (2);

11 (B) by striking the comma at the end of  
12 paragraph (2) and inserting a semicolon; and

13 (C) by inserting after paragraph (3) the  
14 following new paragraphs:

15 “(4) offers, pays, or transfers remuneration to  
16 any individual eligible for benefits under title XVIII  
17 of this Act, or under a State health care program  
18 (as defined in section 1128(h)), that such person  
19 knows or should know is likely to influence such in-  
20 dividual to order or receive from a particular pro-  
21 vider, practitioner, or supplier any item or service  
22 for which payment may be made, in whole or in  
23 part, under title XVIII, or a State health care pro-  
24 gram;

1           “(5) in the case of a person who is not an orga-  
2           nization, agency, or other entity, who is excluded  
3           from participating in a program under title XVIII or  
4           a State health care program in accordance with this  
5           section, section 1128, or section 1156 and who, dur-  
6           ing the period of exclusion, retains either a direct or  
7           indirect ownership or control interest of 5 percent or  
8           more in, or an ownership or control interest (as de-  
9           fined in section 1124(a)(3)) in, or who is an officer,  
10          director, agent, or managing employee (as defined in  
11          section 1126(b)) of, an entity that is participating in  
12          a program under title XVIII or a State health care  
13          program;

14          “(6) engages in a practice that circumvents a  
15          payment methodology intended to reimburse for two  
16          or more discreet medical items or services at a single  
17          or fixed amount, including but not limited to, mul-  
18          tiple admissions or readmission to hospitals and  
19          other institutions reimbursed on a diagnosis reim-  
20          bursement grouping basis;

21          “(7) engages in a practice which has the effect  
22          of limiting or discouraging (as compared to other  
23          plan enrollees) the utilization of health care services  
24          covered by law or under the service contract by title  
25          XIX or other publicly subsidized patients, including

1 but not limited to differential standards for the loca-  
2 tion and hours of service offered by providers par-  
3 ticipating in the plan;

4 “(8) substantially fails to cooperate with a qual-  
5 ity assurance program or a utilization review activ-  
6 ity;

7 “(9) fails substantially to provide or authorize  
8 medically necessary items and services that are re-  
9 quired to be provided to an individual covered under  
10 a certified health plan (as defined in section  
11 21011(a)) or public program for the delivery of or  
12 payment for health care items or services, if the fail-  
13 ure has adversely affected (or had a substantial like-  
14 lihood of adversely affecting) the individual;

15 “(10) employs or contracts with any individual  
16 or entity who is excluded from participating in a  
17 program under title XVIII or a State health care  
18 program in accordance with this section, section  
19 1128, or section 1156, for the provision of any serv-  
20 ices (including but not limited to health care, utiliza-  
21 tion review, medical social work, or administrative),  
22 or employs or contracts with any entity for the di-  
23 rect or indirect provision of such services, through  
24 such an excluded individual or entity; or

1           “(11) submits false or fraudulent statements,  
2           data or information, or claims to the Secretary, the  
3           Secretary of Labor, any other Federal agency, a  
4           State health care agency, a purchasing cooperative  
5           (under subtitle D of title XXI), or any other Fed-  
6           eral, State or local agency charged with implementa-  
7           tion or oversight of a certified health plan under this  
8           Act or a public program that the person knows or  
9           should know is fraudulent;”.

10           (2)     REMUNERATION     DEFINED.—Section  
11           1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is  
12           amended by adding at the end the following new  
13           paragraph:

14           “(6) The term ‘remuneration’ includes the waiv-  
15           er of coinsurance and deductible amounts (or any  
16           part thereof), and transfers of items or services for  
17           free or for other than fair market value, except that  
18           such term does not include the waiver of coinsurance  
19           or deductible amounts by a person or entity, if—

20                   “(A) the waiver is not offered as part of  
21                   any advertisement or solicitation;

22                   “(B) the person does not routinely waive  
23                   coinsurance or deductible amounts; and

24                   “(C) the person—

1           “(i) waives the coinsurance and de-  
2           ductible amounts after determining in good  
3           faith that the individual is indigent;

4           “(ii) fails to collect coinsurance or de-  
5           ductible amounts after making reasonable  
6           collection efforts; or

7           “(iii) provides for any permissible  
8           waiver as specified in section 1128B(b)(3)  
9           or in regulations issued by the Secretary.”.

10           (3) CLAIM FOR ITEM OR SERVICE BASED ON IN-  
11           CORRECT CODING OR MEDICALLY UNNECESSARY  
12           SERVICES.—Section 1128A(a)(1) of such Act (42  
13           U.S.C. 1320a-7a(a)(1)) is amended—

14           (A) in subparagraph (A), by striking  
15           “claimed,” and inserting the following:  
16           “claimed, including any person who presents or  
17           causes to be presented a claim for an item or  
18           service which includes a procedure or diagnosis  
19           code that the person knows or should know will  
20           result in a greater payment to the person than  
21           the code applicable to the item or service actu-  
22           ally provided or actual patient medical condi-  
23           tion,”;

24           (B) in subparagraph (C), by striking “or”  
25           at the end;

1 (C) in subparagraph (D), by striking “;  
2 or” and inserting “, or”; and

3 (D) by inserting after subparagraph (D)  
4 the following new subparagraph:

5 “(E) is for a medical or other item or serv-  
6 ice that a person knows or should know is not  
7 medically necessary or appropriate; or”.

8 (c) PENALTIES INCREASED.—

9 (1) GENERAL RULE.—Section 1128A(a) of the  
10 Social Security Act (42 U.S.C. 1320a-7a(a)) is  
11 amended—

12 (A) by striking “\$2,000” and inserting  
13 “\$10,000”; and

14 (B) by striking “twice the amount  
15 claimed” and inserting “3 times the amount  
16 claimed”.

17 (2) INTEREST ON PENALTIES.—Section  
18 1128A(f) of such Act (42 U.S.C. 1320a-7a(f)) is  
19 amended by adding after the first sentence the fol-  
20 lowing: “Interest shall accrue on the penalties and  
21 assessments imposed by a final determination of the  
22 Secretary in accordance with an annual rate estab-  
23 lished by the Secretary under the Federal Claims  
24 Collection Act. The rate of interest charged shall be  
25 the rate in effect on the date the determination be-

1 comes final and shall remain fixed at that rate until  
2 the entire amount due is paid. In addition, the Sec-  
3 retary is authorized to recover the costs of collection  
4 in any case where such penalties and assessments  
5 are not paid within 30 days after the determination  
6 becomes final, or in the case of a compromised  
7 amount, where payments are more than 90 days  
8 past due. In lieu of actual costs, the Secretary is au-  
9 thorized to impose a charge of up to 10 percent of  
10 the amount of such penalties and assessments owed  
11 to cover the costs of collection.”.

12 (d) AUTHORITY OF SECRETARY OF LABOR TO IM-  
13 POSE PENALTIES, ASSESSMENTS, AND EXCLUSIONS.—  
14 Section 1128A of the Social Security Act (42 U.S.C.  
15 1320a-7a) is amended by adding at the end the following  
16 new subsection:

17 “(m)(1) The Secretary of Labor may initiate an ac-  
18 tion to impose a civil monetary penalty, assessment, or  
19 exclusion under this section with respect to actions relat-  
20 ing to a certified multistate self-insured health plan (as  
21 defined on section 21051(b)) pursuant to regulations pro-  
22 mulgated by the Secretary of Health and Human Services,  
23 in consultation with the Attorney General.

24 “(2) Under the regulations promulgated under para-  
25 graph (1), the Attorney General and the Secretary shall

1 review an action proposed by the Secretary of Labor, and  
2 not later than 60 days after receiving notice of the pro-  
3 posed action from the Secretary of Labor, shall—

4 “(A) approve the proposed action to be taken  
5 by the Secretary of Labor;

6 “(B) disapprove the proposed action; or

7 “(C) assume responsibility for initiating a  
8 criminal, civil, or administrative action based on the  
9 information provided in the notice.

10 “(3) If the Attorney General and the Secretary fail  
11 to respond to a proposed action by the Secretary of Labor  
12 within the period described in paragraph (2), the Attorney  
13 General and the Secretary shall be deemed to have ap-  
14 proved the proposed action to be taken by the Secretary  
15 of Labor.”.

16 (e) NOTIFICATION OF LICENSING AUTHORITIES.—  
17 Section 1128A of the Social Security Act (42 U.S.C.  
18 1320a-7a), as amended by subsection (d), is amended by  
19 adding at the end the following new subsection:

20 “(n) Whenever the Secretary’s determination to im-  
21 pose a penalty, assessment, or exclusion under this section  
22 becomes final, the Secretary shall notify the appropriate  
23 State or local licensing agency or organization (including  
24 the agency specified in section 1864(a) and 1902(a)(33))

1 that such a penalty, assessment, or exclusion has become  
2 final and the reasons therefor.”.

3 **SEC. 522. PERMITTING PARTIES TO BRING ACTIONS ON**  
4 **OWN BEHALF.**

5 Subtitle A of title XI of the Social Security Act, as  
6 amended by section 514, is amended by inserting after  
7 section 1128F the following new section:

8 “PRIVATE RIGHTS OF ACTION

9 “SEC. 1128G. (a) IN GENERAL.—Subject to sub-  
10 sections (b) and (c), a certified health plan (as defined  
11 in section 21011(b)) or experience-rated employer (as de-  
12 fined in section 21004(d)(4)) that suffers harm or mone-  
13 tary loss exceeding the sum or value of \$10,000 (excluding  
14 interest) as a result of any activity of an individual or en-  
15 tity which makes the individual or entity subject to a civil  
16 monetary penalty under section 1128A may, in a civil ac-  
17 tion against the individual or entity in the United States  
18 District Court, obtain treble damages and costs including  
19 attorneys’ fees against the individual or entity and such  
20 equitable relief as is appropriate.

21 “(b) REQUIREMENTS FOR BRINGING ACTION.—A  
22 person may bring a civil action under this section only if—

23 “(1) the person provides the Secretary with  
24 written notice of—

25 “(A) the person’s intent to bring an action  
26 under this section,

1           “(B) the identities of the individuals or en-  
2           tities the person intends to name as defendants  
3           to the action, and

4           “(C) all information the person possesses  
5           regarding the activity that is the subject of the  
6           action that may materially affect the Sec-  
7           retary’s decision to initiate a proceeding to im-  
8           pose a civil monetary penalty under section  
9           1128A against the defendants, and

10          “(2) one of the following conditions is met:

11           “(A) During the 60-day period that begins  
12           on the date the Secretary receives the written  
13           notice described in paragraph (1), the Secretary  
14           does not notify the person that the Secretary  
15           intends to initiate an investigation to determine  
16           whether to impose a civil monetary penalty  
17           under section 1128A against the defendants.

18           “(B) The Secretary notifies the person  
19           during the 60-day period described in subpara-  
20           graph (A) that the Secretary intends to initiate  
21           an investigation to determine whether to impose  
22           a civil monetary penalty under such section  
23           against the defendants, and the Secretary sub-  
24           sequently notifies the person that the Secretary  
25           no longer intends to initiate an investigation or

1 proceeding to impose a civil monetary penalty  
2 against the defendants.

3 “(C) After the expiration of the 1-year pe-  
4 riod that begins on the date written notice is  
5 provided to the Secretary, the Secretary has not  
6 initiated a proceeding to impose a civil mone-  
7 tary penalty against the defendants.

8 “(c) TREATMENT OF EXCESS AWARDS.—If a person  
9 is awarded any amounts in an action brought under this  
10 section that are in excess of the damages suffered by the  
11 person as a result of the defendant’s activities, 20 percent  
12 of such amounts shall be withheld from the person for pay-  
13 ment into the Federal Outlays Program Fraud and Abuse  
14 Control Account established under section 1128C(a).

15 “(d) STATUTE OF LIMITATIONS.—No action may be  
16 brought under this section more than 6 years after the  
17 date of the activity with respect to which the action is  
18 brought.

19 “(e) NO LIMITATION ON OTHER ACTIONS.—Nothing  
20 in this section shall limit the right of any person to pursue  
21 any other right of action or remedy available under the  
22 law.

23 “(f) PENDANT JURISDICTION.—Nothing in this sec-  
24 tion shall be construed, by reason of a claim arising under

1 this section, to confer on the Courts of the United States  
2 jurisdiction over any State law claim.”.

3 **SEC. 523. EXCLUSION FROM PROGRAM PARTICIPATION.**

4 (a) MANDATORY EXCLUSION.—Section 1128(a) of  
5 the Social Security Act (42 U.S.C. 1320a-7) is amended—

6 (1) by inserting “(1)” before “The”;

7 (2) by redesignating paragraphs (1) and (2) as  
8 subparagraphs (A) and (B), respectively; and

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

10 “(C) CONVICTION OF CRIMINAL OFFENSE.—  
11 Any individual or entity that has been convicted  
12 after the date of the enactment of this subpara-  
13 graph, under Federal or State law, in connection  
14 with the delivery of a health care item or service of  
15 a criminal offense consisting of a felony relating to  
16 fraud, theft, embezzlement, breach of fiduciary re-  
17 sponsibility, or other financial misconduct.

18 “(D) CONVICTION RELATING TO CONTROLLED  
19 SUBSTANCE.—Any individual or entity has been con-  
20 victed after such date, under Federal or State law,  
21 of a criminal offense consisting of a felony relating  
22 to the unlawful manufacture, distribution, prescrip-  
23 tion, or dispensing of a controlled substance.

24 “(2) WAIVER PERMITTED.—

1           “(A) IN GENERAL.—When, in the opinion of  
2           the Secretary, mandatory exclusion under paragraph  
3           (1) of an individual or entity would significantly  
4           harm the public health or pose a significant risk to  
5           the public health, the Secretary may waive such ex-  
6           clusion and shall apply such other appropriate pen-  
7           alties as authorized under this subtitle.

8           “(B) APPLICATION FOR WAIVER OF EXCLU-  
9           SION.—

10           “(i) IN GENERAL.—An individual or entity  
11           subject to mandatory exclusion under this sub-  
12           section may apply to the Secretary, in a manner  
13           specified by the Secretary in regulations, for  
14           waiver of the exclusion.

15           “(ii) SECRETARIAL RESPONSE.—The Sec-  
16           retary may waive the exclusion for the reasons  
17           described in subparagraph (A).”.

18           (b) PERMISSIVE EXCLUSION.—Section 1128(b) of  
19           the Social Security Act (42 U.S.C. 1320a-7) is amended—

20           (1) in paragraph (1), by inserting “consisting of  
21           a misdemeanor” after “offense”; and

22           (2) in paragraph (3), by inserting “consisting of  
23           a misdemeanor” after “offense”.

24           (c) PERIOD OF EXCLUSION.—

1           (1) MINIMUM PERIOD FOR MANDATORY EXCLU-  
2           SIONS.—Section 1128(c)(3)(B) of the Social Secu-  
3           rity Act (42 U.S.C. 1320a-7(c)(3)(B)) is amended  
4           by striking “five years” and inserting “two years”.

5           (2) MINIMUM PERIOD FOR CERTAIN PERMIS-  
6           SIVE EXCLUSIONS.—Section 1128(c)(3) of such Act  
7           (42 U.S.C. 1320a-7(c)(3)) is amended by adding the  
8           following new subparagraph:

9           “(D)(i) In the case of an exclusion of an individual  
10          excluded from participation in a public program under, or  
11          is otherwise described in, paragraph (1), (2), or (3) of sub-  
12          section (b), the period of exclusion shall be a minimum  
13          of 1 year, unless the Secretary determines that a longer  
14          period is necessary because of aggravating circumstances.

15          “(ii) In the case of an exclusion of an individual or  
16          entity excluded from participation in a public program  
17          under, or is otherwise described in, paragraph (4), (5)(A),  
18          or (5)(B) of subsection (b), the period of the exclusion  
19          shall not be less than the period during which the individ-  
20          ual’s or entity’s license to provide health care is revoked,  
21          suspended or surrendered, or the individual or the entity  
22          is excluded or suspended from a Federal or State health  
23          care program.

1       “(iii) In the case of an exclusion of an individual or  
2 entity described in paragraph (6)(B) of subsection (b), the  
3 period of the exclusion shall be not less than 1 year.”.

4       (d) NOTICE TO ENTITIES ADMINISTERING PUBLIC  
5 PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR  
6 HEALTH CARE ITEMS OR SERVICES.—Section 1128(d) of  
7 the Social Security Act (42 U.S.C. 1320a-7(d)) is amend-  
8 ed—

9           (1) in paragraph (1), by inserting “and all cer-  
10 tified health plans certified under such program for  
11 the delivery of or payment for health care items or  
12 services” after “participate”;

13           (2) in paragraph (2), by inserting “and each  
14 sponsor of a certified health plan” after “program”.

15       (e) EXPANDED OPPORTUNITY FOR ADMINISTRATIVE  
16 HEARINGS.—Section 1128(f)(2) of the Social Security Act  
17 (42 U.S.C. 1320a-7(f)(2)) is amended by striking “sub-  
18 section (b)(7)” and inserting “paragraphs (6)(B), (7), (8),  
19 (9), (11), (12), or (14) of subsection (b)”.

20       (f) NOTIFICATION OF TERMINATION OF EXCLU-  
21 SION.—Section 1128(g)(3) of the Social Security Act (42  
22 U.S.C. 1320a-7(g)(3)) is amended by inserting “and each  
23 sponsor of a certified health plan” after “program”.

1 (g) REQUEST FOR EXCLUSION.—Section 1128(d) of  
2 the Social Security Act (42 U.S.C. 1320a-7(d)) is amend-  
3 ed by adding at the end the following new paragraph:

4 “(4)(A) The sponsor of any certified health plan, the  
5 board of any purchasing cooperative, and the Secretary  
6 of Labor in the case of a multistate self-insured health  
7 plan may request that the Secretary of Health and Human  
8 Services exclude an individual or entity with respect to ac-  
9 tions under a certified health plan in accordance with this  
10 section.

11 “(B) Notwithstanding any other provision of this title  
12 and title XXI, no payment may be made under a certified  
13 health plan for the delivery of or payment for any item  
14 or service (other than an emergency item or service, not  
15 including items or services furnished in an emergency  
16 room of a hospital) furnished—

17 “(i) by an individual or entity during the period  
18 when such individual or entity is excluded pursuant  
19 to this section from participation in a certified  
20 health plan; or

21 “(ii) at the medical direction or on the prescrip-  
22 tion of a physician during the period when the physi-  
23 cian is excluded pursuant to this section from par-  
24 ticipation in a certified health plan and the person  
25 furnishing the item or service knew or had reason to

1 know of the exclusion (after a reasonable time period  
2 after reasonable notice has been furnished to the  
3 person).”.

4 **PART III—AMENDMENTS TO CRIMINAL LAW**

5 **SEC. 531. HEALTH CARE FRAUD.**

6 (a) IN GENERAL.—Chapter 63 of title 18, United  
7 States Code, is amended by adding at the end the follow-  
8 ing:

9 **“§ 1347. Health care fraud**

10 “(a) Whoever knowingly executes, or attempts to exe-  
11 cute, a scheme or artifice—

12 “(1) to defraud any purchasing cooperative,  
13 certified health plan, certified long-term care policy,  
14 or other person, in connection with the delivery of or  
15 payment for health care benefits, items, or services;  
16 or

17 “(2) to obtain, by means of false or fraudulent  
18 pretenses, representations, or promises, any of the  
19 money or property owned by, or under the custody  
20 or control of, any purchasing cooperative, certified  
21 health plan, certified long-term care policy, or per-  
22 son in connection with the delivery of or payment for  
23 health care benefits, items, or services;

24 shall be fined under this title or imprisoned not more than  
25 10 years, or both. If the violation results in serious bodily

1 injury (as defined in section 1365 of this title) such person  
2 shall be imprisoned for any term of years.

3 “(b) As used in this section—

4 “(1) the terms ‘purchasing cooperative’, ‘cer-  
5 tified health plan’, and ‘certified long-term care pol-  
6 icy’ have the meanings given those terms in sections  
7 21100(14), 21011(a)(1), and 21011(b)(2) of the So-  
8 cial Security Act, respectively.”.

9 (b) CLERICAL AMENDMENT.—The table of sections  
10 at the beginning of chapter 63 of title 18, United States  
11 Code, is amended by adding at the end the following:

“1347. Health care fraud.”.

12 **SEC. 532. THEFT OR EMBEZZLEMENT.**

13 (a) IN GENERAL.—Chapter 31 of title 18, United  
14 States Code, is amended by adding at the end the follow-  
15 ing:

16 **“§ 668. Theft or embezzlement in connection with**  
17 **health care**

18 “(a) Whoever embezzles, steals, willfully and unlaw-  
19 fully converts to the use of any person other than the  
20 rightful owner, or intentionally misapplies any of the mon-  
21 eys, securities, premiums, credits, property, or other assets  
22 of a purchasing cooperative, certified health plan, certified  
23 long-term care policy, or of any fund connected with such  
24 a cooperative, plan, or policy, shall be fined under this title  
25 or imprisoned not more than 10 years, or both.

1 “(b) As used in this section, the terms ‘purchasing  
2 cooperative’, ‘certified health plan’, and ‘certified long-  
3 term care policy’ have the meanings given those terms in  
4 sections 21100(14), 21011(a)(1), and 21011(b)(2) of the  
5 Social Security Act, respectively.”.

6 (b) CLERICAL AMENDMENT.—The table of sections  
7 at the beginning of chapter 31 of title 18, United States  
8 Code, is amended by adding at the end the following:

“668. Theft or embezzlement in connection with health care.”.

9 **SEC. 533. FALSE STATEMENTS.**

10 (a) IN GENERAL.—Chapter 47 of title 18, United  
11 States Code, is amended by adding at the end the follow-  
12 ing:

13 **“§ 1033. False statements relating to health care mat-  
14 ters**

15 “(a) Whoever, in any matter involving a purchasing  
16 cooperative, certified health plan, or certified long-term  
17 care policy, knowingly and willfully falsifies, conceals, or  
18 covers up by any trick, scheme, or device a material fact,  
19 or makes any false, fictitious, or fraudulent statements or  
20 representations, or makes or uses any false writing or doc-  
21 ument knowing the same to contain any false, fictitious,  
22 or fraudulent statement or entry, shall be fined under this  
23 title or imprisoned not more than 5 years, or both.

24 “(b) As used in this section, the terms ‘purchasing  
25 cooperative’, ‘certified health plan’, and ‘certified long-

1 term care policy' have the meanings given those terms in  
 2 sections 21100(14), 21011(a)(1), and 21011(b)(2) of the  
 3 Social Security Act, respectively.”.

4 (b) CLERICAL AMENDMENT.—The table of sections  
 5 at the beginning of chapter 47 of title 18, United States  
 6 Code, is amended by adding at the end the following:

“1033. False statements relating to health care matters.”.

7 **SEC. 534. BRIBERY AND GRAFT.**

8 (a) IN GENERAL.—Chapter 11 of title 18, United  
 9 States Code, is amended by adding at the end the follow-  
 10 ing:

11 **“§226. Bribery and graft in connection with health**  
 12 **care**

13 “(a) Whoever—

14 “(1) directly or indirectly, corruptly gives, of-  
 15 fers, or promises anything of value to a health care  
 16 official, or offers or promises a health care official  
 17 to give anything of value to any other person, with  
 18 intent—

19 “(A) to influence any of the health care of-  
 20 ficial’s actions, decisions, or duties relating to a  
 21 purchasing cooperative, certified health plan, or  
 22 certified long-term care policy;

23 “(B) to influence such an official to com-  
 24 mit or aid in the committing, or collude in or  
 25 allow, any fraud, or make opportunity for the

1 commission of any fraud, on a purchasing coop-  
2 erative, certified health plan, or certified long-  
3 term care policy; or

4 “(C) to induce such an official to engage  
5 in any conduct in violation of the lawful duty of  
6 such official; or

7 “(2) being a health care official, directly or in-  
8 directly, corruptly demands, seeks, receives, accepts,  
9 or agrees to accept anything of value personally or  
10 for any other person or entity, the giving of which  
11 violates paragraph (1) of this subsection;

12 shall be fined under this title or imprisoned not more than  
13 15 years, or both.

14 “(b) Whoever, otherwise than as provided by law for  
15 the proper discharge of any duty, directly or indirectly  
16 gives, offers, or promises anything of value to a health  
17 care official, for or because of any of the health care offi-  
18 cial’s actions, decisions, or duties relating to a purchasing  
19 cooperative, certified health plan, or certified long-term  
20 care policy, shall be fined under this title or imprisoned  
21 not more than two years, or both.

22 “(c) As used in this section—

23 “(1) the term ‘health care official’ means—

24 “(A) an administrator, officer, trustee, fi-  
25 duciary, custodian, counsel, agent, or employee

1 of any purchasing cooperative, certified health  
2 plan, or certified long-term care policy;

3 “(B) an officer, counsel, agent, or em-  
4 ployee, of an organization that provides services  
5 under contract to any purchasing cooperative,  
6 certified health plan, or certified long-term care  
7 policy;

8 “(C) an official or employee of a State  
9 agency having regulatory authority over any  
10 purchasing cooperative, certified health plan, or  
11 certified long-term care policy;

12 “(D) an officer, counsel, agent, or em-  
13 ployee of a health care sponsor;

14 “(2) the term ‘health care sponsor’ means any  
15 individual or entity serving as the sponsor of a cer-  
16 tified health plan for purposes of title XXI of the  
17 Social Security Act, and includes the joint board of  
18 trustees or other similar body used by two or more  
19 employers to administer a certified health plan for  
20 purposes of such Act; and

21 “(3) the terms ‘purchasing cooperative’, ‘cer-  
22 tified health plan’, and ‘certified long-term care pol-  
23 icy’ have the meanings given those terms in sections  
24 21100(14), 21011(a)(1), and 21011(b)(2) of the So-  
25 cial Security Act, respectively.”.

1 (b) CLERICAL AMENDMENT.—The table of chapters  
2 at the beginning of chapter 11 of title 18, United States  
3 Code, is amended by adding at the end the following:

“226. Bribery and graft in connection with health care.”.

4 **SEC. 535. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**  
5 **OFFENSES.**

6 Section 1345(a)(1) of title 18, United States Code,  
7 is amended—

8 (1) by striking “or” at the end of subparagraph  
9 (A);

10 (2) by inserting “or” at the end of subpara-  
11 graph (B); and

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

13 “(C) committing or about to commit a Federal  
14 health care offense (as defined in section 1128D of  
15 the Social Security Act);”.

16 **SEC. 536. GRAND JURY DISCLOSURE.**

17 Section 3322 of title 18, United States Code, is  
18 amended—

19 (1) by redesignating subsections (c) and (d) as  
20 subsections (d) and (e), respectively; and

21 (2) by inserting after subsection (b) the follow-  
22 ing:

23 “(c) A person who is privy to grand jury information  
24 concerning a health law violation—



1           (1) in subsection (a)(7), by inserting “or to a  
2 certified health plan or certified long-term care pol-  
3 icy” after “property to the Government”;

4           (2) in the matter following subsection (a)(7), by  
5 inserting “or certified health plan or certified long-  
6 term care policy” before “sustains because of the act  
7 of that person,”;

8           (3) at the end of the first sentence of sub-  
9 section (a), by inserting “or certified health plan or  
10 certified long-term care policy” before “sustains be-  
11 cause of the act of the person.”;

12           (4) in subsection (c)—

13               (A) by inserting “the term” after “sec-  
14 tion,”; and

15               (B) by adding at the end the following:  
16 “The term also includes any request or demand,  
17 whether under contract or otherwise, for money  
18 or property which is made or presented to a  
19 certified health plan or certified long-term care  
20 policy.”; and

21           (5) by adding at the end the following:

22           “(f) CERTIFIED HEALTH PLAN AND CERTIFIED  
23 LONG-TERM CARE POLICY DEFINED.—For purposes of  
24 this section, the terms ‘purchasing cooperative’, ‘certified  
25 health plan’, and ‘certified long-term care policy’ have the

1 meanings given those terms in sections 21100(14),  
 2 21011(a)(1), and 21011(b)(2) of the Social Security Act,  
 3 respectively.”.

#### 4 **PART V—EFFECTIVE DATE**

##### 5 **SEC. 551. EFFECTIVE DATE.**

6 Except as otherwise provided in this subtitle, the pro-  
 7 visions of, and amendments made by, this subtitle shall  
 8 be effective on and after January 1, 1996.

### 9 **TITLE VI—MEDICARE, MEDICAL** 10 **EDUCATION, AND MEDICAID**

#### 11 **SEC. 600. REFERENCES TO SOCIAL SECURITY ACT.**

12 Except as otherwise specifically provided, whenever in  
 13 this title an amendment is expressed in terms of an  
 14 amendment to or repeal of a section or other provision,  
 15 the reference shall be considered to be made to that sec-  
 16 tion or other provision of the Social Security Act.

### 17 **Subtitle A—Medicare**

#### 18 **PART I—RISK CONTRACTING ENTITIES**

##### 19 **SEC. 601. IMPROVEMENTS OF RISK CONTRACTS.**

20 (a) IN GENERAL.—Section 1876 (42 U.S.C.  
 21 1395mm) is amended to read as follows:

22 “PAYMENTS TO CERTAIN CERTIFIED STANDARD HEALTH  
 23 PLANS

24 “SEC. 1876. (a) IN GENERAL.—

25 “(1) GENERAL PERMISSION TO CONTRACT.—

1           “(A) RISK CONTRACTS.—The Secretary  
2           may enter into a risk contract with any certified  
3           standard health plan (as defined in paragraph  
4           (4)(A)) in a service area (as defined in para-  
5           graph (4)(B)) if—

6                   “(i) the plan has at least 5,000 enroll-  
7                   ees (except that the Secretary may enter  
8                   into such a contract with a certified stand-  
9                   ard health plan that has fewer enrollees if  
10                  the plan primarily serves members residing  
11                  outside of urbanized areas); and

12                  “(ii) the plan—

13                   “(I) meets the requirements of  
14                   this section with respect to individuals  
15                   enrolled under this section; and

16                   “(II) meets the requirements nec-  
17                   essary to maintain its status as a cer-  
18                   tified standard health plan with re-  
19                   spect to individuals enrolled under  
20                   this section that do not conflict with  
21                   any of the requirements under this  
22                   section.

23           “(B) REASONABLE COST REIMBURSEMENT  
24           CONTRACTS.—The Secretary may enter into a  
25           reasonable cost reimbursement contract (as de-

1            fined in paragraph (4)(C)) with any certified  
2            standard health plan in a service area if—

3                    “(i)(I) the plan so elects;

4                    “(II) the Secretary is not satisfied  
5                    that the plan has the capacity to bear the  
6                    risk of potential losses under a risk con-  
7                    tract under this section, or

8                    “(III) the plan has an insufficient  
9                    number of individuals enrolled to be eligi-  
10                    ble to enter into a risk contract; and

11                    “(ii) the Secretary is otherwise satis-  
12                    fied that the plan is able to perform its  
13                    contractual obligations effectively and effi-  
14                    ciently.

15            “(2) AVAILABILITY OF PLANS.—

16                    “(A) IN GENERAL.—Subject to the provi-  
17                    sions of subsection (e), every individual entitled  
18                    to benefits under part A and enrolled under  
19                    part B shall be eligible to enroll under this sec-  
20                    tion with any certified standard health plan  
21                    with a contract under this section which serves  
22                    the service area in which the individual resides,  
23                    except that an employer-sponsored plan may  
24                    limit its enrollment to certain classes of individ-

1 uals, as designated by the Secretary in regula-  
2 tions.

3 “(B) ENROLLMENT BY AN INDIVIDUAL.—  
4 An individual may enroll under this section with  
5 a certified standard health plan with a contract  
6 under this section in such manner as may be  
7 prescribed in regulations (including enrollment  
8 through a third party) and the individual may  
9 terminate enrollment—

10 “(i) during an annual period as pre-  
11 scribed by the Secretary, and

12 “(ii) as specified by the Secretary if  
13 the plan is financially insolvent, if the indi-  
14 vidual moves from the service area served  
15 by the plan, or if other special cir-  
16 cumstances exist, as prescribed by the Sec-  
17 retary.

18 “(C) INFORMATION.—

19 “(i) DISTRIBUTION BY PLANS.—The  
20 Secretary may prescribe the procedures  
21 and conditions under which a certified  
22 standard health plan with a contract under  
23 this section may provide individuals eligible  
24 to enroll under this section with informa-  
25 tion about the plan. No brochures, applica-

1           tion forms, or other promotional or infor-  
2           mational material may be distributed by a  
3           plan to (or for the use of) individuals eligi-  
4           ble to enroll with the plan under this sec-  
5           tion unless—

6                   “(I) at least 45 days before its  
7                   distribution, the plan has submitted  
8                   the material to the Secretary for re-  
9                   view, and

10                   “(II) the Secretary has not dis-  
11                   approved the distribution of the mate-  
12                   rial.

13           The Secretary shall review all such mate-  
14           rial submitted and shall disapprove such  
15           material if the Secretary determines, in the  
16           Secretary’s discretion, that the material is  
17           materially inaccurate or misleading or oth-  
18           erwise makes a material misrepresentation.

19                   “(ii) DISTRIBUTION BY THE SEC-  
20                   RETARY.—The Secretary shall develop and  
21                   distribute comparative materials to individ-  
22                   uals eligible to enroll under this section re-  
23                   garding all certified standard health plans  
24                   with contracts under this section.

25                   “(3) PAYMENTS.—

1           “(A) PAYMENTS IN LIEU OF NORMAL PAY-  
2           MENTS.—Subject to subsection (i)(3), payments  
3           under a contract to a certified standard health  
4           plan under this section shall be instead of the  
5           amounts which (in the absence of the contract)  
6           would be otherwise payable, pursuant to sec-  
7           tions 1814(b) and 1833(a), for services fur-  
8           nished by or through the plan to individuals en-  
9           rolled with the plan under this section.

10           “(B) SOURCE OF PAYMENT.—The payment  
11           to a certified standard health plan under this  
12           section for individuals enrolled under this sec-  
13           tion with the plan and entitled to benefits under  
14           part A and enrolled under part B shall be made  
15           from the Federal Hospital Insurance Trust  
16           Fund and the Federal Supplementary Medical  
17           Insurance Trust Fund. The portion of that pay-  
18           ment to the plan for a month to be paid by  
19           each trust fund shall be determined as follows:

20                   “(i) With respect to expenditures by  
21                   certified standard health plans with risk  
22                   contracts under this section, the allocation  
23                   shall be determined each year by the Sec-  
24                   retary based on the ratio of expenditures  
25                   from each trust fund for the preceding

1 year to the expenditures from both trust  
2 funds for the preceding year.

3 “(ii) With respect to expenditures by  
4 a certified standard health plan with a rea-  
5 sonable cost reimbursement contract under  
6 this section, the initial allocation shall be  
7 based on the plan’s most recent budget,  
8 such allocation to be adjusted, as needed,  
9 after cost settlement to reflect the distribu-  
10 tion of actual expenditures.

11 “(4) DEFINITIONS.—For purposes of this sec-  
12 tion:

13 “(A) CERTIFIED STANDARD HEALTH  
14 PLAN.—The term ‘certified standard health  
15 plan’ shall have the meaning given such term in  
16 section 21011(a)(2).

17 “(B) SERVICE AREA.—The term ‘service  
18 area’ means the service areas designated by a  
19 State under section 21128.

20 “(C) REASONABLE COST REIMBURSEMENT  
21 CONTRACT.—The term ‘reasonable cost reim-  
22 bursement contract’ means a contract with a  
23 certified standard health plan pursuant to  
24 which such plan is reimbursed on the basis of  
25 its reasonable cost (as defined in section

1 1861(v)) in the manner prescribed in subsection  
2 (c)(2).

3 “(b) PAYMENT RULES UNDER RISK CONTRACTS.—

4 “(1) IN GENERAL.—

5 “(A) PAYMENTS.—Except as provided in  
6 subparagraph (C), with respect to any calendar  
7 year, each certified standard health plan with a  
8 risk contract under this section shall receive a  
9 payment under this title with respect to each  
10 individual enrolled with the plan for each month  
11 such individual is enrolled equal to the average  
12 medicare per capita rate determined under  
13 paragraph (2) for the plan’s service area ad-  
14 justed by the rate factor determined under sub-  
15 paragraph (B) for the class of such individual.

16 “(B) DETERMINATION OF CLASSES OF IN-  
17 DIVIDUALS AND RATE FACTORS FOR SUCH  
18 CLASSES.—

19 “(i) DETERMINATION OF CLASSES.—

20 For purposes of this section, the Secretary  
21 shall define appropriate classes of individ-  
22 uals, based on age, disability status, and  
23 such other factors as the Secretary deter-  
24 mines to be appropriate.

1           “(ii) RATE FACTORS.—The Secretary  
2           shall annually determine the rate factors  
3           for each class of individuals defined in  
4           clause (i) reflecting the differences in the  
5           average per capita spending for benefits  
6           under parts A and B among individuals in  
7           such classes. The Secretary shall announce  
8           such rate factors (in a manner intended to  
9           provide notice to interested parties) not  
10          later than July 1 before the calendar year  
11          concerned.

12          “(C) BUDGET NEUTRALITY.—The Sec-  
13          retary shall reduce the amount of payments to  
14          be made to certified standard health plans  
15          under subparagraph (A) for a year by an  
16          amount the Secretary determines necessary so  
17          that such payments do not exceed an amount  
18          equal to the total amount that would have been  
19          paid under this section for the year if section  
20          601 of the Health Security Act had not been  
21          enacted.

22          “(2) DETERMINATION OF AVERAGE MEDICARE  
23          PER CAPITA RATE.—

24                 “(A) DETERMINATION BY SECRETARY.—

1           “(i) IN GENERAL.—The Secretary  
2 shall annually determine under subpara-  
3 graph (B), and shall announce (in a man-  
4 ner intended to provide notice to interested  
5 parties) not later than October 1 before  
6 the calendar year concerned, the average  
7 medicare per capita rate of payment for  
8 each service area.

9           “(B) FORMULA FOR AVERAGE MEDICARE  
10 PER CAPITA RATE.—

11           “(i) IN GENERAL.—The monthly aver-  
12 age medicare per capita rate of payment  
13 for a service area served by a certified  
14 standard health plan shall be equal to the  
15 sum of—

16           “(I) the plan component deter-  
17 mined under clause (ii); and

18           “(II) the fee-for-service compo-  
19 nent determined under clause (iii).

20           “(ii) PLAN COMPONENT.—The  
21 amount determined under this clause is the  
22 sum of the following amounts determined  
23 with respect to each certified standard  
24 health plan—

1           “(I) the amount of the uniform  
2           monthly premium submitted by the  
3           plan to the Secretary under subpara-  
4           graph (C), adjusted by a factor deter-  
5           mined by the Secretary to normalize  
6           the difference in the distribution of in-  
7           dividuals projected to be enrolled in  
8           the plan among the various classes of  
9           individuals defined by the Secretary to  
10          the national distribution of all individ-  
11          uals in the program under this title  
12          among such classes; multiplied by

13           “(II) a fraction (expressed as a  
14           percentage), the numerator of which  
15           is the number of all individuals en-  
16           rolled in the plan (as projected by the  
17           plan using either historical experience  
18           or some other methodology developed  
19           by the Secretary), and the denomina-  
20          tor of which is the number of all med-  
21          icare eligible individuals in the service  
22          area.

23           “(iii) FEE-FOR-SERVICE COMPO-  
24          NENT.—The amount determined under  
25          this clause is—

1           “(I) the projected average  
2           monthly per capita fee-for-service  
3           costs (as defined in subparagraph  
4           (D)) for the service area for individ-  
5           uals not enrolled in certified standard  
6           health plans with contracts under this  
7           section, adjusted by the factor de-  
8           scribed in clause (ii)(I); multiplied by

9           “(II) a fraction (expressed as a  
10           percentage), the numerator of which  
11           is equal to the number of all medicare  
12           eligible individuals in the service area  
13           minus the number of individuals who  
14           are enrolled in certified standard  
15           health plans with risk contracts under  
16           this section (as determined in accord-  
17           ance with subclause (I)), and the de-  
18           nominator of which is the number of  
19           all medicare eligible individuals in the  
20           service area.

21           “(C) UNIFORM MONTHLY PREMIUMS; PRE-  
22           MIUM FOR ADDITIONAL SERVICES.—

23           “(i) IN GENERAL.—Each certified  
24           standard health plan with a risk contract  
25           under this section shall, not later than Au-

1           gust 1 of each year, submit to the Sec-  
2           retary a bid for the next calendar year for  
3           each service area with respect to which the  
4           plan has a risk contract. A bid with re-  
5           spect to a service area shall include the fol-  
6           lowing:

7                   “(I) UNIFORM MONTHLY PRE-  
8                   MIUM.—A statement of the uniform  
9                   monthly premium amount that the  
10                  plan intends to charge for individuals  
11                  enrolled under this section with the  
12                  plan and entitled to benefits under  
13                  part A and enrolled in part B and a  
14                  projection of the plan’s enrollment by  
15                  class for such services in the service  
16                  area.

17                  “(II) PREMIUM FOR ADDITIONAL  
18                  SERVICES.—A statement of the pre-  
19                  mium amount that the plan intends to  
20                  charge for each class of individuals  
21                  enrolled under this section with the  
22                  plan for the additional mandatory  
23                  services described in subparagraphs  
24                  (A)(ii) and (B) of subsection (d)(1).

1                   “(III) PREMIUM FOR ADDI-  
2                   TIONAL HEALTH CARE SERVICES.—A  
3                   statement of the premium amount  
4                   that the plan intends to charge for  
5                   each package of additional health care  
6                   services offered by the plan.

7                   “(ii) NOTICE BEFORE BID SUBMIS-  
8                   SIONS.—At least 45 days before the date  
9                   for submitting bids under clause (ii) for a  
10                  year, the Secretary shall provide for notice  
11                  to certified standard health plans with risk  
12                  contracts of proposed changes to be made  
13                  in the methodology or benefit coverage as-  
14                  sumptions from the methodology and as-  
15                  sumptions used in the previous calendar  
16                  year and shall provide such plans an op-  
17                  portunity to comment on such proposed  
18                  changes.

19                  “(D) PROJECTED AVERAGE MONTHLY PER  
20                  CAPITA FEE-FOR-SERVICE COSTS.—

21                  “(i) IN GENERAL.—For purposes of  
22                  subparagraph (B), the term ‘projected av-  
23                  erage monthly per capita fee-for-service  
24                  costs’ means, with respect to a service  
25                  area, the amount, prorated to be expressed

1 as a monthly amount, that the Secretary  
2 estimates in advance would be payable in  
3 any contract year for services covered  
4 under parts A and B and types of expenses  
5 otherwise reimbursable under parts A and  
6 B (including administrative costs incurred  
7 by organizations described in sections 1816  
8 and 1842), if the services were to be fur-  
9 nished by other than a certified standard  
10 health plan with a risk contract under this  
11 section.

12 “(ii) BASIS FOR ESTIMATES.—The es-  
13 timate made by the Secretary under clause  
14 (i) shall be made on the basis of actual ex-  
15 perience of the service area or, if the Sec-  
16 retary determines that the data in that  
17 service area are inadequate to make an ac-  
18 curate estimate, the Secretary may use the  
19 actual experience of a similar area, with  
20 appropriate adjustments to assure actuar-  
21 ial equivalence, including adjustments the  
22 Secretary may determine appropriate to  
23 adjust for demographics, health status,  
24 and the presence of specific medical condi-  
25 tions.

1           “(3) PAYMENT RULES.—

2                   “(A) AMOUNT OF PREMIUM.—Each cer-  
3           tified standard health plan with a contract  
4           under this section must provide to individuals  
5           enrolled with the plan under this section, for  
6           the duration of such enrollment during each  
7           contract period, a fixed monthly premium equal  
8           to the sum of the uniform monthly premium  
9           amount determined by the plan with respect to  
10          the individual under paragraph (2)(C) and the  
11          premium amount determined under such para-  
12          graph for the additional mandatory services de-  
13          scribed in subparagraphs (A)(ii) and (B) of  
14          subsection (d)(1). An individual enrolled in the  
15          plan shall be responsible for paying to the plan  
16          the difference between the fixed monthly pre-  
17          mium amount described in the preceding sen-  
18          tence and the average medicare per capita rate  
19          paid to the plan in accordance with subpara-  
20          graph (B).

21                   “(B) AVERAGE MEDICARE PER CAPITA  
22          RATE.—

23                           “(i) IN GENERAL.—The Secretary  
24                           shall make monthly payments in advance  
25                           and in accordance with the rate deter-

1           mined under paragraph (2) to each cer-  
2           tified standard health plan with a risk con-  
3           tract under this section for each individual  
4           enrolled with the plan under this section.

5           “(ii) ADJUSTMENTS.—

6                   “(I) IN GENERAL.—The amount  
7                   of payment under this paragraph may  
8                   be retroactively adjusted to take into  
9                   account any difference between the  
10                  actual number of individuals enrolled  
11                  in the plan under this section and the  
12                  number of such individuals estimated  
13                  to be so enrolled in determining the  
14                  amount of the advance payment.

15                  “(II) SPECIAL RULE.—The Sec-  
16                  retary may make retroactive adjust-  
17                  ments under subclause (I) to take into  
18                  account individuals enrolled during  
19                  the period beginning on the date on  
20                  which the individual enrolls with a  
21                  certified standard health plan with a  
22                  risk contract under this section under  
23                  a health benefit plan operated, spon-  
24                  sored, or contributed to, by the indi-  
25                  vidual’s employer or former employer

1 (or the employer or former employer  
2 of the individual's spouse) and ending  
3 on the date on which the individual is  
4 enrolled in the plan under this section,  
5 except that for purposes of making  
6 such retroactive adjustments under  
7 this clause, such period may not ex-  
8 ceed 90 days. No adjustment may be  
9 made under the preceding sentence  
10 with respect to any individual who  
11 does not certify that the plan provided  
12 the individual with the explanation de-  
13 scribed in subsection (e)(6) at the  
14 time the individual enrolled with the  
15 plan.

16 “(iii) PAYMENT TO PLAN ONLY.—Sub-  
17 ject to subsection (i)(3), if an individual is  
18 enrolled under this section with a certified  
19 standard health plan with a risk contract  
20 under this section, only the plan shall be  
21 entitled to receive payments from the Sec-  
22 retary under this title for services fur-  
23 nished to the individual.

24 “(C) PAYMENT GREATER THAN FIXED  
25 MONTHLY PREMIUM.—If, with respect to any

1 individual enrolled in a certified standard health  
2 plan with a risk contract under this section, the  
3 average medicare per capita rate paid under  
4 this section to the plan exceeds the fixed  
5 monthly premium amount described in subpara-  
6 graph (A), the plan shall pay such excess to the  
7 individual, at the election of the plan, in the  
8 form of cash or as a contribution to a premium  
9 for any policy for additional health care serv-  
10 ices.

11 “(c) PAYMENT RULES FOR REASONABLE COST REIM-  
12 BURSEMENT CONTRACTS.—

13 “(1) REIMBURSEMENT.—

14 “(A) IN GENERAL.—A certified standard  
15 health plan with a reasonable cost reimburse-  
16 ment contract under this section may, at the  
17 option of such plan, provide that the Sec-  
18 retary—

19 “(i) will reimburse hospitals and  
20 skilled nursing facilities either for the rea-  
21 sonable cost (as determined under section  
22 1861(v)) or for payment amounts deter-  
23 mined in accordance with section 1886, as  
24 applicable, of services furnished to individ-  
25 uals enrolled with such plan, and

1           “(ii) will deduct the amount of such  
2 reimbursement from payment which would  
3 otherwise be made to such plan.

4           “(B) DIRECT PAYMENTS.—If a certified  
5 standard health plan with a reasonable cost re-  
6 imbursement contract under this section pays a  
7 hospital or skilled nursing facility directly, the  
8 amount paid shall not exceed the reasonable  
9 cost of the services (as determined under sec-  
10 tion 1861(v)) or the amount determined under  
11 section 1886, as applicable, unless such plan  
12 demonstrates to the satisfaction of the Sec-  
13 retary that such excess payments are justified  
14 on the basis of advantages gained by the plan.

15           “(2) PAYMENTS TO PLANS.—Payments made to  
16 a certified standard health plan with a reasonable  
17 cost reimbursement contract under this section shall  
18 be subject to appropriate retroactive corrective ad-  
19 justment at the end of each contract year so as to  
20 assure that such plan is paid for the reasonable cost  
21 actually incurred (excluding any part of incurred  
22 cost found to be unnecessary in the efficient delivery  
23 of health services) or the amounts otherwise deter-  
24 mined under section 1886 for the types of expenses  
25 otherwise reimbursable under this title for providing

1 services covered under this title to individuals en-  
2 rolled in the plan.

3 “(3) REPORTS BY PLANS.—A certified standard  
4 health plan with a reasonable cost reimbursement  
5 contract under this subsection shall provide that the  
6 Secretary shall require, at such time following the  
7 expiration of each accounting period of the plan  
8 (and in such form and in such detail) as the Sec-  
9 retary may prescribe—

10 “(A) that the plan report to the Secretary  
11 in an independently certified financial state-  
12 ment its per capita incurred cost based on the  
13 types of components of expenses otherwise re-  
14 imburseable under this title for providing serv-  
15 ices under parts A and B, including therein, in  
16 accordance with accounting procedures pre-  
17 scribed by the Secretary, its methods of allocat-  
18 ing costs between individuals enrolled under  
19 this section and other individuals enrolled with  
20 such plan;

21 “(B) that failure to report such informa-  
22 tion as may be required may be deemed to con-  
23 stitute evidence of likely overpayment on the  
24 basis of which appropriate collection action may  
25 be taken;

1           “(C) that in any case in which a plan is re-  
2           lated to another plan by common ownership or  
3           control, a consolidated financial statement shall  
4           be filed and that the allowable costs for such  
5           organization may not include costs for the types  
6           of expense otherwise reimbursable under this  
7           title, in excess of those which would be deter-  
8           mined to be reasonable in accordance with regu-  
9           lations (providing for limiting reimbursement to  
10          costs rather than charges to the plan by related  
11          plans and owners) issued by the Secretary; and

12           “(D) that in any case in which compensa-  
13          tion is paid by a plan substantially in excess of  
14          what is normally paid for similar services by  
15          similar practitioners (regardless of method of  
16          compensation), such compensation may as ap-  
17          propriate be considered to constitute a distribu-  
18          tion of profits.

19          “(d) COVERAGE OF BENEFITS.—

20           “(1) IN GENERAL.—

21           “(A) SERVICES PROVIDED.—A certified  
22          standard health plan with a contract under this  
23          section must provide to individuals enrolled in  
24          the plan under this section, through providers

1 and other persons that meet the applicable re-  
2 quirements of this title and part A of title XI—

3 “(i) except as provided in subpara-  
4 graph (B), the services covered under parts  
5 A and B of this title; and

6 “(ii) preventive care services, as de-  
7 fined by the Secretary.

8 “(B) ADDITIONS TO PART A COVERAGE.—  
9 For purposes of subparagraph (A)(i)—

10 “(i) inpatient hospital services shall  
11 not be limited to 150 days pursuant to sec-  
12 tion 1812(a)(1); and

13 “(ii) the requirement that an individ-  
14 ual be an inpatient in a hospital for 3 con-  
15 secutive days prior to the individual’s re-  
16 ceipt of post-hospital extended care serv-  
17 ices pursuant to section 1861(i) shall not  
18 apply.

19 “(2) PROVISION OF MEDICALLY NECESSARY  
20 CARE.—Each certified standard health plan with a  
21 contract under this section must—

22 “(A) make the services described in para-  
23 graph (1) (and such other health care services  
24 as enrolled individuals have contracted for)—

1           “(i) available and accessible to en-  
2           rolled individuals within the service area  
3           with reasonable promptness and in a man-  
4           ner which assures continuity, and

5           “(ii) when medically necessary, avail-  
6           able and accessible twenty-four hours a  
7           day and seven days a week, and

8           “(B) provide for reimbursement with re-  
9           spect to services which are described in sub-  
10          paragraph (A) and which are provided to such  
11          an individual other than through the plan, if—

12           “(i) the services were medically nec-  
13           essary and immediately required because of  
14           an unforeseen illness, injury, or condition,  
15           and

16           “(ii) it was not reasonable given the  
17           circumstances to obtain the services  
18           through the plan.

19          “(3) SPECIAL EXCEPTION.—If there is a na-  
20          tional coverage determination made in the period be-  
21          ginning on the date for the submission of bids under  
22          subsection (b)(2)(C) and ending on the next such  
23          date of submission that the Secretary projects will  
24          result in a significant change in the costs to a cer-  
25          tified standard health plan with a risk contract

1 under this section of providing the benefits that are  
2 the subject of such national coverage determination  
3 and that was not incorporated in the determination  
4 of the bid for such period, and if such coverage de-  
5 termination provides for coverage of additional bene-  
6 fits or under additional circumstances, subsection  
7 (a)(3)(A) shall not apply to payment for such addi-  
8 tional benefits or benefits provided under such addi-  
9 tional circumstances until the first contract year  
10 that begins after the end of such period, unless oth-  
11 erwise required by law.

12 “(4) COST SHARING.—

13 “(A) IN GENERAL.—Each certified stand-  
14 ard health plan with a contract under this sec-  
15 tion must provide to individuals enrolled under  
16 this section with respect to the services de-  
17 scribed in paragraph (1), cost sharing require-  
18 ments that are no greater than the cost sharing  
19 requirements for such services under the plan  
20 for individuals not enrolled in the plan under  
21 this section.

22 “(B) COST SHARING FIXED DURING CON-  
23 TRACT PERIOD.—Each certified standard plan  
24 must provide to individuals enrolled under this  
25 section, for the duration of such enrollment

1           during each contract period, cost sharing that  
2           is fixed during the duration of the contract pe-  
3           riod.

4           “(e) ENROLLMENT PERIODS.—

5           “(1) IN GENERAL.—Each certified standard  
6           health plan with a contract under this section must  
7           have an open enrollment period (which may be speci-  
8           fied by the Secretary), for the enrollment of individ-  
9           uals under this section, of at least 30 days duration  
10          every year and for the additional periods specified  
11          under paragraphs (2) through (4), and must provide  
12          that at any time during which enrollments are ac-  
13          cepted, the plan will accept up to the limits of its  
14          capacity (as determined by the Secretary) and with-  
15          out restrictions, except as may be authorized in reg-  
16          ulations, individuals who are eligible to enroll in the  
17          plan in the order in which they apply for enrollment,  
18          unless to do so would result in failure to meet the  
19          requirements of subsection (f) or would result in the  
20          enrollment of enrollees substantially  
21          nonrepresentative, as determined in accordance with  
22          regulations of the Secretary, of the population in the  
23          service area served by the plan.

24          “(2) NONRENEWAL OR TERMINATION.—

1           “(A) IN GENERAL.—If a contract under  
2 this section is not renewed or is otherwise ter-  
3 minated, certified standard health plans with  
4 contracts under this section and serving the  
5 same service area as under the terminated con-  
6 tract are required to have an open enrollment  
7 period for individuals who were enrolled under  
8 the terminated contract as of the date of notice  
9 of such termination.

10           “(B) OPEN ENROLLMENT PERIOD.—The  
11 open enrollment periods required under sub-  
12 paragraph (A) shall be for 30 days and shall  
13 begin 30 days after the date that the Secretary  
14 provides notice of such requirement.

15           “(C) EFFECTIVENESS OF ENROLLMENT.—  
16 Enrollment under this paragraph shall be effec-  
17 tive 30 days after the end of the open enroll-  
18 ment period, or, if the Secretary determines  
19 that such date is not feasible, such other date  
20 as the Secretary specifies.

21           “(3) SPECIAL RULE.—Each certified standard  
22 health plan with a contract under this section shall  
23 have an open enrollment period for each individual  
24 who enrolls in a plan during any enrollment period  
25 specified by section 1837 that applies to that indi-

1       vidual. Enrollment under this clause shall be effective as specified by section 1838.

2               “(4) RESIDENTS OUTSIDE SERVICE AREA.—  
3       Each certified standard health plan with a contract  
4       under this section shall have an open enrollment period  
5       for each individual eligible to enroll in such a  
6       plan who has previously resided outside the service  
7       area. The enrollment period shall begin with the beginning  
8       of the month that precedes the month in  
9       which the individual becomes a resident of that service  
10      area and shall end at the end of the following  
11      month. Enrollment under this subparagraph shall be  
12      effective as of the first of the month following the  
13      month in which the individual enrolls.

14              “(5) CONTINUED ENROLLMENT PROTECTED.—  
15      Each certified standard health plan with a contract  
16      under this section must provide assurances to the  
17      Secretary that it will not expel or refuse to re-enroll  
18      any enrolled individual because of the individual’s  
19      health status or requirements for health care services,  
20      and that it will notify each such individual of  
21      such fact at the time of the individual’s enrollment.  
22      such fact at the time of the individual’s enrollment.

23              “(6) NOTICE OF RIGHTS, ETC.—Each certified  
24      standard health plan with a contract under this section  
25      shall provide each enrollee, at the time of enrollment

1 ment and not less frequently than annually there-  
2 after, an explanation of the enrollee's rights under  
3 this section, including an explanation of—

4 “(A) the enrollee's rights to benefits from  
5 the plan,

6 “(B) the restrictions on payments under  
7 this title for services furnished other than by or  
8 through the plan,

9 “(C) out-of-area coverage provided by the  
10 plan,

11 “(D) the plan's coverage of emergency  
12 services and urgently needed care,

13 “(E) appeal rights of enrollees, and

14 “(F) the health care providers with whom  
15 the plan has entered into contracts for the pro-  
16 vision of services.

17 “(7) CONTINUATION OF COVERAGE.—Each cer-  
18 tified standard plan that provides items and services  
19 pursuant to a contract under this section shall pro-  
20 vide assurances to the Secretary that in the event  
21 the plan ceases to provide such items and services,  
22 the plan shall provide or arrange for supplemental  
23 coverage of benefits under this title related to a pre-  
24 existing condition with respect to any exclusion pe-  
25 riod, to all individuals enrolled with the plan who re-

1 ceive benefits under this title, for the lesser of six  
2 months or the duration of such period.

3 “(8) NOTICE OF RIGHT OF TERMINATION.—

4 “(A) IN GENERAL.—Each certified stand-  
5 ard health plan with a risk contract under this  
6 section shall notify individuals eligible to enroll  
7 with the plan under this section and individuals  
8 enrolled with the plan under this section that—

9 “(i) the plan is authorized by law to  
10 terminate or refuse to renew the contract,  
11 and

12 “(ii) termination or nonrenewal of the  
13 contract may result in termination of the  
14 enrollments of individuals enrolled with the  
15 plan under this section.

16 “(B) PLACEMENT OF NOTICE.—The notice  
17 required by subparagraph (A) shall be included  
18 in—

19 “(i) any marketing materials de-  
20 scribed in subsection (a)(2)(C) that are  
21 distributed by a plan to individuals eligible  
22 to enroll under this section with the plan,  
23 and

1           “(ii) any explanation provided to en-  
2           rollees by the plan pursuant to paragraph  
3           (6).

4           “(f) MEMBERSHIP ENROLLMENT REQUIREMENTS.—

5           “(1) IN GENERAL.—Each certified standard  
6           health plan with a contract under this section shall  
7           have, for the duration of such contract, an enrolled  
8           membership at least one-half of which consists of in-  
9           dividuals who are not entitled to benefits under this  
10          title or under a State plan approved under title XIX.

11          “(2) WAIVER.—

12           “(A) IN GENERAL.—The Secretary may  
13           modify or waive the requirement imposed by  
14           paragraph (1) if the plan demonstrates that it  
15           provides for an adequate quality of care for  
16           beneficiaries by—

17           “(i) meeting the quality standards for  
18           plans with contracts under this section;

19           “(ii) meeting the fiscal soundness re-  
20           quirements under title XIII of the Public  
21           Health Service Act and any such require-  
22           ments necessary to remain a certified  
23           standard health plan for at least the 3  
24           years immediately preceding an application  
25           for a waiver under this paragraph;

1           “(iii) demonstrating successful oper-  
2           ational experience as a certified standard  
3           health plan with a contract under this sec-  
4           tion for at least the 3 years immediately  
5           preceding an application for a waiver  
6           under this paragraph; and

7           “(iv) demonstrating that the number  
8           of individuals enrolled in the plan or its  
9           parent organization is at least 50,000 at  
10          the time of application for a waiver under  
11          this paragraph.

12          “(B) STANDARDS.—In reviewing a plan’s  
13          quality performance, the Secretary may accept  
14          quality performance standards as measured by  
15          private organizations acceptable to the Sec-  
16          retary or organizations designated by the Sec-  
17          retary, including peer review organizations.

18          “(3) SUSPENSION OF ENROLLMENT.—If the  
19          Secretary determines that a certified standard health  
20          plan with a contract under this section has failed to  
21          comply with the requirements of this subsection, the  
22          Secretary may provide for the suspension of enroll-  
23          ment of individuals under this section or of payment  
24          to the plan under this section for individuals newly

1 enrolled with the plan, after the date the Secretary  
2 notifies the plan of such noncompliance.

3 “(4) TERMINATION OF REQUIREMENT.—The  
4 Secretary may terminate the requirement under  
5 paragraph (1) when the Secretary determines that  
6 health plans have established alternative quality as-  
7 surance mechanisms that effectively provide suffi-  
8 cient quality safeguards.

9 “(g) PAYMENT RULES FOR PLANS.—

10 “(1) SUBROGATION RIGHTS.—Notwithstanding  
11 any other provision of law, each certified standard  
12 health plan with a contract under this section may  
13 (in the case of the provision of services to an individ-  
14 ual enrolled under this section by a primary plan  
15 under section 1862(b)(2)) charge or authorize the  
16 provider of such services to charge, in accordance  
17 with the charges allowed under such law or policy—

18 “(A) the insurance carrier, employer, or  
19 other entity which under such law, plan, or pol-  
20 icy is to pay for the provision of such services,  
21 or

22 “(B) such individual to the extent that the  
23 individual has been paid under such law, plan,  
24 or policy for such services.

25 “(2) PROMPT PAYMENT REQUIREMENT.—

1           “(A) IN GENERAL.—A risk contract under  
2 this section shall require the certified standard  
3 health plan to provide prompt payment (consist-  
4 ent with the provisions of sections 1816(c)(2)  
5 and 1842(c)(2)) of claims submitted for serv-  
6 ices and supplies furnished to individuals pursu-  
7 ant to such contract, if the services or supplies  
8 are not furnished under a contract between the  
9 plan and the provider or supplier.

10           “(B) FAILURE.—In the case of a plan  
11 which the Secretary determines, after notice  
12 and opportunity for a hearing, has failed to  
13 make payments of amounts in compliance with  
14 subparagraph (A), the Secretary may provide  
15 for direct payment of the amounts owed to pro-  
16 viders and suppliers for such covered services  
17 furnished to individuals enrolled under this sec-  
18 tion under the contract. If the Secretary pro-  
19 vides for such direct payments, the Secretary  
20 shall provide for an appropriate reduction in  
21 the amount of payments otherwise made to the  
22 plan under this section to reflect the amount of  
23 the Secretary’s payments (and costs incurred by  
24 the Secretary in making such payments).

1       “(h) DURATION, TERMINATION, EFFECTIVE DATE,  
2 AND TERMS OF CONTRACT; POWERS AND DUTIES OF  
3 SECRETARY.—

4           “(1) DURATION AND TERMINATION.—

5               “(A) IN GENERAL.—Except as provided in  
6 subparagraph (B), each contract under this sec-  
7 tion shall be for a term of at least one year, as  
8 determined by the Secretary, and may be made  
9 automatically renewable from term to term in  
10 the absence of notice by either party of inten-  
11 tion to terminate at the end of the current  
12 term.

13               “(B) EXCEPTION.—The Secretary may  
14 terminate a contract at any time (after such  
15 reasonable notice and opportunity for hearing  
16 to the certified standard health plan involved as  
17 the Secretary may provide in regulations), if the  
18 Secretary finds that the plan—

19                   “(i) has failed substantially to carry  
20 out the contract,

21                   “(ii) is carrying out the contract in a  
22 manner inconsistent with the efficient and  
23 effective administration of this section, or

24                   “(iii) no longer substantially complies  
25 with the requirements of this section.

1           “(2) EFFECTIVE DATE.—The effective date of  
2 any contract executed pursuant to this section shall  
3 be specified in the contract.

4           “(3) TERMS.—Each contract under this sec-  
5 tion—

6                   “(A) shall provide that the Secretary, or  
7 any person or organization designated by the  
8 Secretary—

9                           “(i) shall have the right to inspect or  
10 otherwise evaluate—

11                                   “(I) the quality, appropriateness,  
12 and timeliness of services performed  
13 under the contract, and

14                                   “(II) the facilities of the organi-  
15 zation when there is reasonable evi-  
16 dence of some need for such inspec-  
17 tion, and

18                           “(ii) shall have the right to audit and  
19 inspect any books and records of the cer-  
20 tified standard health plan that pertain—

21                                   “(I) to the ability of the plan to  
22 bear the risk of potential financial  
23 losses, or

1                   “(II) to services performed or de-  
2                   terminations of amounts payable  
3                   under the contract;

4                   “(B) shall require the plan with a contract  
5                   to provide (and pay for) written notice in ad-  
6                   vance of the contract’s termination, as well as  
7                   a description of alternatives for obtaining bene-  
8                   fits under this title, to each individual enrolled  
9                   under this section with the plan; and

10                  “(C)(i) shall require the plan to comply  
11                  with subsections (a) and (c) of section 1318 of  
12                  the Public Health Service Act (relating to dis-  
13                  closure of certain financial information) and  
14                  with the requirement of section 1301(c)(8) of  
15                  such Act (relating to liability arrangements to  
16                  protect members);

17                  “(ii) shall require the plan to provide and  
18                  supply information determined appropriate by  
19                  the Secretary in the manner determined appro-  
20                  priate by the Secretary;

21                  “(iii) shall require the plan to notify the  
22                  Secretary of loans and other special financial  
23                  arrangements which are made between the plan  
24                  and subcontractors, affiliates, and related par-  
25                  ties; and

1           “(D) shall contain such other terms and  
2           conditions not inconsistent with this section (in-  
3           cluding requiring the organization to provide  
4           the Secretary with such information) as the  
5           Secretary may find necessary and appropriate.

6           “(4) PERIOD OF DISQUALIFICATION.—The Sec-  
7           retary may not enter into a risk contract with a cer-  
8           tified standard health plan if a previous risk con-  
9           tract with that plan under this section was termi-  
10          nated at the request of the plan within the preceding  
11          five-year period, except in circumstances which war-  
12          rant special consideration, as determined by the Sec-  
13          retary.

14          “(5) DISREGARD OF CERTAIN INCONSISTENT  
15          LAWS, ETC.—The authority vested in the Secretary  
16          by this section may be performed without regard to  
17          such provisions of law or regulations relating to the  
18          making, performance, amendment, or modification of  
19          contracts of the United States as the Secretary may  
20          determine to be inconsistent with the furtherance of  
21          the purpose of this title.

22          “(6) FINDINGS OF FAILURE.—

23                  “(A) IN GENERAL.—If the Secretary deter-  
24                  mines that a certified standard health plan with  
25                  a contract under this section—

1           “(i) fails substantially to provide  
2 medically necessary items and services that  
3 are required (under law or under the con-  
4 tract) to be provided to an individual cov-  
5 ered under the contract, if the failure has  
6 adversely affected (or has substantial like-  
7 lihood of adversely affecting) the individ-  
8 ual;

9           “(ii) imposes premiums on individuals  
10 enrolled under this section in excess of the  
11 premiums permitted;

12           “(iii) acts to expel or to refuse to re-  
13 enroll an individual in violation of the pro-  
14 visions of this section;

15           “(iv) engages in any practice that  
16 would reasonably be expected to have the  
17 effect of denying or discouraging enroll-  
18 ment (except as permitted by this section)  
19 by eligible individuals with the plan whose  
20 medical condition or history indicates a  
21 need for substantial future medical serv-  
22 ices;

23           “(v) misrepresents or falsifies infor-  
24 mation that is furnished—

1                   “(I) to the Secretary under this  
2                   section, or

3                   “(II) to an individual or to any  
4                   other entity under this section;

5                   “(vi) fails to comply with the require-  
6                   ments of subsection (g)(2)(A) or para-  
7                   graph (8);

8                   “(vii) employs or contracts with any  
9                   individual or entity that is excluded from  
10                  participation under this title under section  
11                  1128 or 1128A for the provision of health  
12                  care, utilization review, medical social  
13                  work, or administrative services or employs  
14                  or contracts with any entity for the provi-  
15                  sion (directly or indirectly) through such  
16                  an excluded individual or entity of such  
17                  services; or

18                  “(viii) substantially fails to cooperate  
19                  with the utilization and quality control  
20                  peer review organization;

21                  the Secretary may provide, in addition to any  
22                  other remedies authorized by law, for any of the  
23                  remedies described in subparagraph (B).

24                  “(B) REMEDIES.—The remedies described  
25                  in this subparagraph are—

1           “(i) civil money penalties of not more  
2 than \$ 25,000 for each determination  
3 under subparagraph (A) or, with respect to  
4 a determination under clause (iv) or (v)(I)  
5 of such subparagraph, of not more than \$  
6 100,000 for each such determination, plus,  
7 with respect to a determination under sub-  
8 paragraph (A)(ii), double the excess  
9 amount charged in violation of such sub-  
10 paragraph (and the excess amount charged  
11 shall be deducted from the penalty and re-  
12 turned to the individual concerned), and  
13 plus, with respect to a determination under  
14 subparagraph (A)(iv), \$ 15,000 for each  
15 individual not enrolled as a result of the  
16 practice involved,

17           “(ii) suspension of enrollment of indi-  
18 viduals under this section after the date  
19 the Secretary notifies the plan of a deter-  
20 mination under subparagraph (A) and  
21 until the Secretary is satisfied that the  
22 basis for such determination has been cor-  
23 rected and is not likely to recur, or

24           “(iii) suspension of payment to the  
25 plan under this section for individuals en-

1           rolled after the date the Secretary notifies  
2           the plan of a determination under subpara-  
3           graph (A) and until the Secretary is satis-  
4           fied that the basis for such determination  
5           has been corrected and is not likely to  
6           recur.

7           The provisions of section 1128A (other than  
8           subsections (a) and (b)) shall apply to a civil  
9           money penalty under clause (i) in the same  
10          manner as they apply to a civil money penalty  
11          or proceeding under section 1128A(a).

12          “(7) AGREEMENT WITH UTILIZATION AND  
13          QUALITY CONTROL PEER REVIEW ORGANIZATION.—

14                 “(A) IN GENERAL.—Each risk contract  
15                 with a certified standard health plan under this  
16                 section shall provide that the plan will maintain  
17                 an agreement with a utilization and quality con-  
18                 trol peer review organization (which has a con-  
19                 tract with the Secretary under part B of title  
20                 XI for the area in which the eligible organiza-  
21                 tion is located) or with an entity selected by the  
22                 Secretary under section 1154(a)(4)(C) under  
23                 which the review organization will perform  
24                 functions under section 1154(a)(4)(B) and sec-  
25                 tion 1154(a)(14) (other than those performed

1 under contracts described in section  
2 1866(a)(1)(F)) with respect to services, fur-  
3 nished by the plan, for which payment may be  
4 made under this title.

5 “(B) COST OF SERVICES.—For purposes of  
6 payment under this title, the cost of such agree-  
7 ment to the plan shall be considered a cost in-  
8 curred by a provider of services in providing  
9 covered services under this title and shall be  
10 paid directly by the Secretary to the review or-  
11 ganization on behalf of such plan in accordance  
12 with a schedule established by the Secretary.

13 “(C) SOURCE OF PAYMENTS.—Such pay-  
14 ments—

15 “(i) shall be transferred in appro-  
16 priate proportions from the Federal Hos-  
17 pital Insurance Trust Fund and from the  
18 Supplementary Medical Insurance Trust  
19 Fund, without regard to amounts appro-  
20 priated in advance in appropriation Acts,  
21 in the same manner as transfers are made  
22 for payment for services provided directly  
23 to beneficiaries, and

24 “(ii) shall not be less in the aggregate  
25 for such plans for a fiscal year than the

1 amounts the Secretary determines to be  
2 sufficient to cover the costs of such plans'  
3 conducting activities described in subpara-  
4 graph (A) with respect to such plans under  
5 part B of title XI.

6 “(i) OTHER GENERAL REQUIREMENTS ON PLANS.—

7 “(1) GRIEVANCE PROCEDURES.—Each certified  
8 standard health plan with a contract under this sec-  
9 tion must provide meaningful procedures for hearing  
10 and resolving grievances between the plan (including  
11 any entity or individual through which the plan pro-  
12 vides health care services) and individuals enrolled  
13 with the plan under this section.

14 “(2) APPEALS.—An individual enrolled with a  
15 certified standard health plan under this section who  
16 is dissatisfied by reason of the individual’s failure to  
17 receive any health service to which the individual be-  
18 lieves the individual is entitled and at no greater  
19 charge than the individual believes the individual is  
20 required to pay is entitled, if the amount in con-  
21 troversy is \$100 or more, to a hearing before the  
22 Secretary to the same extent as is provided in sec-  
23 tion 205(b), and in any such hearing the Secretary  
24 shall make the plan a party. If the amount in con-  
25 troversy is \$1,000 or more, the individual or plan

1 shall, upon notifying the other party, be entitled to  
2 judicial review of the Secretary's final decision as  
3 provided in section 205(g), and both the individual  
4 and the plan shall be entitled to be parties to that  
5 judicial review.

6 “(3) ADVANCE DIRECTIVES.—A contract under  
7 this section shall provide that the certified standard  
8 health plan shall meet the requirement of section  
9 1866(f) (relating to maintaining written policies and  
10 procedures respecting advance directives).

11 “(4) SPECIAL REQUIREMENT RELATING TO SUB-  
12 SECTION (d) HOSPITALS.—A risk contract under this  
13 section shall provide that in the case of an individual  
14 who is receiving inpatient hospital services from a  
15 subsection (d) hospital (as defined in section  
16 1886(d)(1)(B)) as of the effective date of the indi-  
17 vidual's—

18 “(A) enrollment with such plan under this  
19 section—

20 “(i) payment for such services until  
21 the date of the individual's discharge shall  
22 be made under this title as if the individual  
23 were not enrolled with the plan,

24 “(ii) the plan shall not be financially  
25 responsible for payment for such services

1           until the date after the date of the individ-  
2           ual's discharge, and

3           “(iii) the plan shall nonetheless be  
4           paid the full amount otherwise payable to  
5           the plan under this section; or

6           “(B) termination of enrollment with a plan  
7           under this section—

8           “(i) the plan shall be financially re-  
9           sponsible for payment for such services  
10          after such date and until the date of the  
11          individual's discharge,

12          “(ii) payment for such services during  
13          the stay shall not be made under section  
14          1886(d), and

15          “(iii) the plan shall not receive any  
16          payment with respect to the individual  
17          under this section during the period the in-  
18          dividual is not enrolled.

19          “(j) LIMIT ON CHARGES FOR CERTAIN SERVICES.—

20                 “(1) IN GENERAL.—(A) In the case of physi-  
21                 cians' services or renal dialysis services described in  
22                 paragraph (2) which are furnished by a participating  
23                 physician to an individual enrolled with a certified  
24                 standard health plan under this section and enrolled  
25                 under part B, the applicable participation agreement

1 is deemed to provide that the physician or provider  
2 of services or renal dialysis facility will accept as  
3 payment in full from the eligible plan the amount  
4 that would be payable to the physician or provider  
5 of services or renal dialysis facility under part B and  
6 from the individual under such part, if the individual  
7 were not enrolled with a plan under this section.

8 “(B) In the case of physicians’ services de-  
9 scribed in paragraph (2) which are furnished by a  
10 nonparticipating physician, the limitations on actual  
11 charges for such services otherwise applicable under  
12 part B (to services furnished by individuals not en-  
13 rolled with an eligible organization under this sec-  
14 tion) shall apply in the same manner as such limita-  
15 tions apply to services furnished to individuals not  
16 enrolled with such an organization.

17 “(2) SERVICES DESCRIBED.—The ‘physicians’  
18 services described in this paragraph are physicians’  
19 services which are furnished to an enrollee of a cer-  
20 tified standard health plan under this section by a  
21 physician, provider of services, or renal dialysis facil-  
22 ity who is not under a contract with the plan.

23 “(k) STUDY ON CERTIFIED STANDARD HEALTH  
24 PLANS.—

1           “(1) IN GENERAL.—The Prospective Payment  
2           Assessment Commission (established under section  
3           1886(e)(2)) and the Physician Payment Review  
4           Commission (established under section 1845) shall  
5           study and make recommendations to Congress on  
6           the matters described in paragraph (2).

7           “(2) MATTERS DESCRIBED.—The matters de-  
8           scribed in this paragraph include—

9                   “(A) ways in which enrollment in certified  
10                   standard health plans with risk contracts under  
11                   this section could be increased;

12                   “(B) alternatives to the current payment  
13                   methodology that might encourage more health  
14                   plans to enter into certified standard health  
15                   plans with risk contracts under this section and  
16                   encourage more individuals to enroll in such  
17                   plans;

18                   “(C) whether the demographic characteris-  
19                   tics and health status of beneficiaries enrolled  
20                   in certified standard health plans with risk con-  
21                   tracts under this section differs from other indi-  
22                   viduals entitled to benefits under part A and  
23                   enrolled under part B; and

24                   “(D) whether the volume and quality of  
25                   care rendered to individuals enrolled in certified

1 standard health plans with risk contracts under  
2 this section differs from that rendered to other  
3 individuals entitled to benefits under part A  
4 and enrolled under part B.”.

5 (b) TECHNICAL AND CONFORMING AMENDMENTS.—  
6 The Secretary of Health and Human Services shall, within  
7 90 days of the date of the enactment of this section, sub-  
8 mit to the appropriate committees of Congress, a legisla-  
9 tive proposal providing for such technical and conforming  
10 amendments in the law as are required by the provisions  
11 of this section.

12 (c) EFFECTIVE DATE.—The amendments made by  
13 this section shall be effective with respect to contracts en-  
14 tered into on or after January 1, 1996.

15 **PART II—PROVISIONS RELATED TO PART A**

16 **SEC. 611. INPATIENT HOSPITAL SERVICES UPDATE FOR**  
17 **PPS HOSPITALS.**

18 Section 1886(b)(3)(B)(i) (42 U.S.C.  
19 1395ww(b)(3)(B)(i)) is amended—

20 (1) by amending subclause (XII) to read as fol-  
21 lows:

22 “(XII) for fiscal years 1997 through 2000, the  
23 market basket percentage minus 2.0 percentage  
24 points for hospitals in all areas, and”; and

1           (2) in subclause (XIII), by striking “1998” and  
2           inserting “2001”.

3   **SEC. 612. REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-**  
4                   **ED COSTS FOR INPATIENT HOSPITAL SERV-**  
5                   **ICES.**

6           (a) REDUCTION IN BASE PAYMENT RATES FOR PPS  
7 HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C.  
8 1395ww(g)(1)(A)) is amended by adding at the end the  
9 following new sentence: “In addition to the reduction de-  
10 scribed in the preceding sentence, for discharges occurring  
11 after September 30, 1995, the Secretary shall reduce by  
12 7.31 percent the unadjusted standard Federal capital pay-  
13 ment rate (as described in 42 CFR 412.308(c), as in effect  
14 on the date of the enactment of the Health Security Act)  
15 and shall reduce by 10.41 percent the unadjusted hospital-  
16 specific rate (as described in 42 CFR 412.328(e)(1), as  
17 in effect on the date of the enactment of the Health Secu-  
18 rity Act).”.

19           (b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT  
20 HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1))  
21 is amended by adding at the end the following new sub-  
22 paragraph:

23           “(T) Such regulations shall provide that, in determin-  
24 ing the amount of the payments that may be made under  
25 this title with respect to the capital-related costs of inpa-

1 tient hospital services furnished by a hospital that is not  
2 a subsection (d) hospital (as defined in section  
3 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital  
4 (as defined in section 1886(d)(9)(A)), the Secretary shall  
5 reduce the amounts of such payments otherwise estab-  
6 lished under this title by 15 percent for payments attrib-  
7 utable to portions of cost reporting periods occurring dur-  
8 ing each of the fiscal years 1996 through 2003.”.

9 **SEC. 613. REDUCTIONS IN DISPROPORTIONATE SHARE PAY-**  
10 **MENTS.**

11 (a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.  
12 1395ww(d)(5)(F)) is amended—

13 (1) in clause (ii), by striking “The amount”  
14 and inserting “Subject to clause (ix), the amount”;  
15 and

16 (2) by adding at the end the following new  
17 clauses:

18 “(ix) Notwithstanding any other provision of this  
19 subparagraph, the Secretary shall reduce the amount of  
20 any additional payment made to a hospital under this sub-  
21 paragraph for discharges occurring on or after October 1,  
22 1997, by 25 percent.

23 “(x) Not later than July 1, 1996, the Secretary and  
24 the Prospective Payment Assessment Commission shall  
25 submit to the Congress a recommendation on a methodol-

1 ogy for measuring and allocating funds for hospitals that  
2 receive an additional payment under this paragraph in-  
3 cluding a replacement for the fraction described in clause  
4 (vi)(II).”.

5 **SEC. 614. REVISED PAYMENT METHODOLOGY FOR REHA-**  
6 **BILITATION AND LONG-TERM CARE HOS-**  
7 **PITALS.**

8 (a) REHABILITATION HOSPITALS AND DISTINCT  
9 PART UNITS.—

10 (1) DEFINITION.—Section 1886(d)(1)(B) (42  
11 U.S.C. 1395ww(d)(1)(B)) is amended by adding at  
12 the end the following new sentence: “In defining a  
13 rehabilitation hospital and a rehabilitation unit of a  
14 hospital which is a distinct part of a hospital, the  
15 Secretary shall take into account the impact of new  
16 technologies, survival rates, and changes in the prac-  
17 tice of rehabilitation medicine.”.

18 (2) TARGET AMOUNT CALCULATION FOR REHA-  
19 BILITATION HOSPITALS AND DISTINCT PART  
20 UNITS.—

21 (A) IN GENERAL.—Section 1886(b)(3) (42  
22 U.S.C. 1395ww(b)(3)) is amended—

23 (i) in subparagraph (A), by striking  
24 “(D), and (E)” and inserting “(D), (E),  
25 and (F)”;

1 (ii) in subparagraph (B)(ii), by strik-  
2 ing “and (E)” and inserting “(E), and  
3 (F)””; and

4 (iii) by adding at the end the follow-  
5 ing new subparagraph:

6 “(F)(i) Subject to clause (ii), for cost re-  
7 porting periods beginning on or after October 1,  
8 1994, in the case of a hospital described in sub-  
9 section (d)(1)(B)(ii) or a rehabilitation unit de-  
10 scribed in such subparagraph, the term ‘target  
11 amount’ means—

12 “(I) with respect to the first 12-  
13 month cost reporting period in which this  
14 subparagraph is applied to the hospital or  
15 unit—

16 “(aa) the allowable operating  
17 costs of inpatient hospital services (as  
18 defined in subsection (a)(4)) recog-  
19 nized under this title for the hospital  
20 or unit for the 12-month cost report-  
21 ing period (in this subparagraph re-  
22 ferred to as the ‘base cost reporting  
23 period’) preceding the first cost re-  
24 porting period for which this subpara-  
25 graph was in effect with respect to

1 such hospital, increased (in a  
2 compounded manner), by

3 “(bb) the applicable percentage  
4 increases applied to such hospital or  
5 unit under this paragraph for cost re-  
6 porting periods after the base cost re-  
7 porting period and up to and includ-  
8 ing such first 12-month cost reporting  
9 period, or

10 “(II) with respect to a later cost re-  
11 porting period, the target amount for the  
12 preceding 12-month cost reporting period,  
13 increased by the applicable percentage in-  
14 crease under subparagraph (B).

15 There shall be substituted for the allowable av-  
16 erage costs of inpatient hospital services deter-  
17 mined under subclause (I)(aa), the average of  
18 the allowable average costs of inpatient hospital  
19 services (as so defined) recognized under this  
20 title for the hospital or unit for cost reporting  
21 periods beginning during fiscal years 1990 and  
22 1991 (if any).

23 “(ii)(I) Notwithstanding the provisions of  
24 clause (i), in the case of a hospital or unit to  
25 which the last sentence of clause (i) applies, the

1 hospital or unit's target amount under such  
2 clause for a cost reporting period shall be—

3 “(aa) not less than 70 percent of the  
4 national weighted average of all target  
5 amounts calculated under such clause for  
6 all hospitals and units described in such  
7 clause (as determined by the Secretary),  
8 and

9 “(bb) not less than the allowable oper-  
10 ating costs of inpatient hospital services  
11 (as defined in subsection (a)(4) for such  
12 hospital or unit in the base cost reporting  
13 period (including any payments made to  
14 such hospital or unit pursuant to para-  
15 graph (1)(A)), multiplied by the applicable  
16 percentage increase for such cost reporting  
17 period under subparagraph (B).

18 “(II) Notwithstanding the provisions of  
19 clause (i), in the case of a hospital or unit that  
20 is not described in subclause (I), the hospital or  
21 unit's target amount under such clause for a  
22 cost reporting period shall be—

23 “(aa) not less than the amount de-  
24 scribed in subclause (I)(aa), and

1           “(bb) not greater than 110 percent of  
2           the national weighted average of all target  
3           amounts calculated under clause (i) for all  
4           hospitals and units described in such  
5           clause (as determined by the Secretary).”.

6           (B) EFFECTIVE DATE.—The amendments  
7           made by subparagraph (A) shall apply with re-  
8           spect to cost reporting periods beginning on or  
9           after October 1, 1994.

10          (3) DEVELOPMENT OF NATIONAL PROSPECTIVE  
11          RATES FOR REHABILITATION HOSPITALS AND DIS-  
12          TINCT PART UNITS.—

13           (A) DEVELOPMENT OF PROPOSAL.—The  
14           Secretary of Health and Human Services (here-  
15           after in this section referred to as the “Sec-  
16           retary”) shall develop a proposal to replace the  
17           current system under which rehabilitation hos-  
18           pitals and rehabilitation units of a hospital  
19           which are a distinct part of a hospital (as de-  
20           scribed in section 1886(d)(1)(B) of the Social  
21           Security Act (42 U.S.C. 1395ww(d)(1)(B))) re-  
22           ceive payment for the operating and capital-re-  
23           lated costs of inpatient hospital services under  
24           part A of title XVIII of such Act with a pro-  
25           spective payment system. In developing any

1           proposal under this paragraph to replace the  
2           current system with a prospective payment sys-  
3           tem, the Secretary shall develop a system that  
4           provides for—

5                   (i) a payment on a per-discharge  
6                   basis, and

7                   (ii) an appropriate weighting of such  
8                   payment amount as it relates to the classi-  
9                   fication of the discharge.

10           (B) REPORTS.—Not later than October 1,  
11           1996, the Secretary shall submit the proposal  
12           developed under subparagraph (A) to the Con-  
13           gress.

14           (b) ASSIGNMENT OF NEW BASE YEAR FOR CER-  
15           TIFIED LONG-STAY HOSPITALS THAT ALSO SERVE A SIG-  
16           NIFICANT PROPORTION OF LOW-INCOME PATIENTS.—

17                   (1) REBASING FOR LONG-TERM HOSPITALS.—

18                   (A) IN GENERAL.—Section 1886(b)(3) (42  
19                   U.S.C. 1395ww(b)(3)), as amended by sub-  
20                   section (a), is further amended—

21                   (i) in subparagraph (A), by striking  
22                   “(E), and (F)” and inserting “(E), (F),  
23                   and (G)”;

1 (ii) in subparagraph (B)(ii), by strik-  
2 ing “(E), and (F)” and inserting “(E),  
3 (F), and (G)”;

4 (iii) by inserting after subparagraph  
5 (F) the following new subparagraph:

6 “(G)(i) For cost reporting periods begin-  
7 ning on or after October 1, 1994, in the case  
8 of a hospital described in subsection  
9 (d)(1)(B)(iv) that—

10 “(I) has not received the additional  
11 payment amount described in paragraph  
12 (1)(A) for at least the preceding 2 consecu-  
13 tive 12-month cost reporting periods; and

14 “(II) for which the sum of the  
15 amounts described in subclauses (I) and  
16 (II) of subsection (d)(5)(F)(vi) during the  
17 period described in clause (I) exceeds 25  
18 percent,

19 the term ‘target amount’ has the meaning given  
20 such term by clause (ii).

21 “(ii) In the case of a hospital described in  
22 clause (i), the term ‘target amount’ means—

23 “(I) with respect to the first 12-  
24 month cost reporting period in which this  
25 subparagraph is applied to the hospital—

1           “(aa) the average allowable oper-  
2           ating costs of inpatient hospital serv-  
3           ices (as defined in subsection (a)(4))  
4           recognized under this title for the hos-  
5           pital during cost reporting periods of  
6           the hospital beginning during fiscal  
7           years 1990 and 1991 for such hos-  
8           pital (in this subparagraph referred to  
9           as the ‘base cost reporting period’),  
10          increased (in a compounded manner),  
11          by

12           “(bb) the applicable percentage  
13           increases applied to such hospital or  
14           under this paragraph for cost report-  
15           ing periods after the base cost report-  
16           ing period and up to and including  
17           such first 12-month cost reporting pe-  
18           riods, or

19           “(II) with respect to a subsequent 12-  
20           month cost reporting period, the target  
21           amount for the preceding 12-month cost  
22           reporting period, increased by the applica-  
23           ble percentage increase under subpara-  
24           graph (B).

1           “(iii) Notwithstanding clause (ii)(II), if,  
2           after 2 consecutive 12-month cost reporting pe-  
3           riods, a hospital continues to be described in  
4           subclauses (I) and (II) of clause (i), there shall  
5           be substituted for the base cost reporting period  
6           described in clause (ii)(I)(aa) the most recent  
7           preceding 2 12-month cost reporting periods of  
8           the hospital for which data is available (as de-  
9           termined by the Secretary), but only if such  
10          substituting results in an increase in the target  
11          amount for the hospital. The substitution under  
12          the preceding sentence may not occur more  
13          often than every 2 years.

14          “(iv) Effective October 1, 1994, the Sec-  
15          retary shall take into account the enactment of  
16          this subparagraph in making available to the  
17          hospital the payments described in section  
18          1815(e)(2), and, shall increase such payments  
19          as if the target amount of the hospital had been  
20          established pursuant to this subparagraph as of  
21          such date.”.

22          (2) EFFECTIVE DATE.—The amendments made  
23          by this subsection shall be effective with respect to  
24          cost reporting periods beginning on or after October  
25          1, 1994.

1 **SEC. 615. MORATORIUM ON DESIGNATION OF NEW LONG-**  
2 **TERM HOSPITALS.**

3 Effective October 1, 1994, notwithstanding clause  
4 (iv) of section 1886(d)(1)(B) of the Social Security Act  
5 (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an av-  
6 erage inpatient length of stay (as determined by the Sec-  
7 retary of Health and Human Services) of greater than 25  
8 days shall not be treated as a hospital described in such  
9 clause for purposes of such title unless such hospital was  
10 treated as a hospital described in such clause for purposes  
11 of such title as of the date of the enactment of this Act.

12 **SEC. 616. EXTENSION OF FREEZE ON UPDATES TO ROUTINE**  
13 **SERVICE COST LIMITS FOR SKILLED NURS-**  
14 **ING FACILITIES.**

15 (a) PAYMENTS BASED ON COST LIMITS.—Section  
16 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking  
17 “112 percent” each place it appears and inserting “100  
18 percent (adjusted by such amount as the Secretary deter-  
19 mines to be necessary to preserve the savings resulting  
20 from the enactment of section 13503(a)(1) of the Omni-  
21 bus Budget Reconciliation Act of 1993)”.

22 (b) ADJUSTMENTS TO LIMITS.—Section 1888(c) (42  
23 U.S.C. 1395yy(c)) is amended by inserting the following  
24 sentence at the end: “The effect of the amendment made  
25 by section 616(a) of the Health Security Act shall not be

1 considered by the Secretary in making adjustments pursu-  
2 ant to this subsection.”

3 (c) PAYMENTS DETERMINED ON PROSPECTIVE  
4 BASIS.—Section 1888(d)(2)(B) (42 U.S.C.  
5 1395yy(d)(2)(B)) is amended by striking “105 percent”  
6 and inserting “100 percent (adjusted by such amount as  
7 the Secretary determines to be necessary to preserve the  
8 savings resulting from the enactment of section 13503(b)  
9 of the Omnibus Budget Reconciliation Act of 1993)”.

10 (d) EFFECTIVE DATE.—The amendments made by  
11 subsections (a), (b), and (c) shall apply to cost reporting  
12 periods beginning on or after October 1, 1995.

13 **SEC. 617. PAYMENTS FOR SOLE COMMUNITY HOSPITALS**  
14 **WITH TEACHING PROGRAMS AND**  
15 **MULTIHOSPITAL CAMPUSES.**

16 (a) IN GENERAL.—Section 1886(d)(5)(D) (42 U.S.C.  
17 1395ww(d)(5)(D)) is amended by adding at the end the  
18 following new clause:

19 “(vi) The Secretary shall determine payment under  
20 clause (i) for a sole-community hospital that is a part of  
21 a multi-campus hospital by making the determination  
22 under such clause for each facility of the multi-campus  
23 hospital if any facility of the hospital would have a value  
24 of ‘r’ greater than 0, as ‘r’ is defined in subparagraph  
25 (B)(ii). In making a determination for each such facility,

1 the Secretary shall determine the DRG-specific rate appli-  
2 cable to the facility based on its location in accordance  
3 with paragraph (3)(D).”.

4 (b) EFFECTIVE DATE.—The amendment made by  
5 subsection (a) shall apply to discharges occurring on or  
6 after October 1, 1993, from multi-campus hospitals that  
7 merged facilities on or after October 1, 1987.

8 **SEC. 618. MEDICARE-DEPENDENT, SMALL RURAL HOS-**  
9 **PITALS.**

10 (a) CLARIFICATION OF ADDITIONAL PAYMENT.—  
11 Section 1886(d)(5)(G)(ii)(I) (42 U.S.C.  
12 1395ww(d)(5)(G)(ii)(I)) is amended by striking “the first  
13 3 12-month cost reporting periods that begin” and insert-  
14 ing “the 36-month period beginning with the first day of  
15 the cost reporting period that begins”.

16 (b) SPECIAL TREATMENT EXTENDED.—Section  
17 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amend-  
18 ed—

19 (1) in clause (i), by striking “October 1, 1994”  
20 and inserting “October 1, 1999”; and

21 (2) in clause (ii)(II), by striking “October 1,  
22 1994” and inserting “October 1, 1999”.

23 (c) EXTENSION OF TARGET AMOUNT.—Section  
24 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amend-  
25 ed—

1 (1) in the matter preceding clause (i), by strik-  
2 ing “March 31, 1993” and inserting “September 30,  
3 1999”; and

4 (2) by amending clause (iii) to read as follows:

5 “(iii) with respect to discharges occurring in fis-  
6 cal years 1994 through 1999, the target amount for  
7 the cost reporting period beginning in the previous  
8 fiscal year increased by the applicable percentage in-  
9 crease under subparagraph (B)(iv).”.

10 **SEC. 619. PROVISIONS RELATING TO RURAL HEALTH TRAN-**  
11 **SITION GRANT PROGRAM.**

12 (a) ELIGIBILITY OF RURAL PRIMARY CARE HOS-  
13 PITALS FOR GRANTS.—

14 (1) IN GENERAL.—Section 4005(e)(2) of the  
15 Omnibus Budget Reconciliation Act of 1987 is  
16 amended in the matter preceding subparagraph (A)  
17 by inserting “any rural primary care hospital as de-  
18 fined in section 1861(mm)(1), or” after “means”.

19 (2) EFFECTIVE DATE.—The amendment made  
20 by paragraph (1) shall apply to grants made on or  
21 after October 1, 1993.

22 (b) EXTENSION OF AUTHORIZATION OF APPROPRIA-  
23 TIONS.—Section 4005(e)(9) of Omnibus Budget Reconcili-  
24 ation Act of 1987 is amended—

1 (1) by striking “1989 and” and inserting  
2 “1989,”; and

3 (2) by striking “1992” and inserting “1992  
4 and \$30,000,000 for each of the fiscal years 1993  
5 through 1999”.

6 (c) FREQUENCY OF REQUIRED REPORTS.—Section  
7 4008(e)(8)(B) of the Omnibus Budget Reconciliation Act  
8 of 1987 is amended by striking “every 6 months” and in-  
9 serting “every 12 months”.

10 **SEC. 620. LIMITED SERVICE HOSPITAL PROGRAM.**

11 (a) LIMITED SERVICE HOSPITAL PROGRAM.—Sec-  
12 tion 1820 (42 U.S.C. 13951–4) is amended to read as fol-  
13 lows:

14 “LIMITED SERVICE HOSPITAL PROGRAM

15 “SEC. 1820. (a) PURPOSE.—The purpose of this sec-  
16 tion is to—

17 “(1) make available alternative hospital models  
18 to small rural or isolated rural communities in which  
19 facilities are relieved of the burden of selected regu-  
20 latory requirements by limiting the scope of inpa-  
21 tient acute services required to be offered;

22 “(2) alter medicare reimbursement policy to  
23 support the financial viability of alternative facilities  
24 by limiting the financial risk faced by such small  
25 hospitals through the use of reasonable cost reim-  
26 bursement; and

1           “(3) promote linkages between facilities des-  
2           ignated by the State under this section and broader  
3           programs supporting the development of and transi-  
4           tion to integrated provider networks.

5           “(b) IN GENERAL.—Any State that submits an appli-  
6           cation in accordance with subsection (c) may establish a  
7           limited hospital program described in subsection (d).

8           “(c) APPLICATION.—A State may establish a limited  
9           hospital program described in subsection (d) if the State  
10          submits to the Secretary at such time and in such form  
11          as the Secretary may require an application containing—

12               “(1) assurances that the State—

13                       “(A) has developed, or is in the process of  
14                       developing, a State rural health care plan  
15                       that—

16                               “(i) in the case of a State applying to  
17                               establish a rural primary care hospital pro-  
18                               gram (described in subsection (d)(1)(A)),  
19                               provides for the creation of one or more  
20                               rural health networks (as defined in sub-  
21                               section (e)) in the State,

22                               “(ii) promotes regionalization of rural  
23                               health services in the State, and

1           “(iii) improves access to hospital and  
2           other health services for rural residents of  
3           the State;

4           “(B) has developed the rural health care  
5           plan described in subparagraph (A) in consulta-  
6           tion with the hospital association of the State,  
7           rural hospitals located in the State, and the  
8           State Office of Rural Health (or, in the case of  
9           a State in the process of developing such plan,  
10          that assures the Secretary that it will consult  
11          with its State hospital association, rural hos-  
12          pitals located in the State, and the State Office  
13          of Rural Health in developing such plan); and

14          “(2) assurances that the State has designated  
15          (consistent with the rural health care plan described  
16          in paragraph (1)(A)), or is in the process of des-  
17          ignating, rural nonprofit or public hospitals or facili-  
18          ties located in the State as rural primary care hos-  
19          pitals facilities or medical assistance facilities; and

20          “(3) such other information and assurances as  
21          the Secretary may require.

22          “(d) LIMITED HOSPITAL PROGRAM DESCRIBED.—

23                  “(1) IN GENERAL.—A State that has submitted  
24          an application in accordance with subsection (c),

1       may establish a limited hospital program that in-  
2       cludes—

3               “(A) a rural primary care hospital pro-  
4       gram under which—

5                       “(i) at least one facility in the State  
6       shall be designated as a rural primary care  
7       hospital in accordance with paragraph (2),  
8       and

9                       “(ii) the State shall develop at least  
10       one rural health network (as defined in  
11       subsection (e)) in the State;

12               “(B) a medical assistance facility program  
13       under which at least one facility in the State  
14       shall be designated as a medical assistance fa-  
15       cility in accordance with paragraph (2); or

16               “(C) both.

17               “(2) STATE DESIGNATION OF FACILITIES.—A  
18       State may designate one or more facilities as a rural  
19       primary care hospital or medical assistance facility  
20       in accordance with subparagraph (A) or (B).

21               “(A) CRITERIA FOR DESIGNATION AS  
22       RURAL PRIMARY CARE HOSPITAL.—A State  
23       may designate a facility as a rural primary care  
24       hospital only if the facility—

1           “(i) is located in a rural area (as de-  
2           fined in section 1886(d)(2)(D)), or is lo-  
3           cated in a county whose geographic area is  
4           substantially larger than the average geo-  
5           graphic area for urban counties in the  
6           United States and whose hospital service  
7           area is characteristic of service areas of  
8           hospitals located in rural areas;

9           “(ii) at the time such facility applies  
10          to the State for designation as a rural pri-  
11          mary care hospital, is a hospital (or, in the  
12          case of a facility that closed during the 12-  
13          month period that ends on the date the fa-  
14          cility applies for such designation, at the  
15          time the facility closed), with a participa-  
16          tion agreement in effect under section  
17          1866(a);

18          “(iii) has in effect an agreement to  
19          participate with other hospitals and facili-  
20          ties in a rural health network;

21          “(iv) provides 24-hour emergency  
22          services to ill or injured persons prior to  
23          admission to the facility or prior to their  
24          transportation to a full-service hospital;

1           “(v) provides not more than 15 inpa-  
2           tient beds (meeting such conditions as the  
3           Secretary may establish) for providing  
4           acute inpatient care;

5           “(vi) provides inpatient care for a pe-  
6           riod not to exceed an average length of 96  
7           hours (unless a longer period is required  
8           because transfer to a hospital is precluded  
9           because of inclement weather or other  
10          emergency conditions);

11          “(vii) meets such staffing require-  
12          ments as would apply under section  
13          1861(e), to a hospital located in a rural  
14          area, except that—

15               “(I) the facility need not meet  
16               hospital standards relating to the  
17               number of hours during a day, or  
18               days during a week, in which the fa-  
19               cility must be open and fully staffed,  
20               except insofar as the facility is re-  
21               quired to provide emergency care on a  
22               24-hour basis under clause (v) and  
23               must have nursing services available  
24               on a 24-hour basis, but need not oth-

1 otherwise staff the facility except when  
2 an inpatient is present,

3 “(II) the facility may provide any  
4 services otherwise required to be pro-  
5 vided by a full-time, onsite dietician,  
6 pharmacist, laboratory technician,  
7 medical technologist, and radiological  
8 technologist on a part-time, offsite  
9 basis under arrangements as defined  
10 in section 1861(w)(1), and

11 “(III) the inpatient care de-  
12 scribed in clause (vii) may be provided  
13 by a physician’s assistant, nurse prac-  
14 titioner, or clinical nurse specialist  
15 subject to the oversight of a physician  
16 who need not be present in the facil-  
17 ity; and

18 “(viii) meets the requirements of sub-  
19 paragraphs (C) through (I) of paragraph  
20 (2) of section 1861(aa), and of clauses (ii)  
21 and (iv) of the second sentence of that  
22 paragraph, except that in determining  
23 whether a facility meets the requirements  
24 of this subparagraph, subparagraphs (E)  
25 and (F) of that paragraph shall be applied

1 as if any reference to ‘physician’ is a ref-  
2 erence to a physician as defined in section  
3 1861(r)(1).

4 “(B) CRITERIA FOR DESIGNATION AS MED-  
5 ICAL ASSISTANCE FACILITY.—A State may des-  
6 ignate a facility as a medical assistance facility  
7 only if the facility—

8 “(i) is located in a county (or equiva-  
9 lent unit of local government)—

10 “(I) with fewer than 6 residents  
11 per square mile, or

12 “(II) in a rural area (as defined  
13 in section 1886(d)(2)(D)) that is lo-  
14 cated more than a 35-mile or 45-  
15 minute drive from a hospital, a rural  
16 primary care hospital, or another fa-  
17 cility described in this subsection;

18 “(ii) at the time such facility applies  
19 to the State for designation as a medical  
20 assistance facility—

21 “(I) is a hospital (or in the case  
22 of a facility that closed during the 12-  
23 month period that ends on the date  
24 the facility applies for such designa-  
25 tion, at the time the facility closed),

1 with a participation agreement in ef-  
2 fect under section 1866(a); or

3 “(II) is licensed in accordance  
4 with applicable State and local laws  
5 and regulations;

6 “(iii) meets the requirements of  
7 clauses (iv), (vi), and (vii) of subparagraph  
8 (A); and

9 “(iv) meets the requirements of sub-  
10 subparagraph (I) of paragraph (2) of section  
11 1861(aa).

12 “(e) RURAL HEALTH NETWORK DEFINED.—For  
13 purposes of this section, the term ‘rural health network’  
14 means, with respect to a State, an organization—

15 “(1) consisting of—

16 “(A) at least 1 facility that the State has  
17 designated or plans to designate as a rural pri-  
18 mary care hospital, and

19 “(B) at least 1 hospital that furnishes  
20 services that a rural primary care hospital can-  
21 not furnish, and

22 “(2) the members of which have entered into  
23 agreements regarding—

24 “(A) patient referral and transfer,

1           “(B) the development and use of commu-  
2           nications systems, including (where feasible) te-  
3           lemetry systems and systems for electronic  
4           sharing of patient data,

5           “(C) the provision of emergency and non-  
6           emergency transportation among the members,  
7           and

8           “(D) credentialing and quality assurance.

9           “(f) CERTIFICATION BY THE SECRETARY.—The Sec-  
10          retary shall certify a facility as a rural primary care hos-  
11          pital or medical assistance facility (as the case may be)  
12          if the facility—

13           “(1) is located in a State that has established  
14          a limited hospital program in accordance with sub-  
15          section (d);

16           “(2) is designated as a rural primary care hos-  
17          pital or medical assistance facility by the State in  
18          which it is located; and

19           “(3) meets such other criteria as the Secretary  
20          may require.

21          “(g) PERMITTING MAINTENANCE OF SWING BEDS.—  
22          Nothing in this section shall be construed to prohibit a  
23          State from designating or the Secretary from certifying  
24          a facility as a rural primary care hospital or medical as-  
25          sistance facility solely because, at the time the facility ap-

1 plies to the State for designation as a rural primary care  
2 hospital or medical assistance facility, there is in effect  
3 an agreement between the facility and the Secretary under  
4 section 1883 under which the facility's inpatient hospital  
5 facilities are used for the furnishing of extended care serv-  
6 ices, except that the number of beds used for the furnish-  
7 ing of such services may not exceed the total number of  
8 licensed inpatient beds at the time the facility applies to  
9 the State for such designation (minus the number of inpa-  
10 tient beds used for providing inpatient care in a rural pri-  
11 mary care facility pursuant to subsection (d)(2)(A)(vi)).  
12 The Secretary may establish additional conditions of par-  
13 ticipation for rural primary care hospitals with a substan-  
14 tial number of such beds. For purposes of the first sen-  
15 tence, the number of beds of the facility used for the fur-  
16 nishing of extended care services shall not include any  
17 beds of a unit of the facility that is licensed as a distinct-  
18 part skilled nursing facility at the time the facility applies  
19 to the State for designation as a rural primary care hos-  
20 pital or medical assistance facility.

21 “(h) GRANTS.—

22 “(1) LIMITED HOSPITAL PROGRAM.—The Sec-  
23 retary may award grants to States that have submit-  
24 ted applications in accordance with subsection (c)  
25 for—

1           “(A) engaging in activities relating to plan-  
2           ning and implementing a rural health care plan;

3           “(B) in the case of a rural primary care  
4           hospital program described in subsection  
5           (d)(1)(A), engaging in activities relating to  
6           planning and implementing rural health net-  
7           works; and

8           “(C) designation of facilities as rural pri-  
9           mary care hospitals or medical assistance facili-  
10          ties.

11          “(2) RURAL EMERGENCY MEDICAL SERVICES.—

12           “(A) IN GENERAL.—The Secretary may  
13           award grants to States that have submitted ap-  
14           plications in accordance with subparagraph (B)  
15           for the establishment or expansion of a pro-  
16           gram for the provision of rural emergency medi-  
17           cal services.

18           “(B) APPLICATION.—An application is in  
19           accordance with this subparagraph if the State  
20           submits to the Secretary at such time and in  
21           such form as the Secretary may require an ap-  
22           plication containing the assurances described in  
23           subparagraphs (A)(ii), (A)(iii), and (B) of sub-  
24           section (c)(1) and paragraph (3) of such sub-  
25           section.

1       “(i) STUDY ON CLINICALLY BASED ALTERNATIVE TO  
2 96-HOUR RULE.—The Secretary shall conduct a study on  
3 the feasibility of admitting patients to rural primary care  
4 hospitals and medical assistance facilities on a limited  
5 DRG basis instead of using the 96-hour average length  
6 of stay criteria described in subsection (d)(2)(A)(vii).

7       “(j) WAIVER OF CONFLICTING PART A PROVI-  
8 SIONS.—The Secretary is authorized to waive such provi-  
9 sions of this part and part C as are necessary to conduct  
10 the program established under this section.

11       “(k) AUTHORIZATION OF APPROPRIATIONS.—There  
12 are authorized to be appropriated from the Federal Hos-  
13 pital Insurance Trust Fund—

14               “(1) for making grants under subsection (h)(1)  
15 to States that have established a rural primary care  
16 hospital program in the State under subsection  
17 (d)(1)(A), \$15,000,000 for each of fiscal years 1993  
18 through 1995; and

19               “(2) for making grants to all States under sub-  
20 section (h), \$25,000,000 in each of the fiscal years  
21 1996 through 1999.”.

22       (b) PART A AMENDMENTS RELATING TO RURAL PRI-  
23 MARY CARE HOSPITALS AND MEDICAL ASSISTANCE FA-  
24 CILITIES.—

1 (1) DEFINITIONS.—Section 1861 (42 U.S.C.  
2 1395x) is amended by adding at the end the follow-  
3 ing new subsection:

4 “MEDICAL ASSISTANCE FACILITY; MEDICAL ASSISTANCE  
5 FACILITY SERVICES

6 “(oo)(1) The term ‘medical assistance facility’ means  
7 a facility certified by the Secretary as a medical assistance  
8 facility under section 1820(f).

9 “(2) The term ‘medical assistance facility services’  
10 means items and services, furnished to an inpatient for  
11 a medical assistance facility by such facility, that would  
12 be inpatient hospital services if furnished to an inpatient  
13 of a hospital by a hospital.”.

14 (2) COVERAGE AND PAYMENT.—(A)(i) Section  
15 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by  
16 striking “inpatient hospital services” the first place  
17 it appears and inserting “, inpatient hospital serv-  
18 ices and inpatient medical assistance facility serv-  
19 ices”; and

20 (ii) by striking “inpatient hospital services” the  
21 second place it appears and inserting “such serv-  
22 ices”.

23 (B) Section 1814 (42 U.S.C. 1395f) is amend-  
24 ed—

25 (i) in subsection (b), by striking “inpatient  
26 rural primary care hospital services,” and in-

1           serting “inpatient rural primary care hospital  
2           services, other than a medical assistance facility  
3           providing inpatient medical assistance facility  
4           services,”; and

5                   (ii) by amending subsection (l) to read as  
6           follows:

7           “(l) PAYMENT FOR INPATIENT RURAL PRIMARY  
8 CARE SERVICES AND INPATIENT MEDICAL ASSISTANCE  
9 FACILITY SERVICES.—The amount of payment under this  
10 part for inpatient rural primary care services and inpa-  
11 tient medical assistance facility services is the reasonable  
12 costs of the rural primary care hospital or medical assist-  
13 ance facility in providing such services.”.

14                   (3) TREATMENT OF MEDICAL ASSISTANCE FA-  
15 CILITIES AS PROVIDERS OF SERVICES.—(A) Section  
16 1861(u) (42 U.S.C. 1395x(u)) is amended by insert-  
17 ing “medical assistance facility,” after “rural primary  
18 care hospital,”.

19                   (B) The first sentence of section 1864(a) (42  
20 U.S.C. 1395aa(a)) is amended by inserting “a medi-  
21 cal assistance facility, as defined in section  
22 1861(oo)(1),” after “1861(mm)(1),”.

23                   (C) The third sentence of section 1865(a) of  
24 such Act (42 U.S.C. 1395bb(a)) is amended by

1 striking “or 1861(mm)(1)” and inserting  
2 “1861(mm)(1), or 1861(oo)(1),”.

3 (4) CONFORMING AMENDMENTS.—(A) Section  
4 1128A(b)(1) (42 U.S.C. 1320a–7a(b)(1)) is amend-  
5 ed—

6 (i) by striking “or a rural primary care  
7 hospital” the first place it appears and insert-  
8 ing “, a rural primary care hospital, or a medi-  
9 cal assistance facility”; and

10 (ii) by striking “or a rural primary care  
11 hospital” the second place it appears and in-  
12 serting “, the rural primary care hospital, or  
13 the medical assistance facility”.

14 (B) Section 1128B(c) (42 U.S.C. 1320a–7b(c))  
15 is amended by inserting “medical assistance facil-  
16 ity,” after “rural primary care hospital,”.

17 (C) Section 1134 (42 U.S.C. 1320b–4) is  
18 amended by striking “or rural primary care hos-  
19 pitals” each place it appears and inserting “, rural  
20 primary care hospitals, or medical assistance facili-  
21 ties”.

22 (D) Section 1138(a)(1) (42 U.S.C. 1320b–  
23 8(a)(1)) is amended—

24 (i) in the matter preceding subparagraph

25 (A), by striking “or rural primary care hos-

1           pital” and inserting “, rural primary care hos-  
2           pital, or medical assistance facility”, and

3           (ii) in the matter preceding clause (i) of  
4           subparagraph (A), by striking “or rural pri-  
5           mary care hospital” and inserting “, rural pri-  
6           mary care hospital, or medical assistance facil-  
7           ity”.

8           (E) Section 1164(e) (42 U.S.C. 1320c-13(e)) is  
9           amended by inserting “medical assistance facilities,”  
10          after “rural primary care hospitals,”.

11          (F) Section 1816(c)(2)(C) (42 U.S.C.  
12          1395h(c)(2)(C)) is amended by inserting “medical  
13          assistance facility,” after “rural primary care hos-  
14          pital,”.

15          (G) Section 1833 (42 U.S.C. 1395*l*) is amend-  
16          ed—

17                 (i) in subsection (h)(5)(A)(iii)—

18                         (I) by striking “or rural primary care  
19                         hospital” and inserting “rural primary  
20                         care hospital, or medical assistance facil-  
21                         ity”; and

22                         (II) by striking “to the hospital” and  
23                         inserting “to the hospital or the facility”;

1           (ii) in subsection (i)(1)(A), by inserting  
2           “medical assistance facility,” after “rural pri-  
3           mary care hospital,”;

4           (iii) in subsection (i)(3)(A), by striking “or  
5           rural primary care hospital services” and in-  
6           serting “rural primary care hospital services, or  
7           medical assistance facility services”;

8           (iv) in subsection (l)(5)(A), by inserting  
9           “medical assistance facility,” after “rural pri-  
10          mary care hospital,” each place it appears; and

11          (v) in subsection (l)(5)(C), by striking “or  
12          rural primary care hospital” each place it ap-  
13          pears and inserting “, rural primary care hos-  
14          pital, or medical assistance facility”.

15          (H) Section 1835(c) (42 U.S.C. 1395n(c)) is  
16          amended by adding at the end the following: “A  
17          medical assistance facility shall be considered a hos-  
18          pital for purposes of this subsection.”.

19          (I) Section 1842(b)(6)(A)(ii) (42 U.S.C.  
20          1395u(b)(6)(A)(ii)) is amended by inserting “medi-  
21          cal assistance facility,” after “rural primary care  
22          hospital,”.

23          (J) Section 1861 (42 U.S.C. 1395x) is amend-  
24          ed—

1 (i) in the last sentence of subsection (e), by  
2 striking “1861(mm)(1)” and inserting  
3 “1861(mm)(1) or a medical assistance facility  
4 (as defined in section 1861(oo)(1)).”,

5 (ii) in subsection (w)(1) by inserting “med-  
6 ical assistance facility,” after “rural primary  
7 care hospital,” and

8 (iii) in subsection (w)(2), by striking “or  
9 rural primary care hospital” each place it ap-  
10 pears and inserting “, rural primary care hos-  
11 pital, or medical assistance facility”.

12 (K) Section 1862(a)(14) (42 U.S.C.  
13 1395y(a)(14)) is amended by striking “or rural pri-  
14 mary care hospital” each place it appears and in-  
15 serting “, rural primary care hospital, or medical as-  
16 sistance facility”.

17 (L) Section 1866(a)(1) (42 U.S.C  
18 1395cc(a)(1)) is amended—

19 (i) in subparagraph (F)(ii), by inserting  
20 “medical assistance facilities,” after “rural pri-  
21 mary care hospitals,”;

22 (ii) in subparagraph (H)—

23 (I) in the matter preceding clause (i),  
24 by inserting “and in the case of medical  
25 assistance facilities which provide inpatient

1 medical assistance facility services” after  
2 “rural primary care hospital services”; and

3 (II) in clauses (i) and (ii), by striking  
4 “hospital” each place it appears and in-  
5 serting “hospital or facility”;

6 (iii) in subparagraph (I)—

7 (I) in the matter preceding clause (i),  
8 by striking “or rural primary care hos-  
9 pital” and inserting “, a rural primary  
10 care hospital, or a medical assistance facil-  
11 ity”; and

12 (II) in clause (ii), by striking “the  
13 hospital” and inserting “the hospital or the  
14 facility”; and

15 (iv) in subparagraph (N)—

16 (I) in the matter preceding clause (i),  
17 by striking “and rural primary hospitals”  
18 and inserting “, rural primary care hos-  
19 pitals, and medical assistance facilities”;

20 (II) in clause (i), by striking “or rural  
21 primary care hospital,” and inserting “,  
22 rural primary care hospital, or medical as-  
23 sistance facility,”; and

24 (III) in clause (ii), by striking “hos-  
25 pital” and inserting “hospital or facility”.

1 (M) Section 1866(a)(3) (42 U.S.C.  
2 1395cc(a)(3)) is amended—

3 (i) by striking “rural primary care hos-  
4 pital,” each place it appears in subparagraphs  
5 (A) and (B) and inserting “rural primary care  
6 hospital, medical assistance facility,”, and

7 (ii) in subparagraph (C)(ii)(II), by striking  
8 “rural primary care hospitals,” each place it  
9 appears and inserting “rural primary care hos-  
10 pitals, medical assistance facilities”.

11 (N) Section 1867(e)(5) (42 U.S.C.  
12 1395dd(e)(5)) is amended by striking  
13 “1861(mm)(1))” and inserting “1861(mm)(1)) or a  
14 medical assistance facility (as defined in section  
15 1861(oo)(1)).”.

16 (c) PART B AMENDMENTS RELATING TO RURAL PRI-  
17 MARY CARE HOSPITALS AND MEDICAL ASSISTANCE FA-  
18 CILITIES.—

19 (1) COVERAGE.—(A) Section 1861(oo) (42  
20 U.S.C. 1395x(oo)) as added by subsection (b)(1), is  
21 amended by adding at the end the following new  
22 paragraph:

23 “(3) The term ‘outpatient medical assistance facility  
24 services’ means medical and other health services fur-

1 nished by a medical assistance facility on an outpatient  
2 basis.”.

3 (B) Section 1832(a)(2) (42 U.S.C.  
4 1395k(a)(2)) is amended—

5 (i) in subparagraph (I), by striking “and”  
6 at the end;

7 (ii) in subparagraph (J), by striking the  
8 period at the end and inserting “; and”; and

9 (iii) by adding at the end the following new  
10 subparagraph:

11 “(K) outpatient medical assistance facility  
12 services (as defined in section 1861(oo)(3)).”.

13 (2) PAYMENT.—(A) Section 1833(a) (42 U.S.C.  
14 1395l(a)) is amended—

15 (i) in paragraph (2), in the matter preced-  
16 ing subparagraph (A), by striking “and (I)”  
17 and inserting “(I), and (K)”;

18 (ii) in paragraph (6), by striking “and” at  
19 the end;

20 (iii) in paragraph (7), by striking the pe-  
21 riod at the end and inserting “; and”; and

22 (iv) by adding at the end the following new  
23 paragraph:

1           “(8) in the case of outpatient medical assist-  
2           ance facility services, the amounts described in sec-  
3           tion 1834(g).”.

4           (B) Section 1834(g) (42 U.S.C. 1395m(g)) is  
5           amended—

6           (i) in the subsection heading by inserting  
7           “AND OUTPATIENT MEDICAL ASSISTANCE FA-  
8           CILITY SERVICES” after “SERVICES”;

9           (ii) in paragraph (1), by striking “provided  
10           during a year before 1993 in a rural primary  
11           care hospital under this part shall be deter-  
12           mined by one of the following methods as elect-  
13           ed by the rural primary care hospital” and in-  
14           serting “in a rural primary care hospital or  
15           medical assistance facility under this part shall  
16           be determined by one of the following methods  
17           as elected by the rural primary care hospital or  
18           medical assistance facility”;

19           (iii) in paragraph (1)(A)(ii), by striking  
20           “outpatient rural primary care hospital serv-  
21           ices” each place it appears and inserting “out-  
22           patient rural primary care hospital services or  
23           outpatient medical assistance facility services”;  
24           and

1 (iv) in paragraph (1)(B), by striking “hos-  
2 pital” and inserting “hospital or facility”.

3 (d) PAYMENT CONTINUED TO DESIGNATED  
4 EACHs.—

5 (1) TERMINATION OF EACH DESIGNATION.—  
6 Section 1820(i)(1)(A) (42 U.S.C. 1395l(4)(i)(1)(A))  
7 is amended by inserting at the end the following new  
8 flush sentence:

9 “The Secretary shall not designate any hospital as  
10 an essential access community hospital on or after  
11 July 1, 1994.”.

12 (2) PERMITTING PAYMENT TO PRIOR DES-  
13 IGNATED EACHS.—Section 1886(d)(5)(D) (42  
14 U.S.C. 1395ww(d)(5)(D)) is amended—

15 (A) in clause (iii)(III), by inserting “as  
16 such section was in effect as of July 1, 1994”  
17 before the period at the end; and

18 (B) in clause (v), by inserting “as such  
19 section was in effect as of July 1, 1994” after  
20 “1820(i)(1).”

21 (3) EFFECTIVE DATE.—The amendments made  
22 by this subsection shall take effect on July 1, 1994.

23 (e) TECHNICAL AMENDMENT RELATING TO PART A  
24 DEDUCTIBLE, COINSURANCE AND SPELL OF ILLNESS.—

1 (1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)), as  
2 amended by subsection (b)(2)(A), is amended—

3 (A) by striking “inpatient medical assistance fa-  
4 cility services” and inserting “inpatient medical as-  
5 sistance facility services, inpatient rural primary  
6 care hospital services, or inpatient medical assist-  
7 ance facility services”; and

8 (B) by striking “and inpatient rural primary  
9 care hospital services”.

10 (2) Sections 1813(a) and 1813(b)(3)(A) (42 U.S.C.  
11 1395e(a), 1395e(b)(3)(A)) are each amended by striking  
12 “inpatient hospital services” each place it appears and in-  
13 sserting “inpatient hospital services, inpatient rural pri-  
14 mary care hospital services, or inpatient medical assist-  
15 ance facility services,”.

16 (3) Section 1813(b)(3)(B) (42 U.S.C.  
17 1395e(b)(3)(B)) is amended by striking “inpatient hos-  
18 pital services” and inserting “inpatient hospital services,  
19 inpatient rural primary care hospital services, inpatient  
20 medical assistance facility services,”.

21 (4) Section 1861(a) (42 U.S.C. 1395x(a)) is amend-  
22 ed—

23 (A) in paragraph (1), by striking “inpatient  
24 hospital services” and inserting “inpatient hospital  
25 services, inpatient rural primary care hospital serv-

1 ices, inpatient medical assistance facility services,”;  
2 and

3 (B) in paragraph (2), by striking “hospital”  
4 and inserting “hospital, rural primary care hospital,  
5 or medical assistance facility”.

6 (f) REPEAL OF DEVELOPMENT OF PPS SYSTEM FOR  
7 INPATIENT RURAL PRIMARY CARE HOSPITAL SERV-  
8 ICES.—

9 (1) IN GENERAL.—Section 1814(*l*) (42 U.S.C.  
10 1395f(*l*)) is amended by striking paragraph (2).

11 (2) CONFORMING AMENDMENTS.—Section  
12 1814(*l*)(1) (42 U.S.C. 1395F(*l*)(1)) is amended—

13 (A) by striking “(*l*)(1)” and inserting  
14 “(*l*)”;

15 (B) by redesignating subparagraphs (A)  
16 and (B) as paragraphs (1) and (2), respectively;

17 (C) in paragraph (2), as redesignated, by  
18 striking “paragraph” and inserting “sub-  
19 section”; and

20 (D) in the last sentence, by striking “para-  
21 graph” and inserting “subsection”.

22 (g) REPEAL OF DEVELOPMENT AND IMPLEMENTA-  
23 TION OF ALL INCLUSIVE PPS SYSTEM FOR OUTPATIENT  
24 RURAL PRIMARY CARE SERVICES.—

1 (1) IN GENERAL.—Section 1834(g) (42 U.S.C.  
2 1395m(g)), as amended by subsection (c)(2)(B), is  
3 amended by striking paragraph (2).

4 (2) CONFORMING AMENDMENTS.—Section  
5 1834(g)(1) (42 U.S.C. 1395m(g)(1)) is amended—

6 (A) by striking “(1) IN GENERAL.—”

7 (B) by redesignating subparagraph (A)  
8 and clauses (i) and (ii) of such subparagraph as  
9 paragraph (1) and subparagraphs (A) and (B)  
10 of such paragraph, respectively;

11 (C) by redesignating subparagraph (B) as  
12 paragraph (2);

13 (D) in paragraph (1)(A), as redesignated,  
14 by striking “subparagraph (B)”;

15 (E) in paragraph (1)(B), as so redesign-  
16 ated, by striking “subparagraph” and insert-  
17 ing “paragraph”.

18 (h) EFFECTIVE DATE.—Except as otherwise pro-  
19 vided, the amendments made by this section shall apply  
20 to services furnished on or after October 1, 1994.

21 **SEC. 621. TERMINATION OF INDIRECT MEDICAL EDU-**  
22 **CATION PAYMENTS.**

23 (a) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C.  
24 1395ww(d)(5)(B)) is amended in the matter preceding  
25 clause (i) by striking “The Secretary” and inserting “For

1 discharges occurring before January 1, 1996, the Sec-  
2 retary”.

3 (b) ADJUSTMENT TO STANDARDIZED AMOUNTS.—  
4 Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i))  
5 is amended by striking “excluding” and inserting “for dis-  
6 charges occurring before January 1, 1996, excluding”.

7 **SEC. 622. SUBACUTE CARE STUDY.**

8 (a) STUDY.—The Secretary of Health and Human  
9 Services (hereafter in this section referred to as the “Sec-  
10 retary”) shall—

11 (1) define the level and type of care that should  
12 constitute subacute care;

13 (2) determine the appropriateness of furnishing  
14 subacute care in different settings by evaluating the  
15 quality of care and patient outcomes;

16 (3) determine the cost and effectiveness of pro-  
17 viding subacute care under the medicare program  
18 under title XVIII of such Act to individuals who are  
19 eligible for benefits under part A of such title;

20 (4) determine the extent to which hospital DRG  
21 prospective payment rates under section 1886(d) of  
22 such Act (42 U.S.C. 1395ww(d)) are appropriate for  
23 the less restrictive institutional settings that provide  
24 subacute care; and

1           (5) study the relationships between institutions  
2           and their payment methodologies in order to develop  
3           ways in which to maximize the continuity of care for  
4           each patient episode in which subacute care is fur-  
5           nished.

6           (b) REPORT.—Not later than October 1, 1996, the  
7           Secretary shall submit to the Congress a report on the  
8           matters studied under subsection (a).

9           **PART III—PROVISIONS RELATING TO PART B**

10          **SEC. 631. UPDATES FOR PHYSICIANS' SERVICES.**

11          Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is  
12          amended—

13                 (1) in subparagraph (A), by inserting after  
14                 “subparagraph (B)” the following: “and, in the case  
15                 of 1995, specified in subparagraph (C)”;

16                 (2) by redesignating subparagraph (C) as sub-  
17                 paragraph (D); and

18                 (3) by inserting after subparagraph (B) the fol-  
19                 lowing new subparagraph:

20                         “(C) SPECIAL PROVISION FOR 1995.—For  
21                         purposes of subparagraph (A), the conversion  
22                         factor specified in this subparagraph for 1995  
23                         is—

24                                 “(i) in the case of physicians' services  
25                                 included in the category of primary care

1 services (as defined for purposes of sub-  
2 section (j)(1)), the conversion factor estab-  
3 lished under this subsection for 1994 re-  
4 duced by 1 percent and adjusted by the  
5 update established under paragraph (3) for  
6 1995; and

7 “(ii) in the case of any other physi-  
8 cians’ services, the conversion factor estab-  
9 lished under this subsection for 1994 re-  
10 duced by 4.0 percent and adjusted by the  
11 update established under paragraph (3) for  
12 1995.”.

13 **SEC. 632. SUBSTITUTION OF REAL GDP TO ADJUST FOR**  
14 **VOLUME AND INTENSITY; REPEAL OF RE-**  
15 **STRICTION ON MAXIMUM REDUCTION PER-**  
16 **MITTED IN DEFAULT UPDATE.**

17 (a) USE OF REAL GDP TO ADJUST FOR VOLUME  
18 AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C.  
19 1395w-4(f)(2)(A)(iii)) is amended to read as follows:

20 “(iii) 1 plus the average per capita  
21 growth in the real gross domestic product  
22 (divided by 100) for the 5-fiscal-year pe-  
23 riod ending with the previous fiscal year  
24 (increased by 1.5 percentage points for the

1 category of services consisting of primary  
2 care services), and”.

3 (b) REPEAL OF RESTRICTION ON MAXIMUM REDUC-  
4 TION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w-  
5 4(d)(3)(B)(ii)) is amended—

6 (1) in the heading, by inserting “IN CERTAIN  
7 YEARS” after “ADJUSTMENT”;

8 (2) in the matter preceding subclause (I), by  
9 striking “for a year”;

10 (3) in subclause (I), by adding “and” at the  
11 end;

12 (4) in subclause (II), by striking “, and” and  
13 inserting a period; and

14 (5) by striking subclause (III).

15 (c) REPEAL OF PERFORMANCE STANDARD FAC-  
16 TOR.—

17 (1) IN GENERAL.—Section 1848(f)(2) is  
18 amended by striking subparagraph (B) and redesi-  
19 gnating subparagraph (C) as subparagraph (B).

20 (2) CONFORMING AMENDMENT.—Section  
21 1848(f)(2)(A) is amended in the matter following  
22 clause (iv) by striking “1, multiplied by 100” and all  
23 that follows through “subparagraph (B))” and in-  
24 serting “1 and multiplied by 100”.

25 (d) EFFECTIVE DATE.—

1 (1) VOLUME PERFORMANCE STANDARDS.—The  
2 amendments made by subsections (a) and (c) shall  
3 apply with respect to volume performance standards  
4 established beginning with fiscal year 1995.

5 (2) REPEAL OF RESTRICTION ON MAXIMUM RE-  
6 DUCTION.—The amendments made by subsection (b)  
7 shall apply to services furnished on or after January  
8 1, 1997.

9 **SEC. 633. PAYMENT FOR PHYSICIANS' SERVICES RELATING**  
10 **TO INPATIENT STAYS IN CERTAIN HOS-**  
11 **PITALS.**

12 (a) IN GENERAL.—

13 (1) LIMITATIONS DESCRIBED.—Part B of title  
14 XVIII (42 U.S.C. 1831 et seq.) is amended by in-  
15 serting after section 1848 the following new section:

16 “LIMITATIONS ON PAYMENT FOR PHYSICIANS’ SERVICES  
17 RELATING TO INPATIENT STAYS IN CERTAIN HOSPITALS

18 “SEC. 1849. (a) DEFINITIONS.—In this section, the  
19 following definitions apply:

20 “(1) HOSPITAL.—The term ‘hospital’ means a  
21 subsection (d) hospital as defined in section  
22 1886(d)(1)(B).

23 “(2) MEDICAL STAFF.—An individual furnish-  
24 ing a physician’s service is considered to be on the  
25 medical staff of a hospital—

1           “(A) if (in accordance with requirements  
2           for hospitals established by the Joint Commis-  
3           sion on Accreditation of Health Organiza-  
4           tions)—

5                   “(i) the individual is subject to by-  
6                   laws, rules, and regulations established by  
7                   the hospital to provide a framework for the  
8                   self-governance of medical staff activities;

9                   “(ii) subject to such bylaws, rules, and  
10                  regulations, the individual has clinical  
11                  privileges granted by the hospital’s govern-  
12                  ing body; and

13                  “(iii) under such clinical privileges,  
14                  the individual may provide physicians’  
15                  services independently within the scope of  
16                  the individual’s clinical privileges, or

17           “(B) if such physician provides at least one  
18           service to a medicare beneficiary in such hos-  
19           pital.

20           “(3) RURAL AREA; URBAN AREA.—The terms  
21           ‘rural area’ and ‘urban area’ have the meaning given  
22           such terms under section 1886(d)(2)(D).

23           “(4) TEACHING HOSPITAL.—The term ‘teaching  
24           hospital’ means a hospital which has a teaching pro-  
25           gram approved as specified in section 1861(b)(6).

1 “(b) SERVICES SUBJECT TO REDUCTION.—

2 “(1) DETERMINATION OF HOSPITAL-SPECIFIC  
3 PER ADMISSION RELATIVE VALUE.—Not later than  
4 October 1 of each year (beginning with 1997), the  
5 Secretary shall determine for each hospital—

6 “(A) the hospital-specific per admission  
7 relative value under subsection (c)(2) for the  
8 following year; and

9 “(B) whether such hospital-specific relative  
10 value is projected to exceed the allowable aver-  
11 age per admission relative value applicable to  
12 the hospital for the following year under sub-  
13 section (c)(1).

14 “(2) REDUCTION FOR SERVICES AT HOSPITALS  
15 EXCEEDING ALLOWABLE AVERAGE PER ADMISSION  
16 RELATIVE VALUE.—If the Secretary determines  
17 (under paragraph (1)) that a medical staff’s hos-  
18 pital-specific per admission relative value for a year  
19 (beginning with 1998) is projected to exceed the al-  
20 lowable average per admission relative value applica-  
21 ble to the medical staff for the year, the Secretary  
22 shall reduce (in accordance with subsection (d)) the  
23 amount of payment otherwise determined under this  
24 part for each physician’s service furnished during  
25 the year to an inpatient of the hospital by an indi-

1       vidual who is a member of the hospital's medical  
2       staff.

3           “(3) TIMING OF DETERMINATION; NOTICE TO  
4       HOSPITALS AND CARRIERS.—Not later than October  
5       1 of each year (beginning with 1997), the Secretary  
6       shall notify the medical executive committee of each  
7       hospital (as set forth in the Standards of the Joint  
8       Commission on the Accreditation of Health Organi-  
9       zations) of the determinations made with respect to  
10      the medical staff of such hospital under paragraph  
11      (1).

12       “(c) DETERMINATION OF ALLOWABLE AVERAGE PER  
13      ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC  
14      PER ADMISSION RELATIVE VALUES.—

15           “(1) ALLOWABLE AVERAGE PER ADMISSION  
16      RELATIVE VALUE.—

17           “(A) URBAN HOSPITALS.—In the case of a  
18      hospital located in an urban area, the allowable  
19      average per admission relative value established  
20      under this subsection for a year is equal to 125  
21      percent (or 120 percent for years after 1999) of  
22      the median of 1996 hospital-specific per admis-  
23      sion relative values determined under paragraph  
24      (2) for all hospital medical staffs.

1           “(B) RURAL HOSPITALS.—In the case of a  
2 hospital located in a rural area, the allowable  
3 average per admission relative value established  
4 under this subsection for 1998 and each suc-  
5 ceeding year, is equal to 140 percent of the me-  
6 dian of the 1996 hospital-specific per admission  
7 relative values determined under paragraph (2)  
8 for all hospital medical staffs.

9           “(2) HOSPITAL-SPECIFIC PER ADMISSION REL-  
10 ATIVE VALUE.—

11           “(A) IN GENERAL.—The hospital-specific  
12 per admission relative value projected for a hos-  
13 pital (other than a teaching hospital) for a cal-  
14 endar year shall be equal to the average per ad-  
15 mission relative value (as determined under sec-  
16 tion 1848(c)(2)) for physicians’ services fur-  
17 nished to inpatients of the hospital by the hos-  
18 pital’s medical staff (excluding interns and resi-  
19 dents) during the second year preceding such  
20 calendar year, adjusted for variations in case-  
21 mix and disproportionate share status among  
22 hospitals (as determined by the Secretary under  
23 subparagraph (C)).

24           “(B) SPECIAL RULE FOR TEACHING HOS-  
25 PITALS.—The hospital-specific per admission

1 relative value projected for a teaching hospital  
2 in a calendar year shall be equal to the sum  
3 of—

4 “(i) the average per admission relative  
5 value (as determined under section  
6 1848(c)(2)) for physicians’ services fur-  
7 nished to inpatients of the hospital by the  
8 hospital’s medical staff (excluding interns  
9 and residents) during the second year pre-  
10 ceeding such calendar year adjusted for  
11 variations in case-mix, disproportionate  
12 share status, and teaching status among  
13 hospitals (as determined by the Secretary  
14 under subparagraph (C)); and

15 “(ii) the equivalent per admission rel-  
16 ative value (as determined under section  
17 1848(c)(2)) for physicians’ services fur-  
18 nished to inpatients of the hospital by in-  
19 terns and residents of the hospital during  
20 the second calendar year preceding such  
21 calendar year, adjusted for variations in  
22 case-mix, disproportionate share status,  
23 and teaching status among hospitals (as  
24 determined by the Secretary under sub-  
25 paragraph (C)). The Secretary shall deter-

1           mine such equivalent relative value unit  
2           per admission for interns and residents  
3           based on the best available data for teach-  
4           ing hospitals and may make such adjust-  
5           ment in the aggregate.

6           “(C) ADJUSTMENT FOR TEACHING AND  
7           DISPROPORTIONATE SHARE HOSPITALS.—The  
8           Secretary shall adjust the allowable per admis-  
9           sion relative values otherwise determined under  
10          this paragraph to take into account the needs  
11          of teaching hospitals and hospitals receiving ad-  
12          ditional payments under subparagraphs (F) and  
13          (G) of section 1886(d)(5). The adjustment for  
14          teaching status or disproportionate share shall  
15          not be less than zero.

16          “(d) AMOUNT OF REDUCTION.—The amount of pay-  
17          ment otherwise made under this part for a physician’s  
18          service that is subject to a reduction under subsection (b)  
19          during a year shall be reduced by 15 percent, in the case  
20          of a service furnished by a member of the medical staff  
21          of the hospital for which the Secretary determines under  
22          subsection (b)(1) that the hospital medical staff’s pro-  
23          jected relative value per admission exceeds the allowable  
24          average per admission relative value.

1       “(e) RECONCILIATION OF REDUCTIONS BASED ON  
2 HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION  
3 WITH ACTUAL RELATIVE VALUES.—

4           “(1) DETERMINATION OF ACTUAL AVERAGE  
5 PER ADMISSION RELATIVE VALUE.—Not later than  
6 October 1 of each year (beginning with 1999), the  
7 Secretary shall determine the actual average per ad-  
8 mission relative value (as determined pursuant to  
9 section 1848(c)(2)) for the physicians’ services fur-  
10 nished by members of a hospital’s medical staff to  
11 inpatients of the hospital during the previous year,  
12 on the basis of claims for payment for such services  
13 that are submitted to the Secretary not later than  
14 90 days after the last day of such previous year. The  
15 actual average per admission relative value shall be  
16 adjusted by the appropriate case-mix, disproportion-  
17 ate share factor, and teaching factor for the hospital  
18 medical staff (as determined by the Secretary under  
19 subsection (c)(2)(C)).

20           “(2) RECONCILIATION WITH REDUCTIONS  
21 TAKEN.—

22           “(A) REIMBURSEMENT.—In the case of a  
23 hospital for which the payment amounts for  
24 physicians’ services furnished by members of  
25 the hospital’s medical staff to inpatients of the

1 hospital were reduced under this section for a  
2 year—

3 “(i) if the actual average per admis-  
4 sion relative value for such hospital’s medi-  
5 cal staff during the year (as determined by  
6 the Secretary under paragraph (1)) did not  
7 exceed the allowable average per admission  
8 relative value applicable to the hospital’s  
9 medical staff under subsection (c)(1) for  
10 the year, the Secretary shall reimburse the  
11 fiduciary agent for the medical staff by the  
12 amount by which payments for such serv-  
13 ices were reduced for the year under sub-  
14 section (d), including interest at an appro-  
15 priate rate determined by the Secretary;  
16 and

17 “(ii) if the actual average per admis-  
18 sion relative value for such hospital’s medi-  
19 cal staff during the year (as determined by  
20 the Secretary under paragraph (1)) ex-  
21 ceeded the allowable average per admission  
22 relative value applicable to the hospital’s  
23 medical staff under subsection (c)(1) for  
24 the year, the Secretary shall reimburse the  
25 fiduciary agent for the medical staff, as a

1           percent of the total amount of payment  
2           otherwise determined under this part for  
3           physicians' services furnished during the  
4           year to inpatients of the hospital by the  
5           hospital's medical staff (prior to the reduc-  
6           tion under subsection (d)), the difference  
7           between 15 percentage points and the ac-  
8           tual number of percentage points that the  
9           medical staff exceeded the allowable aver-  
10          age per admission relative value, including  
11          interest at any appropriate rate determined  
12          by the Secretary.

13           “(B) NO REIMBURSEMENT.—The Sec-  
14          retary shall not pay the fiduciary agent for the  
15          medical staff of a hospital any amounts by  
16          which payments for physicians' services pro-  
17          vided by the medical staff were reduced for a  
18          year under this section if the actual average per  
19          admission relative value for such hospital's  
20          medical staff during the year (as determined by  
21          the Secretary under paragraph (1)) exceeded  
22          the allowable average per admission relative  
23          value applicable to the hospital's medical staff  
24          under subsection (c)(1) for the year by 15 per-  
25          centage points or more.

1           “(3) MEDICAL EXECUTIVE COMMITTEE OF A  
2 HOSPITAL.—Each medical executive committee of a  
3 hospital whose medical staff is projected to exceed  
4 the allowable relative value per admission for a year,  
5 shall have 1 year from the date of notification that  
6 such medical staff is projected to exceed the allow-  
7 able relative value per admission to designate a fidu-  
8 ciary agent for the medical staff to receive and dis-  
9 burse any appropriate amounts withheld made by  
10 the carrier.

11           “(4) ALTERNATIVE REIMBURSEMENT TO MEM-  
12 BERS OF STAFF.—At the request of a fiduciary  
13 agent for the medical staff, if the fiduciary agent for  
14 the medical staff is owed the reimbursement de-  
15 scribed in paragraph (2)(A)(ii) for excess reductions  
16 in payments during a year, the Secretary shall make  
17 such reimbursement to the members of the hospital’s  
18 medical staff, on a pro-rata basis according to the  
19 proportion of physicians’ services furnished to inpa-  
20 tients of the hospital during the year that were fur-  
21 nished by each member of the medical staff.

22           “(f) CLAIMS TO BE SUBMITTED NOT LATER THAN  
23 90 DAYS AFTER END OF YEAR.—Notwithstanding any  
24 other provision of law, no payment may be made under  
25 this part for any physician’s service furnished by a mem-

1 ber of the medical staff of a hospital to an inpatient of  
2 the hospital during a year unless the hospital submits a  
3 claim to the Secretary for the payment for such service  
4 not later than 90 days after the last day of the year.”.

5 (2) CONFORMING AMENDMENTS.—(A) Section  
6 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is  
7 amended by inserting “(subject to reduction under  
8 section 1849)” after “1848(a)(1)”.

9 (B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-  
10 4(a)(1)(B)) is amended by striking “this sub-  
11 section,” and inserting “this subsection and section  
12 1849,”.

13 (b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL  
14 AT WHICH SERVICE FURNISHED.—Section  
15 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is  
16 amended by striking “beneficiary,” and inserting “bene-  
17 ficiary (and, in the case of a service furnished to an inpa-  
18 tient of a hospital, report the hospital identification num-  
19 ber on such claim form),”.

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to services furnished on or after  
22 January 1, 1998.

1 **SEC. 634. CHANGES IN UNDERSERVED AREA BONUS PAY-**  
2 **MENTS.**

3 (a) IN GENERAL.—Section 1833(m) (42 U.S.C.  
4 1395l(m)) is amended—

5 (1) by inserting “(1)” after “(m)”,

6 (2) by inserting “described in paragraph (2)”  
7 after “physicians’ services”,

8 (3) by striking “10 percent” and inserting “the  
9 applicable percent”,

10 (4) by striking “service” the last place it ap-  
11 pears and inserting “services”, and

12 (5) by adding at the end the following new  
13 paragraph:

14 “(2)(A) The applicable percent referred to in para-  
15 graph (1) is 20 percent in the case of primary care serv-  
16 ices, as defined in section 1842(i)(4), and 10 percent for  
17 services other than primary care services furnished in  
18 health professional shortage areas located in rural areas  
19 as defined in section 1886(d)(2)(D).

20 “(B) The Secretary shall reduce payments for all  
21 services (other than primary care services) for which pay-  
22 ment may be made under this section by such percentage  
23 as the Secretary determines necessary so that, beginning  
24 on the date of the enactment of the Health Security Act,  
25 the amendments made by section 634(a) of such Act  
26 would not result in expenditures under this section that

1 exceed the amount of such expenditures that would have  
2 been made if such amendment had not been made.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) are effective for services furnished on or  
5 after January 1, 1995.

6 **SEC. 635. DEVELOPMENT AND IMPLEMENTATION OF RE-**  
7 **SOURCE-BASED METHODOLOGY FOR PRAC-**  
8 **TICE EXPENSES.**

9 (a) DEVELOPMENT.—

10 (1) IN GENERAL.—The Secretary of Health and  
11 Human Services shall develop a methodology for im-  
12 plementing in 1997 a resource-based system for de-  
13 termining practice expense relative value units for  
14 each physician’s service. The methodology utilized  
15 shall recognize the staff, equipment, and supplies  
16 used in the provision of various medical and surgical  
17 services in various settings.

18 (2) REPORT.—The Secretary shall transmit a  
19 report by January 1, 1996, on the methodology de-  
20 veloped under paragraph (1) to the Committee on  
21 Ways and Means and the Committee on Energy and  
22 Commerce of the House of Representatives and the  
23 Committee on Finance of the Senate. The report  
24 shall include a presentation of data utilized in devel-

1 oping the methodology and an explanation of the  
2 methodology.

3 (b) IMPLEMENTATION.—

4 (1) IN GENERAL.—Section 1848(c)(2)(C)(ii)  
5 (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is amended—

6 (A) by inserting “for the service for years  
7 before 1997” before “equal to”,

8 (B) by striking the period at the end of  
9 subclause (II) and inserting a comma, and

10 (C) by adding after and below subclause  
11 (II) the following:

12 “and for years beginning with 1997 based  
13 on the relative practice expense resources  
14 involved in furnishing the service.”.

15 (2) CONFORMING AMENDMENT.—Section  
16 1848(c)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii))  
17 is amended by striking “The practice” and inserting  
18 “For years before 1997, the practice”.

19 (3) APPLICATION OF CERTAIN PROVISIONS.—In  
20 implementing the amendment made by paragraph  
21 (1)(C), the provisions of clauses (ii)(II) and (iii) of  
22 section 1848(c)(2)(B) of the Social Security Act  
23 shall apply in the same manner as they apply to ad-  
24 justments under clause (ii)(I) of such section.

1 **SEC. 636. DEMONSTRATION PROJECTS FOR MEDICARE**  
2 **STATE-BASED PERFORMANCE STANDARD**  
3 **RATE OF INCREASE.**

4 Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended  
5 by adding at the end the following new paragraph:

6 “(6) STATE-BASED PERFORMANCE STANDARD  
7 RATES OF INCREASE DEMONSTRATION PROJECTS.—  
8 The Secretary shall establish demonstration projects  
9 in not more than 3 States under which a State  
10 elects State-based performance standard rates of in-  
11 crease to substitute for the national performance  
12 standard rates of increase established for the year  
13 under paragraph (2). The Secretary shall develop  
14 criteria for the establishment of such demonstration  
15 projects which shall include the requirement of  
16 budget-neutrality for payments made under this part  
17 with respect to physicians’ services furnished in a  
18 State participating in the demonstration project.”.

19 **SEC. 637. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**  
20 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**  
21 **SERVICES.**

22 (a) AMBULATORY SURGICAL CENTER PROCE-  
23 DURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.  
24 1395l(i)(3)(B)(i)(II)) is amended—

25 (1) by striking “of 80 percent”; and

1           (2) by striking the period at the end and insert-  
2           ing the following: “, less the amount a provider may  
3           charge as described in clause (ii) of section  
4           1866(a)(2)(A).”.

5           (b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-  
6 DURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.  
7 1395l(n)(1)(B)(i)(II)) is amended—

8           (1) by striking “of 80 percent”; and

9           (2) by striking the period at the end and insert-  
10          ing the following: “, less the amount a provider may  
11          charge as described in clause (ii) of section  
12          1866(a)(2)(A).”.

13          (c) EFFECTIVE DATE.—The amendments made by  
14 this section shall apply to services furnished during por-  
15 tions of cost reporting periods occurring on or after Janu-  
16 ary 1, 1995.

17 **SEC. 638. EYE OR EYE AND EAR HOSPITALS.**

18          Section 1833(i)(4)(A) (42 U.S.C. 1395l(i)(4)(A)) is  
19 amended in the matter following clause (iii) by striking  
20 “January 1, 1995” and inserting “September 30, 1997”.

21 **SEC. 639. IMPOSITION OF COINSURANCE ON LABORATORY**  
22 **SERVICES.**

23          (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of  
24 section 1833(a) (42 U.S.C. 1395l(a)) are each amended—

1 (1) by striking “(or 100 percent” and all that  
2 follows through “the first opinion))”; and

3 (2) by striking “100 percent of such negotiated  
4 rate” and inserting “80 percent of such negotiated  
5 rate”.

6 (b) EFFECTIVE DATE.—The amendments made by  
7 subsection (a) shall apply to tests furnished on or after  
8 January 1, 1995.

9 **SEC. 640. APPLICATION OF COMPETITIVE ACQUISITION**

10 **PROCESS FOR PART B ITEMS AND SERVICES.**

11 (a) GENERAL RULE.—Part B of title XVIII is  
12 amended by inserting after section 1846 the following:

13 “COMPETITION ACQUISITION FOR ITEMS AND SERVICES

14 “SEC. 1847. (a) ESTABLISHMENT OF BIDDING  
15 AREAS.—

16 “(1) IN GENERAL.—The Secretary shall estab-  
17 lish competitive acquisition areas for the purpose of  
18 awarding a contract or contracts for the furnishing  
19 under this part of the items and services described  
20 in subsection (c) on or after January 1, 1995. The  
21 Secretary may establish different competitive acqui-  
22 sition areas under this subsection for different class-  
23 es of items and services under this part.

24 “(2) CRITERIA FOR ESTABLISHMENT.—The  
25 competitive acquisition areas established under para-  
26 graph (1) shall—

1           “(A) initially be, or be within, metropolitan  
2           statistical areas; and

3           “(B) be chosen based on the availability  
4           and accessibility of suppliers and the probable  
5           savings to be realized by the use of competitive  
6           bidding in the furnishing of items and services  
7           in the area.

8           “(b) AWARDING OF CONTRACTS IN AREAS.—

9           “(1) IN GENERAL.—The Secretary shall con-  
10          duct a competition among individuals and entities  
11          supplying items and services under this part for  
12          each competitive acquisition area established under  
13          subsection (a) for each class of items and services.

14          “(2) CONDITIONS FOR AWARDING CONTRACT.—  
15          The Secretary may not award a contract to any indi-  
16          vidual or entity under the competition conducted  
17          pursuant to paragraph (1) to furnish an item or  
18          service under this part unless the Secretary finds  
19          that the individual or entity meets quality standards  
20          specified by the Secretary for the furnishing of such  
21          item or service.

22          “(3) CONTENTS OF CONTRACT.—A contract en-  
23          tered into with an individual or entity under the  
24          competition conducted pursuant to paragraph (1)

1 shall specify (for all of the items and services within  
2 a class)—

3 “(A) the quantity of items and services the  
4 entity shall provide; and

5 “(B) such other terms and conditions as  
6 the Secretary may require.

7 “(c) SERVICES DESCRIBED.—The items and services  
8 to which the provisions of this section shall apply are as  
9 follows:

10 “(1) Magnetic resonance imaging tests and  
11 computerized axial tomography scans, including a  
12 physician’s interpretation of the results of such tests  
13 and scans.

14 “(2) Oxygen and oxygen equipment.”.

15 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
16 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)  
17 (42 U.S.C. 1395y(a)) is amended—

18 (1) by striking “or” at the end of paragraph  
19 (15);

20 (2) by striking the period at the end of para-  
21 graph (16) and inserting “; or”; and

22 (3) by inserting after paragraph (16) the fol-  
23 lowing new paragraph:

24 “(17) where such expenses are for an item or  
25 service furnished in a competitive acquisition area

1 (as established by the Secretary under section  
2 1847(a)) by an individual or entity other than the  
3 supplier with whom the Secretary has entered into  
4 a contract under section 1847(b) for the furnishing  
5 of such item or service in that area, unless the Sec-  
6 retary finds that such expenses were incurred in a  
7 case of urgent need.”.

8 (c) REDUCTION IN PAYMENT AMOUNTS IF COMPETI-  
9 TIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUC-  
10 TION IN PAYMENTS.—Notwithstanding any other provi-  
11 sion of title XVIII of the Social Security Act, if the estab-  
12 lishment of competitive acquisition areas under section  
13 1847 of such Act (as added by subsection (a)) and the  
14 limitation of coverage for items and services under part  
15 B of such title to items and services furnished by providers  
16 with competitive acquisition contracts under such section  
17 does not result in a reduction of at least 10 percent in  
18 the projected payment amount that would have applied to  
19 the item or service under part B if the item or service  
20 had not been furnished through competitive acquisition  
21 under such section, the Secretary shall reduce the pay-  
22 ment amount by such percentage as the Secretary deter-  
23 mines necessary to result in such a reduction.

24 (d) EFFECTIVE DATE.—The amendments made by  
25 this section shall apply to items and services furnished

1 under part B of title XVIII of the Social Security Act on  
2 or after January 1, 1995.

3 **SEC. 641. APPLICATION OF COMPETITIVE ACQUISITION**  
4 **PROCEDURES FOR LABORATORY SERVICES.**

5 (a) IN GENERAL.—Section 1847(c), as added by sec-  
6 tion 640, is amended by inserting after paragraph (2) the  
7 following new paragraph:

8 “(3) Clinical diagnostic laboratory tests.”.

9 (b) REDUCTION IN FEE SCHEDULE AMOUNTS IF  
10 COMPETITIVE ACQUISITION FAILS TO ACHIEVE SAV-  
11 INGS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended  
12 by adding at the end the following new paragraph:

13 “(7) Notwithstanding any other provision of this sub-  
14 section, if the Secretary applies the authority provided  
15 under section 1847 to establish competitive acquisition  
16 areas for the furnishing of clinical diagnostic laboratory  
17 tests in a year and the application of such authority does  
18 not result in a reduction of at least 10 percent in the pro-  
19 jected payment amount that would have applied to such  
20 tests under this section if the tests had not been furnished  
21 through competitive acquisition under section 1847, the  
22 Secretary shall reduce each payment amount otherwise de-  
23 termined under the fee schedules and negotiated rates es-  
24 tablished under this subsection by such percentage as the

1 Secretary determines necessary to result in such a reduc-  
2 tion.”.

3 **SEC. 642. EXPANDED COVERAGE FOR PHYSICIAN ASSIST-**  
4 **ANTS AND NURSE PRACTITIONERS.**

5 (a) COVERAGE IN OUTPATIENT SETTINGS.—Section  
6 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

7 (1) in clause (i)—

8 (A) by striking “or” at the end of  
9 subclause (II); and

10 (B) by inserting “or (IV) in an outpatient  
11 setting as defined by the Secretary” following  
12 “shortage area,”; and

13 (2) in clause (ii), by striking “section 1919(a)”  
14 and inserting “section 1919(a) or in an outpatient  
15 setting as defined by the Secretary”.

16 (b) PAYMENT BASED ON PHYSICIAN FEE SCHED-  
17 ULE.—

18 (1) Section 1833(a)(1)(O) (42 U.S.C.  
19 1395l(a)(1)(O)) is amended—

20 (A) by striking “section 1861(s)(2)(K)(iii)  
21 (relating to nurse practitioner and clinical nurse  
22 specialist services provided in a rural area)”  
23 and inserting “section 1861(s)(2)(K)”;

24 (B) by striking “for services furnished on  
25 or after January 1, 1992,” and inserting “for

1 services described in section 1861(s)(2)(K)(iii)  
2 furnished on or after January 1, 1992, and for  
3 services described in clauses (i), (ii), and (iv) of  
4 section 1861(s)(2)(K) furnished on or after  
5 January 1, 1997,”; and

6 (C) by striking “subsection (r)(2)” and in-  
7 serting “subsection (r)(2) or subparagraph (A)  
8 or (B) of section 1842(b)(12)”.

9 (2) Section 1842(b)(12)(A) (42 U.S.C.  
10 1395u(b)(12)(A)) is amended—

11 (A) by striking “and” at the end of clause  
12 (i);

13 (B) in clause (ii) in the matter preceding  
14 subclause (I), by striking “the prevailing” and  
15 inserting “for services furnished before January  
16 1, 1997, the prevailing”;

17 (C) by striking the period at the end of  
18 clause (ii)(II) and inserting “; and”; and

19 (D) by inserting at the end the following  
20 clause:

21 “(iii) in the case of services furnished  
22 on or after January 1, 1997, the fee sched-  
23 ule amount shall be equal to—

1           “(I) in the case of services per-  
2           formed as an assistant at surgery, 65  
3           percent of the amount that would oth-  
4           erwise be recognized if performed by a  
5           physician who is serving as an assist-  
6           ance at surgery,

7           “(II) in the case of services per-  
8           formed (other than as an assistant at  
9           surgery) in a hospital, 75 percent of  
10          the fee schedule amount specified  
11          under section 1848, and

12          “(III) in the case of other serv-  
13          ices, 85 percent of the fee schedule  
14          amount specified under section 1848.

15          (c) RURAL NURSE PRACTITIONERS AS ASSISTANTS  
16          AT SURGERY IN URBAN AREAS.—Section  
17          1861(s)(2)(K)(ii) (42 U.S.C. 1395x(s)(2)(K)(ii)), as  
18          amended by subsection (a)(2), is further amended by add-  
19          ing “or services as an assistant at surgery furnished by  
20          a nurse practitioner whose primary practice location (as  
21          defined by the Secretary) is in a rural area (as defined  
22          in section 1886(d)(2)(D)) to an individual who resides in  
23          a rural area when the service is furnished to such individ-  
24          ual in an urban area by such practitioner when such prac-  
25          titioner refers such individual to an urban area for the

1 furnishing of services” after “as defined by the Sec-  
2 retary”.

3 (d) CONFORMING AMENDMENTS.—

4 (1) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4))  
5 is amended by striking “subsection (s)(2)(K)(i)” and  
6 inserting “subsection (s)(2)(K)”.

7 (2) Section 1862(a)(14) (42 U.S.C.  
8 1395y(a)(14)), as amended by section 620(b)(4)(K),  
9 is amended by striking “section 1861(s)(2)(K)(i)”  
10 and inserting “section 1861(s)(2)(K)”.

11 (3) Section 1866(a)(1)(H) (42 U.S.C.  
12 1395cc(a)(1)(H)), as amended by section  
13 620(b)(4)(L)(ii), is further amended by striking  
14 “section 1861(s)(2)(K)(i)” and inserting “section  
15 1861(s)(2)(K)”.

16 (e) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to services furnished on or after  
18 January 1, 1997.

19 **SEC. 643. GENERAL PART B PREMIUM.**

20 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

21 (1) in paragraph (1)(A), by striking “and prior  
22 to January 1999”; and

23 (2) in paragraph (2), by striking “prior to Jan-  
24 uary 1998”.



1 (as defined in section 1886(d)(2)(D)) by an entity  
2 if—

3 “(A) the entity is located more than 100  
4 miles from other like entities;

5 “(B) no less than 50 percent of the pa-  
6 tient-users in the entity’s service area utilize  
7 the entity; or

8 “(C) because of the area’s local topography  
9 or periods of prolonged severe weather condi-  
10 tions, other entities providing like services are  
11 not readily accessible for at least 30 days in 2  
12 out of 3 years.”.

13 **SEC. 653. EXPANSION OF CENTERS OF EXCELLENCE.**

14 (a) IN GENERAL.—The Secretary of Health and  
15 Human Services shall use a competitive process to con-  
16 tract with centers of excellence for cataract surgery and  
17 coronary artery by-pass surgery. Payment under title  
18 XVIII of the Social Security Act will be made for services  
19 subject to such contracts on the basis of negotiated or all-  
20 inclusive rates as follows:

21 (1) The center shall cover services provided in  
22 an urban area (as defined in section 1886(d)(2)(D)  
23 of the Social Security Act) for years beginning with  
24 fiscal year 1995.

1           (2) The amount of payment made by the Sec-  
2           retary to the center under title XVIII of the Social  
3           Security Act for services covered under the contract  
4           shall be less than the aggregate amount of the pay-  
5           ments that the Secretary would have made to the  
6           center for such services had the contract not been in  
7           effect.

8           (3) The Secretary shall make payments to the  
9           center on such a basis for the following services fur-  
10          nished to individuals entitled to benefits under such  
11          title:

12                   (A) Facility, professional, and related serv-  
13                   ices relating to cataract surgery.

14                   (B) Coronary artery bypass surgery and  
15                   related services.

16          (b) REBATE OF PORTION OF SAVINGS.—In the case  
17          of any services provided under a contract conducted under  
18          subsection (a), the Secretary shall make a payment to  
19          each individual to whom such services are furnished (at  
20          such time and in such manner as the Secretary may pro-  
21          vide) in an amount equal to 10 percent of the amount by  
22          which—

23                   (1) the amount of payment that would have  
24                   been made by the Secretary under title XVIII of the  
25                   Social Security Act to the center for such services if

1 the services had not been provided under the con-  
2 tract, exceeds

3 (2) the amount of payment made by the Sec-  
4 retary under such title to the center for such serv-  
5 ices.

6 **SEC. 654. MEDICARE SELECT.**

7 (a) AMENDMENTS TO PROVISIONS RELATING TO  
8 MEDICARE SELECT POLICIES.—

9 (1) PERMITTING MEDICARE SELECT POLICIES  
10 IN ALL STATES.—Subsection (c) of section 4358 of  
11 the Omnibus Budget Reconciliation Act of 1990 is  
12 hereby repealed.

13 (2) REQUIREMENTS OF MEDICARE SELECT  
14 POLICIES.—Section 1882(t)(1) (42 U.S.C.  
15 1395ss(t)(1)) is amended to read as follows:

16 “(1)(A) If a medicare supplemental policy meets the  
17 requirements of the 1991 NAIC Model Regulation or 1991  
18 Federal Regulation and otherwise complies with the re-  
19 quirements of this section except that—

20 “(i) the benefits under such policy are re-  
21 stricted to items and services furnished by certain  
22 entities (or reduced benefits are provided when items  
23 or services are furnished by other entities), and

24 “(ii) in the case of a policy described in sub-  
25 paragraph (C)(i)—

1           “(I) the benefits under such policy are not  
2           one of the groups or packages of benefits de-  
3           scribed in subsection (p)(2)(A),

4           “(II) except for nominal copayments im-  
5           posed for services covered under part B of this  
6           title, such benefits include at least the core  
7           group of basic benefits described in subsection  
8           (p)(2)(B), and

9           “(III) an enrollee’s liability under such pol-  
10          icy for physician’s services covered under part  
11          B of this title is limited to the nominal  
12          copayments described in subclause (II),

13          the policy shall nevertheless be treated as meeting  
14          those requirements if the policy meets the require-  
15          ments of subparagraph (B).

16          “(B) A policy meets the requirements of this sub-  
17          paragraph if—

18               “(i) full benefits are provided for items and  
19               services furnished through a network of entities  
20               which have entered into contracts or agreements  
21               with the issuer of the policy,

22               “(ii) full benefits are provided for items and  
23               services furnished by other entities if the services are  
24               medically necessary and immediately required be-  
25               cause of an unforeseen illness, injury, or condition

1 and it is not reasonable given the circumstances to  
2 obtain the services through the network,

3 “(iii) the network offers sufficient access,

4 “(iv) the issuer of the policy has arrangements  
5 for an ongoing quality assurance program for items  
6 and services furnished through the network,

7 “(v)(I) the issuer of the policy provides to each  
8 enrollee at the time of enrollment an explanation  
9 of—

10 “(aa) the restrictions on payment under  
11 the policy for services furnished other than by  
12 or through the network,

13 “(bb) out of area coverage under the pol-  
14 icy,

15 “(cc) the policy’s coverage of emergency  
16 services and urgently needed care, and

17 “(dd) the availability of a policy through  
18 the entity that meets the 1991 Model NAIC  
19 Regulation or 1991 Federal Regulation without  
20 regard to this subsection and the premium  
21 charged for such policy, and

22 “(II) each enrollee prior to enrollment acknowl-  
23 edges receipt of the explanation provided under  
24 subclause (I), and

1           “(vi) the issuer of the policy makes available to  
2 individuals, in addition to the policy described in this  
3 subsection, any policy (otherwise offered by the is-  
4 suer to individuals in the State) that meets the 1991  
5 Model NAIC Regulation or 1991 Federal Regulation  
6 and other requirements of this section without re-  
7 gard to this subsection.

8           “(C)(i) A policy described in this subparagraph—

9           “(I) is offered by an eligible organization (as  
10 defined in section 1876(b)),

11           “(II) is not a policy or plan providing benefits  
12 pursuant to a contract under section 1876 or an ap-  
13 proved demonstration project described in section  
14 603(c) of the Social Security Amendments of 1983,  
15 section 2355 of the Deficit Reduction Act of 1984,  
16 or section 9412(b) of the Omnibus Budget Reconcili-  
17 ation Act of 1986, and

18           “(III) provides benefits which, when combined  
19 with benefits which are available under this title, are  
20 substantially similar to benefits under policies of-  
21 fered to individuals who are not entitled to benefits  
22 under this title.

23           “(ii) In making a determination under subclause (III)  
24 of clause (i) as to whether certain benefits are substan-  
25 tially similar, there shall not be taken into account, except

1 in the case of preventive services, benefits provided under  
2 policies offered to individuals who are not entitled to bene-  
3 fits under this title which are in addition to the benefits  
4 covered by this title and which are benefits an entity must  
5 provide in order to meet the definition of an eligible orga-  
6 nization under section 1876(b)(1).”.

7 (b) RENEWABILITY OF MEDICARE SELECT POLI-  
8 CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is  
9 amended—

10 (1) by striking “(1) Each” and inserting  
11 “(1)(A) Except as provided in subparagraph (B),  
12 each”;

13 (2) by redesignating subparagraphs (A) and  
14 (B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(B)(i) In the case of a policy that meets the  
18 requirements of subsection (t), an issuer may cancel  
19 or nonrenew such policy with respect to an individ-  
20 ual who leaves the service area of such policy; except  
21 that, if such individual moves to a geographic area  
22 where such issuer, or where an affiliate of such is-  
23 suer, is issuing medicare supplemental policies, such  
24 individual must be permitted to enroll in any medi-  
25 care supplemental policy offered by such issuer or

1 affiliate that provides benefits comparable to or less  
2 than the benefits provided in the policy being can-  
3 celed or nonrenewed. An individual whose coverage  
4 is canceled or nonrenewed under this subparagraph  
5 shall, as part of the notice of termination or  
6 nonrenewal, be notified of the right to enroll in other  
7 medicare supplemental policies offered by the issuer  
8 or its affiliates.

9 “(ii) For purposes of this subparagraph, the  
10 term ‘affiliate’ shall have the meaning given such  
11 term by the 1991 NAIC Model Regulation.”

12 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.  
13 1395ss(t)(2)) is amended—

14 (1) by striking “(2)” and inserting “(2)(A)”;

15 (2) by redesignating subparagraphs (A), (B),  
16 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-  
17 spectively;

18 (3) in clause (iv), as redesignated—

19 (A) by striking “paragraph (1)(E)(i)” and  
20 inserting “paragraph (1)(B)(v)(I); and

21 (B) by striking “paragraph (1)(E)(ii)” and  
22 inserting “paragraph (1)(B)(v)(II)”;

23 (4) by striking “the previous sentence” and in-  
24 serting “this subparagraph”; and

1           (5) by adding at the end the following new sub-  
2           paragraph:

3           “(B) If the Secretary determines that an issuer of  
4 a policy approved under paragraph (1) has made a mis-  
5 representation to the Secretary or has provided the Sec-  
6 retary with false information regarding such policy, the  
7 issuer is subject to a civil money penalty in an amount  
8 not to exceed \$100,000 for each such determination. The  
9 provisions of section 1128A (other than the first sentence  
10 of subsection (a) and other than subsection (b)) shall  
11 apply to a civil money penalty under this subparagraph  
12 in the same manner as such provisions apply to a penalty  
13 or proceeding under section 1128A(a).”.

14           (d) EFFECTIVE DATES.—

15           (1) NAIC STANDARDS.—If, within 9 months  
16 after the date of the enactment of this Act, the Na-  
17 tional Association of Insurance Commissioners  
18 (hereafter in this subsection referred to as the  
19 “NAIC”) makes changes in the 1991 NAIC Model  
20 Regulation (as defined in section 1882(p)(1)(A) of  
21 the Social Security Act) to incorporate the additional  
22 requirements imposed by the amendments made by  
23 this section, section 1882(g)(2)(A) of such Act shall  
24 be applied in each State, effective for policies issued  
25 to policyholders on and after the date specified in

1 paragraph (3), as if the reference to the Model Reg-  
2 ulation adopted on June 6, 1979, were a reference  
3 to the 1991 NAIC Model Regulation (as so defined)  
4 as changed under this paragraph (such changed  
5 Regulation referred to in this subsection as the  
6 “1995 NAIC Model Regulation”).

7 (2) SECRETARY STANDARDS.—If the NAIC  
8 does not make changes in the 1991 NAIC Model  
9 Regulation (as so defined) within the 9-month period  
10 specified in paragraph (1), the Secretary of Health  
11 and Human Services (hereafter in this subsection re-  
12 ferred to as the “Secretary”) shall promulgate a reg-  
13 ulation and section 1882(g)(2)(A) of the Social Se-  
14 curity Act shall be applied in each State, effective  
15 for policies issued to policyholders on and after the  
16 date specified in paragraph (3), as if the reference  
17 to the Model Regulation adopted on June 6, 1979,  
18 were a reference to the 1991 NAIC Model Regula-  
19 tion (as so defined) as changed by the Secretary  
20 under this paragraph (such changed Regulation re-  
21 ferred to in this subsection as the “1995 Federal  
22 Regulation”).

23 (3) DATE SPECIFIED.—

1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), the date specified in this paragraph  
3 for a State is the earlier of—

4 (i) the date the State adopts the 1995  
5 NAIC Model Regulation or the 1995 Fed-  
6 eral Regulation, or

7 (ii) 1 year after the date the NAIC or  
8 the Secretary first adopts such regulations.

9 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
10 QUIRED.—In the case of a State which the Sec-  
11 retary identifies, in consultation with the NAIC,  
12 as—

13 (i) requiring State legislation (other  
14 than legislation appropriating funds) in  
15 order for medicare supplemental policies to  
16 meet the 1995 NAIC Model Regulation or  
17 the 1995 Federal Regulation, but

18 (ii) having a legislature which is not  
19 scheduled to meet in 1995 in a legislative  
20 session in which such legislation may be  
21 considered,

22 the date specified in this paragraph is the first  
23 day of the first calendar quarter beginning after  
24 the close of the first legislative session of the  
25 State legislature that begins on or after Janu-

1           ary 1, 1996. For purposes of the previous sen-  
2           tence, in the case of a State that has a 2-year  
3           legislative session, each year of such session  
4           shall be deemed to be a separate regular session  
5           of the State legislature.

6 **SEC. 655. MEDIGAP.**

7           (a) 30-DAY OPEN ENROLLMENT PERIOD.—Section  
8 1882(s) (42 U.S.C. 1395ss(s)) is amended—

9           (1) in paragraph (3), by striking “paragraphs  
10          (1) and (2)” and inserting “paragraph (1), (2), or  
11          (3)”,

12          (2) by redesignating paragraph (3) as para-  
13          graph (4), and

14          (3) by inserting after paragraph (2) the follow-  
15          ing new paragraph:

16          “(3) Each issuer of a medicare supplemental policy  
17 shall have an open enrollment period of at least 30 days  
18 duration every year (which shall be the period specified  
19 by the Secretary under section 1876(e)(1)), during which  
20 the issuer may not deny or condition the issuance or effec-  
21 tiveness of a medicare supplemental policy, or discriminate  
22 in the pricing of the policy, because of age, health status,  
23 claims experience, receipt of health care, or medical condi-  
24 tion. The policy may not provide any time period applica-  
25 ble to pre-existing conditions, waiting periods, elimination

1 periods, and probationary periods (except as provided by  
2 paragraph (2)(B)).”.

3 (b) EFFECTIVE DATES.—

4 (1) NAIC STANDARDS.—If, within 9 months  
5 after the date of the enactment of this Act, the Na-  
6 tional Association of Insurance Commissioners  
7 (hereafter in this subsection referred to as the  
8 “NAIC”) makes changes in the 1991 NAIC Model  
9 Regulation (as defined in section 1882(p)(1)(A) of  
10 the Social Security Act) to incorporate the additional  
11 requirements imposed by the amendments made by  
12 this section, section 1882(g)(2)(A) of such Act shall  
13 be applied in each State, effective for policies issued  
14 to policyholders on and after the date specified in  
15 paragraph (3), as if the reference to the Model Reg-  
16 ulation adopted on June 6, 1979, were a reference  
17 to the 1991 NAIC Model Regulation (as so defined)  
18 as changed under this paragraph (such changed  
19 Regulation referred to in this subsection as the  
20 “1995 NAIC Model Regulation”).

21 (2) SECRETARY STANDARDS.—If the NAIC  
22 does not make changes in the 1991 NAIC Model  
23 Regulation (as so defined) within the 9-month period  
24 specified in paragraph (1), the Secretary of Health  
25 and Human Services (hereafter in this subsection re-

1       ferred to as the “Secretary”) shall promulgate a reg-  
2       ulation and section 1882(g)(2)(A) of the Social Se-  
3       curity Act shall be applied in each State, effective  
4       for policies issued to policyholders on and after the  
5       date specified in paragraph (3), as if the reference  
6       to the Model Regulation adopted on June 6, 1979,  
7       were a reference to the 1991 NAIC Model Regula-  
8       tion (as so defined) as changed by the Secretary  
9       under this paragraph (such changed Regulation re-  
10      ferred to in this subsection as the “1995 Federal  
11      Regulation”).

12   **SEC. 656. REDUCTION IN ROUTINE COST LIMITS FOR HOME**  
13                   **HEALTH SERVICES.**

14       (a) REDUCTION IN UPDATE TO MAINTAIN FREEZE  
15   IN 1996.—

16           (1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42  
17   U.S.C. 1395x(v)(1)(L)(i)) is amended—

18                   (A) in subclause (II), by striking “or” at  
19                   the end;

20                   (B) in subclause (III), by striking “112  
21                   percent,” and inserting “and before July 1,  
22                   1996, 112 percent, or”; and

23                   (C) by inserting after subclause (III) the  
24                   following new subclause:

1           “(IV) July 1, 1996, 100 percent (adjusted by  
2           such amount as the Secretary determines to be nec-  
3           essary to preserve the savings resulting from the en-  
4           actment of section 13564(a)(1) of the Omnibus  
5           Budget Reconciliation Act of 1993),”.

6           (2) ADJUSTMENT TO LIMITS.—Section  
7           1861(v)(1)(L)(ii) (42 U.S.C. 1395x(v)(1)(L)(ii)) is  
8           amended by adding at the end the following new  
9           sentence: “The effect of the amendments made by  
10          656(a) of the Health Security Act shall not be con-  
11          sidered by the Secretary in making adjustments pur-  
12          suant to this clause.”.

13          (b) BASING LIMITS IN SUBSEQUENT YEARS ON ME-  
14          DIAN OF COSTS.—

15               (1) IN GENERAL.—Section 1861(v)(1)(L)(i) (42  
16               U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection  
17               (a), is amended in the matter following subclause  
18               (IV) by striking “the mean” and inserting “the me-  
19               dian”.

20               (2) EFFECTIVE DATE.—The amendment made  
21               by paragraph (1) shall apply to cost reporting peri-  
22               ods beginning on or after July 1, 1997.

1 **SEC. 657. TERMINATION OF GRADUATE MEDICAL EDU-**  
2 **CATION PAYMENTS.**

3 (a) IN GENERAL.—Section 1886(h) (42 U.S.C.  
4 1395ww(h)) is amended by adding at the end the following  
5 new paragraph:

6 “(6) TERMINATION OF PAYMENTS ATTRIB-  
7 UTABLE TO COSTS OF TRAINING PHYSICIANS.—Not-  
8 withstanding any other provision of this section or  
9 section 1861(v), no payment may be made under  
10 this title for direct graduate medical education costs  
11 attributable to an approved medical residency train-  
12 ing program for any cost reporting period (or por-  
13 tion thereof) beginning on or after January 1,  
14 1996.”.

15 (b) PROHIBITION AGAINST RECOGNITION OF  
16 COSTS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as  
17 amended by section 612(b), is amended by adding at the  
18 end the following new subparagraph:

19 “(U) Such regulations shall not include any provision  
20 for specific recognition of the costs of graduate medical  
21 education for hospitals for any cost reporting period (or  
22 portion thereof) beginning on or after January 1, 1996.  
23 Nothing in the previous sentence shall be construed to af-  
24 fect in any way payments to hospitals for the costs of any  
25 approved educational activities that are not described in  
26 such sentence.”.

1 **SEC. 658. EXTENSION OF SOCIAL HEALTH MAINTENANCE**  
2 **ORGANIZATION DEMONSTRATIONS.**

3 Section 4018(b) of the Omnibus Budget Reconcili-  
4 ation Act of 1987, as amended by section 4207(b)(4)(B)  
5 of the Omnibus Budget Reconciliation Act of 1990 and  
6 section 13567(a) of the Omnibus Budget Reconciliation  
7 Act of 1993, is amended—

8 (1) in paragraph (1), by striking “December  
9 31, 1997” and inserting “December 31, 1999”; and

10 (2) in paragraph (4), by striking “March 31,  
11 1998” and inserting “March 31, 2000”.

12 **SEC. 659. STUDY ON MEDICARE SPENDING.**

13 The Prospective Payment Assessment Commission  
14 (established under section 1886(e)(2) of the Social Secu-  
15 rity Act (42 U.S.C. 1395ww(e)(2))) and the Physician  
16 Payment Review Commission (established under section  
17 1845 of such Act (42 U.S.C. 1395w-1)) shall each con-  
18 duct a study of the rate of increase in spending under  
19 title XVIII of such Act and make recommendations to  
20 Congress on strategies to slow the rate of growth. Such  
21 studies shall include—

22 (1) an examination of ways to slow both the na-  
23 tional rate of growth and the rate of growth in com-  
24 munity-rating areas; and

1           (2) an assessment of whether setting local ex-  
2           penditure targets or local volume performance stand-  
3           ards would be successful as part of this effort.

4 **SEC. 660. STREAMLINED PROCESSING SYSTEMS.**

5           (a) IN GENERAL.—The Secretary of Health and  
6 Human Services may develop a process to ensure that  
7 claims for services under title XVIII of the such Act are  
8 submitted first by the medicare program under such title,  
9 medicare supplemental policies (described in section  
10 1886(g)(1) of such Act (42 U.S.C. 1395ww(g)(1)), and  
11 other policies that provide supplemental benefits under  
12 such title before providers can submit claims to medicare  
13 beneficiaries.

14           (b) SUPERSEDING CONFLICTING REQUIREMENTS.—  
15 The provisions of sections 1816 and 1842 of the Social  
16 Security Act (42 U.S.C. 1395h and 1395u) (including pro-  
17 vider nominating provisions in such section 1816 of such  
18 Act) are superseded to the extent required to carry out  
19 this section.

20           **Subtitle B—Medical Education**

21 **SEC. 665. MEDICAL EDUCATION.**

22           Title XVIII of the Social Security Act (42 U.S.C.  
23 1395 et seq.) is amended by adding at the end the follow-  
24 ing new part:

1                   **“PART D—MEDICAL EDUCATION**  
2                   **“Subpart I—Approved Physician and Dental**  
3                   **Training Programs**

4                   **“SEC. 1893. APPROVED PHYSICIAN AND DENTAL TRAINING**  
5                   **PROGRAMS.**

6                   “(a) FEDERAL PAYMENTS TO QUALIFIED APPLI-  
7 CANTS.—

8                   “(1) IN GENERAL.—In the case of a qualified  
9 applicant that in accordance with paragraph (2) sub-  
10 mits to the Secretary an application for calendar  
11 year 1996 or any subsequent calendar year, the Sec-  
12 retary shall make payments for such year to the ap-  
13 plicant for the purpose specified in paragraph (3).  
14 The Secretary shall make the payments in an  
15 amount determined in accordance with subsection  
16 (b) and may administer the payments as a contract,  
17 grant, or cooperative agreement.

18                   “(2) APPLICATION FOR PAYMENTS.—For pur-  
19 poses of paragraph (1), an application for payments  
20 under such paragraph for a calendar year is in ac-  
21 cordance with this paragraph if—

22                   “(A) the qualified applicant submits the  
23 application not later than the date specified by  
24 the Secretary;

25                   “(B) the application provides such assur-  
26 ances as the Secretary may require that the

1 qualified applicant will expend payments only  
2 for the purpose described in paragraph (3); and

3 “(C) the application is in such form, is  
4 made in such manner, and contains such agree-  
5 ments, assurances, and information as the Sec-  
6 retary determines to be necessary to carry out  
7 this section.

8 “(3) PAYMENTS FOR OPERATION OF APPROVED  
9 MEDICAL TRAINING PROGRAMS.—The purpose of  
10 payments under paragraph (1) is to assist each ap-  
11 proved medical training program operated by the  
12 qualified applicant with the costs of operation of  
13 such programs.

14 “(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS;  
15 ANNUAL AMOUNT OF PAYMENTS.—

16 “(1) AVAILABILITY OF FUNDS FROM TRUST  
17 FUND.—Except as provided in section 1896, the fol-  
18 lowing amounts shall be available for a calendar year  
19 for making payments under subsection (a) from the  
20 Graduate Medical and Nursing Education Trust  
21 Fund established under section 9552(a)(2)(A) of the  
22 Internal Revenue Code of 1986:

23 “(A) In the case of calendar year 1996,  
24 \$3,200,000,000.

1           “(B) In the case of calendar year 1997,  
2           \$3,550,000,000.

3           “(C) In the case of calendar year 1998,  
4           \$5,800,000,000.

5           “(D) In the case of each subsequent cal-  
6           endar year, the amount specified in this para-  
7           graph in the previous calendar year (without re-  
8           gard to any reduction of such amount under  
9           section 1896) updated through the midpoint of  
10          the year by the estimated percentage change in  
11          the general health care inflation factor during  
12          the 12-month period ending at that midpoint,  
13          with appropriate adjustments to reflect previous  
14          underestimations or overestimations under this  
15          subparagraph in the projected health care infla-  
16          tion factor.

17          “(2) AMOUNT OF PAYMENTS FOR QUALIFIED  
18          APPLICANTS.—

19                 “(A) IN GENERAL.—Subject to the annual  
20                 amount available under paragraph (1) for a cal-  
21                 endar year, the amount of payments required  
22                 under subsection (a) to be made to a qualified  
23                 applicant that submits to the Secretary an ap-  
24                 plication for such year in accordance with sub-

1 section (a)(2) is an amount equal to the prod-  
2 uct of—

3 “(i) the number of full-time equivalent  
4 training participants in the approved medi-  
5 cal training program operated by the quali-  
6 fied applicant (as determined under sub-  
7 section (c)); and

8 “(ii) the average costs of the qualified  
9 applicant in training such a participant in  
10 a calendar year for the base period, up-  
11 dated through the midpoint of the year by  
12 the estimated percentage change in the  
13 health care inflation factor after the base  
14 period and up to and including the cal-  
15 endar year involved.

16 For purposes of clause (ii), the term ‘base pe-  
17 riod’ means the most recent 2-year period for  
18 which the Secretary can determine the training  
19 costs of the qualified applicant. If the qualified  
20 applicant has not been in operation for suffi-  
21 cient time to have a base period, the amount  
22 determined under clause (ii) for such applicant  
23 shall be the national average costs of all quali-  
24 fied applicants operating the approved medical  
25 training program for the most recent 2-year pe-

1           riod (as determined by the Secretary), updated  
2           in accordance with clause (ii).

3           “(3) LIMITATION.—If the annual amount avail-  
4           able under paragraph (1) for a calendar year is in-  
5           sufficient for providing each qualified applicant that  
6           submits to the Secretary an application for such  
7           year in accordance with subsection (a)(2) with the  
8           amount of payments determined under paragraph  
9           (2) for the program for such year, the Secretary  
10          shall make such pro rata reductions in the amounts  
11          so determined as may be necessary to ensure that  
12          the total of payments made under subsection (a) for  
13          such year equals the total of such amount.

14          “(c) DETERMINATION OF FULL-TIME-EQUIVALENT  
15 TRAINING PARTICIPANTS.—

16           “(1) RULES.—The Secretary shall establish  
17           rules consistent with this subsection for the com-  
18           putation of the number of full-time-equivalent train-  
19           ing participants in approved medical training pro-  
20           grams.

21           “(2) ADJUSTMENT FOR PART-YEAR OR PART-  
22 TIME TRAINING PARTICIPANTS.—Such rules shall  
23           take into account individuals who serve as training  
24           participants for only a portion of a period in an ap-

1 proved medical training program or simultaneously  
2 with more than one such program.

3 “(3) WEIGHTING FACTORS FOR CERTAIN  
4 TRAINING PARTICIPANTS.—Subject to paragraph  
5 (4), such rules shall provide, in calculating the num-  
6 ber of full-time-equivalent training participants in an  
7 approved medical training program—

8 “(A) for a training participant who is in  
9 the participant’s initial training period, the  
10 weighting factor is 1.00, and

11 “(B) for a training participant who is not  
12 in the participant’s initial training period, the  
13 weighting factor is .50.

14 “(4) FOREIGN MEDICAL GRADUATES REQUIRED  
15 TO PASS FMGEMS EXAMINATION.—Such rules shall  
16 provide that, in the case of an individual who is a  
17 foreign medical graduate, the individual shall not be  
18 counted as a training participant unless—

19 “(A) the individual has passed the  
20 FMGEMS examination, or

21 “(B) the individual has previously received  
22 certification from, or has previously passed the  
23 examination of, the Educational Commission for  
24 Foreign Medical Graduates.

1           “(5) COUNTING TIME SPENT IN OUTPATIENT  
2           SETTINGS.—Such rules shall provide that only time  
3           spent in activities relating to patient care shall be  
4           counted and that all the time so spent by a training  
5           participant under an approved physician training  
6           program or approved dental training program shall  
7           be counted toward the determination of full-time  
8           equivalency, without regard to the setting in which  
9           the activities are performed.

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

11           “(1) APPROVED DENTAL TRAINING PRO-  
12           GRAM.—The term ‘approved dental training pro-  
13           gram’ means—

14                   “(A) an internship, residency, or fellowship  
15                   program that is accredited by the Commission  
16                   on Dental Accreditation, or

17                   “(B) a post-doctoral dental training pro-  
18                   gram in oral medicine, oral radiology, dental  
19                   anesthesia, or geriatric dentistry, that is deter-  
20                   mined by the Secretary to meet appropriate  
21                   standards.

22           “(2) APPROVED MEDICAL TRAINING PRO-  
23           GRAM.—the term ‘approved medical training pro-  
24           gram’ means an approved physician training pro-

1       gram, an approved dental training program, or an  
2       approved podiatric training program.

3           “(3) APPROVED PHYSICIAN TRAINING PRO-  
4       GRAM.—

5           “(A) IN GENERAL.—The term ‘approved  
6       physician training program’, with respect to the  
7       medical speciality involved, means a residency  
8       or other postgraduate program that trains phy-  
9       sicians and meets the following conditions:

10           “(i) Participation in the program may  
11       be counted toward certification in the med-  
12       ical speciality.

13           “(ii) The program is accredited by the  
14       Accreditation Council on Graduate Medical  
15       Education, or approved by the Council on  
16       Postgraduate Training of the American  
17       Osteopathic Association.

18           “(B) TRAINING IN OUTPATIENT FACILI-  
19       TIES.—The term ‘approved physician training  
20       program’ includes any postgraduate program  
21       described in subparagraph (A) that provides  
22       health services in an ambulatory setting, with-  
23       out regard to whether the program provides in-  
24       patient hospital services.

1           “(C) NONHOSPITAL TRAINING ENTITIES  
2 INCLUDED.—The term ‘approved physician  
3 training program’ includes any postgraduate  
4 program described in subparagraph (A), wheth-  
5 er operated by academic health centers, teach-  
6 ing hospitals, multispecialty group practices,  
7 ambulatory care providers, prepaid health  
8 plans, or other entities.

9           “(4) APPROVED PODIATRIC TRAINING PRO-  
10 GRAM.—The term ‘approved podiatric training pro-  
11 gram’ includes a training program approved by the  
12 Council of Podiatric Medical Education of the Amer-  
13 ican Podiatric Medical Association.

14           “(5) FOREIGN MEDICAL GRADUATE.—The term  
15 ‘foreign medical graduate’ means a training partici-  
16 pant who is a graduate of a school of medicine,  
17 school of osteopathy, school of dentistry, or school of  
18 podiatry that is not—

19           “(A) a school of medicine accredited by the  
20 Liaison Committee on Medical Education of the  
21 American Medical Association and the Associa-  
22 tion of American Medical Colleges (or approved  
23 by such Committee as meeting the standards  
24 necessary for such accreditation),

1           “(B) a school of osteopathy accredited by  
2           the American Osteopathic Association, or ap-  
3           proved by such Association as meeting the  
4           standards necessary for such accreditation, or

5           “(C) a school of dentistry or podiatry  
6           which is accredited (or meets the standards for  
7           accreditation) by an organization recognized by  
8           the Secretary for such purpose.

9           “(6) FMGEMS EXAMINATION.—The term  
10          ‘FMGEMS examination’ means parts I and II of the  
11          Foreign Medical Graduate Examination in the Medi-  
12          cal Sciences or any successor examination recognized  
13          by the Secretary for this purpose.

14          “(7) GENERAL HEALTH CARE INFLATION FAC-  
15          TOR.—The term ‘general health care inflation factor’  
16          means the consumer price index for medical services  
17          as determined by the Bureau of Labor Statistics.

18          “(8) INITIAL TRAINING PERIOD.—The term  
19          ‘initial training period’ means the period of board  
20          eligibility, except that—

21                 “(A) except as provided in subparagraph  
22                 (B), in no case shall the initial period of partici-  
23                 pation exceed an aggregate period of formal  
24                 training of more than five years for any individ-  
25                 ual, and

1           “(B) a period, of not more than two years,  
2 during which an individual is in a—

3           “(i) joint M.D. and Ph.D. program of  
4 study or research as meets such criteria as  
5 the Secretary may establish;

6           “(ii) residency or fellowship program  
7 in geriatric medicine, preventive medicine,  
8 or adolescent medicine; or

9           “(iii) a primary care fellowship pro-  
10 gram which meets such criteria as the Sec-  
11 retary may establish,

12 shall be treated as part of the initial training  
13 participation period, but shall not be counted  
14 against any limitation on the initial training pe-  
15 riod.

16 The initial training period shall be determined, with  
17 respect to a training participant, as of the time the  
18 training participant enters the approved medical  
19 training program.

20           “(9) PERIOD OF BOARD ELIGIBILITY.—

21           “(A) GENERAL RULE.—Subject to sub-  
22 paragraphs (B) and (C), the term ‘period of  
23 board eligibility’ means, for a training partici-  
24 pant, the minimum number of years of formal  
25 training necessary to satisfy the requirements

1 for initial board eligibility in the particular spe-  
2 cialty for which the training participant is  
3 training.

4 “(B) APPLICATION OF 1985–1986 DIREC-  
5 TORY.—Except as provided in subparagraph  
6 (C), the period of board eligibility shall be such  
7 period specified in the 1985-1986 Directory of  
8 Residency Training Programs published by the  
9 Accreditation Council on Graduate Medical  
10 Education.

11 “(C) CHANGES IN PERIOD OF BOARD ELI-  
12 GIBILITY.—If the Accreditation Council on  
13 Graduate Medical Education, in its Directory of  
14 Residency Training Programs.—

15 “(i) increases the minimum number of  
16 years of formal training necessary to sat-  
17 isfy the requirements for a specialty, above  
18 the period specified in its 1985-1986 Di-  
19 rectory, the Secretary may increase the pe-  
20 riod of board eligibility for that specialty,  
21 but not to exceed the period of board eli-  
22 gibility specified in that later Directory, or

23 “(ii) decreases the minimum number  
24 of years of formal training necessary to  
25 satisfy the requirements for a specialty,

1 below the period specified in its 1985-1986  
2 Directory, the Secretary may decrease the  
3 period of board eligibility for that spe-  
4 cialty, but not below the period of board  
5 eligibility specified in that later Directory.

6 “(10) QUALIFIED APPLICANT.—The term  
7 ‘qualified applicant’ means an entity that operates  
8 an approved medical training program.

9 “(11) TRAINING PARTICIPANT.—The term  
10 ‘training participant’ means an individual who is en-  
11 rolled in an approved medical training program.

12 **“SEC. 1894. GRADUATE NURSING EDUCATION PAYMENTS**

13 “(a) FEDERAL PAYMENTS TO GRADUATE NURSE  
14 TRAINING PROGRAMS.—

15 “(1) IN GENERAL.—In the case of a graduate  
16 nurse training program that in accordance with  
17 paragraph (2) submits to the Secretary an applica-  
18 tion for calendar year 1996 or any subsequent cal-  
19 endar year, the Secretary shall make payments for  
20 such year to the program for the purpose specified  
21 in paragraph (3). The Secretary shall make the pay-  
22 ments in an amount determined in accordance with  
23 subsection (b), and may administer the payments as  
24 a contract, grant, or cooperative agreement.

1           “(2) APPLICATION FOR PAYMENTS.—For pur-  
2           poses of paragraph (1), an application for payments  
3           under such paragraph for a calendar year is in ac-  
4           cordance with this paragraph if—

5                   “(A) the graduate nurse training program  
6                   involved submits the application not later than  
7                   the date specified by the Secretary;

8                   “(B) the application provides such assur-  
9                   ances as the Secretary may require that the  
10                  program will expend payments only for the pur-  
11                  pose described in paragraph (3); and

12                  “(C) the application is in such form, is  
13                  made in such manner, and contains such agree-  
14                  ments, assurances, and information as the Sec-  
15                  retary determines to be necessary to carry out  
16                  this section.

17           “(3) PAYMENTS FOR OPERATION OF GRADUATE  
18           NURSE TRAINING PROGRAMS.—The purpose of pay-  
19           ments under paragraph (1) is to assist a graduate  
20           nurse training program with the costs of operation.

21           “(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS;  
22           ANNUAL AMOUNT OF PAYMENTS.—

23                   “(1) AVAILABILITY OF FUNDS FROM TRUST  
24                   FUND.—Except as provided in section 1896, the fol-  
25                   lowing amounts shall be available for a calendar year

1 for making payments under subsection (a) from the  
2 Graduate Medical and Nursing Education Trust  
3 Fund established under section 9552(a)(2)(A) of the  
4 Internal Revenue Code of 1986:

5 “(A) In the case of calendar year 1996,  
6 \$200,000,000.

7 “(B) In the case of each subsequent cal-  
8 endar year, the amount specified in this para-  
9 graph in the previous calendar year (without re-  
10 gard to any reduction of such amount under  
11 section 1896) updated through the midpoint of  
12 the year by the estimated percentage change in  
13 the general health care inflation factor during  
14 the 12-month period ending at that midpoint,  
15 with appropriate adjustments to reflect previous  
16 underestimations or overestimations under this  
17 subparagraph in the projected health care infla-  
18 tion factor.

19 “(2) AMOUNT OF PAYMENTS FOR INDIVIDUAL  
20 ELIGIBLE PROGRAMS.—Subject to the annual  
21 amount available under paragraph (1) for a calendar  
22 year, the amount of payments required under sub-  
23 section (a) to be made to a graduate nurse training  
24 program that submits to the Secretary an applica-

1 tion for such year in accordance with subsection  
2 (a)(2) is an amount equal to the product of—

3 “(A) the number of full-time equivalent  
4 training participants in the program determined  
5 in accordance with paragraph (3); and

6 “(B) the national average per participant  
7 cost of all graduate nurse training programs for  
8 the most recent 2-year period (as determined by  
9 the Secretary), adjusted for geography and  
10 other factors to be determined by the Secretary  
11 and updated through the midpoint of the year  
12 by the estimated percentage change in the  
13 health care inflation factor after the base period  
14 up to and including the calendar year involved.

15 “(3) DETERMINATION OF FULL-TIME EQUIVA-  
16 LENT TRAINING PARTICIPANTS.—The Secretary  
17 shall develop a method for determining full-time  
18 equivalent training participants in graduate nurse  
19 training programs for purposes of determining pay-  
20 ments under this section.

21 “(4) LIMITATION.—If the annual amount avail-  
22 able under paragraph (1) for a calendar year is in-  
23 sufficient for providing each graduate nurse training  
24 program that submits to the Secretary an applica-  
25 tion for such year in accordance with subsection

1 (a)(2) with the amount of payments determined  
2 under paragraph (2) for the program for such year,  
3 the Secretary shall make such pro rata reductions in  
4 the amounts so determined as may be necessary to  
5 ensure that the total of payments made under sub-  
6 section (a) for such year equals the total of such  
7 amount.

8 “(c) DEFINITIONS.—For purposes of this section—

9 “(1) GRADUATE NURSE TRAINING PROGRAM.—

10 The term ‘graduate nurse training program’ means  
11 a program for advanced nurse education, a program  
12 for education as a nurse practitioner, a program for  
13 education as a nurse midwife, a program for edu-  
14 cation as a nurse anesthetist, and such other pro-  
15 grams for training in clinical nurse specialties as are  
16 determined by the Secretary to require advanced  
17 education.

18 “(2) PROGRAM FOR ADVANCED NURSE EDU-  
19 CATION.—The term ‘program for advanced nurse  
20 education’ means a program meeting the conditions  
21 to be a program for which awards of grants and con-  
22 tracts may be made under section 821 of the Public  
23 Health Service Act.

24 “(3) PROGRAM FOR EDUCATION AS NURSE  
25 PRACTITIONER.—The term ‘program for education

1 as a nurse practitioner' means a program meeting  
2 the conditions to be a program for which awards of  
3 grants and contracts may be made under section  
4 822 of the Public Health Service Act for education  
5 as a nurse practitioners.

6 “(4) PROGRAM FOR EDUCATION AS NURSE MID-  
7 WIFE.—The term ‘program for education as a nurse  
8 midwife’ means a program meeting the conditions  
9 to be a program for which awards of grants and con-  
10 tracts may be made under section 822 of the Public  
11 Health Service Act for education as nurse midwives.

12 “(5) PROGRAM FOR EDUCATION AS NURSE AN-  
13 ESTHETIST.—The term ‘program for education as a  
14 nurse anesthetist’ means a program meeting the  
15 conditions to be a program for which awards of  
16 grants may be made under section 831 of the Public  
17 Health Service Act for education as nurse anes-  
18 thetists.

19 “(6) GENERAL HEALTH CARE INFLATION FAC-  
20 TOR.—The term ‘general health care inflation fac-  
21 tor’, has the meaning given such term in section  
22 1893(d)(7) for such year.

23 **“SEC. 1895. MEDICAL SCHOOL PAYMENTS.**

24 “(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS  
25 FOR CERTAIN COSTS.—

1           “(1) IN GENERAL.—In the case of a medical  
2 school that in accordance with paragraph (2) sub-  
3 mits to the Secretary an application for calendar  
4 year 1996 or any subsequent calendar year, the Sec-  
5 retary shall make payments for such year to the pro-  
6 gram for the purpose specified in paragraph (3).  
7 The Secretary shall make the payments in an  
8 amount determined in accordance with subsection  
9 (b), and may administer the payments as a contract,  
10 grant, or cooperative agreement.

11           “(2) APPLICATION FOR PAYMENTS.—For pur-  
12 poses of paragraph (1), an application for payments  
13 under such paragraph for a calendar year is in ac-  
14 cordance with this paragraph if—

15           “(A) the medical school involved submits  
16 the application not later than the date specified  
17 by the Secretary; and

18           “(B) the application is in such form, is  
19 made in such manner, and contains such agree-  
20 ments, assurances, and information as the Sec-  
21 retary determines to be necessary to carry out  
22 this section.

23           “(3) PURPOSE OF PAYMENTS.—The purpose of  
24 payments under paragraph (1) is to assist a medical  
25 school with the costs associated with the transition

1 to managed competition and expanded ambulatory  
2 teaching services.

3 “(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS;  
4 ANNUAL AMOUNT OF PAYMENTS.—

5 “(1) AVAILABILITY OF TRUST FUND FOR PAY-  
6 MENTS.—Except as provided in section 1896, the  
7 following amounts shall be available for a calendar  
8 year for making payments under subsection (a) from  
9 the Graduate Medical and Nursing Education Trust  
10 Fund established under section 9552(a)(2)(A) of the  
11 Internal Revenue Code of 1986:

12 “(A) In the case of calendar year 1996,  
13 \$200,000,000.

14 “(B) In the case of calendar year 1997,  
15 \$300,000,000.

16 “(C) In the case of calendar year 1998,  
17 \$400,000,000.

18 “(D) In the case of calendar year 1999,  
19 \$500,000,000.

20 “(E) In the case of calendar year 2000,  
21 \$600,000,000.

22 “(F) In the case of each subsequent cal-  
23 endar year, the amount specified in this para-  
24 graph in the previous calendar year (without re-  
25 gard to any reduction of such amount under

1 section 1896) updated through the midpoint of  
2 the year by the estimated percentage change in  
3 the general health care inflation factor (as de-  
4 fined in section 1893(d)(7)) during the 12-  
5 month period ending at that midpoint, with ap-  
6 propriate adjustments to reflect previous  
7 underestimations or overestimations under this  
8 subparagraph in the projected health care infla-  
9 tion factor.

10 “(2) AMOUNT OF PAYMENTS FOR MEDICAL  
11 SCHOOLS.—

12 “(A) IN GENERAL.—Subject to the annual  
13 amount available under paragraph (1) for a cal-  
14 endar year, the amount of payments required  
15 under subsection (a) to be made to a medical  
16 school that submits to the Secretary an applica-  
17 tion for such year in accordance with subsection  
18 (a)(2) is an amount equal to an amount deter-  
19 mined by the Secretary in accordance with sub-  
20 paragraph (B).

21 “(B) DEVELOPMENT OF FORMULA.—The  
22 Secretary shall develop a formula for allocation  
23 of funds to medical schools under this section  
24 consistent with the purpose described in sub-  
25 section (a)(3).

1       “(c) LIMITATION.—If the annual amount available  
2 under subsection (b) for a calendar year is insufficient for  
3 providing each medical school that submits to the Sec-  
4 retary an application for such year in accordance with sub-  
5 section (a)(2) with the amount of payments determined  
6 under subsection (b)(2) for the program for such year, the  
7 Secretary shall make such pro rata reductions in the  
8 amounts so determined as may be necessary to ensure that  
9 the total of payments made under subsection (a) for such  
10 year equals the total of such amount.

11       “(d) MEDICAL SCHOOL DEFINED.—For purposes of  
12 this section, the term ‘medical school’ means a school of  
13 medicine (as defined in section 799 of the Public Health  
14 Service Act) or a school of osteopathic medicine (as de-  
15 fined in such section).

16       **“SEC. 1896. AMOUNTS IN TRUST FUND INSUFFICIENT.**

17       “If the sum of the amounts specified in sections  
18 1893(b)(1), 1894(b)(1), and 1895(b)(1) for a calendar  
19 year exceeds the amounts available for such calendar year  
20 in the Graduate Medical Education and Nursing Trust  
21 Fund established under section 9552(a)(2)(A) of the In-  
22 ternal Revenue Code of 1986, then each such amount shall  
23 be reduced to an amount which bears the same ratio to  
24 such amount as the amounts available bear to the sum  
25 of such amounts.

1     **“Subpart II—Academic Health Centers and Other**  
2                     **Eligible Institutions**

3     **“SEC. 1897. ACADEMIC HEALTH CENTERS AND OTHER ELI-**  
4                     **GIBLE INSTITUTIONS.**

5             “(a) FEDERAL PAYMENTS TO ACADEMIC HEALTH  
6 CENTERS AND OTHER ELIGIBLE INSTITUTIONS.—

7                     “(1) IN GENERAL.—In the case of an eligible  
8 institution, that in accordance with paragraph (2)  
9 submits to the Secretary an application for calendar  
10 year 1996 or any subsequent calendar year, the Sec-  
11 retary shall make payments for such year to the in-  
12 stitution for the purposes specified in paragraph (3).  
13 The Secretary shall make the payments in an  
14 amount determined in accordance with subsection  
15 (b), and may administer the payments as a contract,  
16 grant, or cooperative agreement.

17                     “(2) APPLICATION.—For purposes of para-  
18 graph (1), an application for payments under such  
19 paragraph for a calendar year is in accordance with  
20 this paragraph if—

21                             “(A) the eligible institution involved sub-  
22 mits the application at such time, in such man-  
23 ner, and accompanied by such agreements, and  
24 information as the Secretary may determine  
25 necessary to carry out this section; and

26                             “(B) such application is accompanied by—

1           “(i) an assurance that, in exchange  
2           for receiving payments under paragraph  
3           (1), the eligible institution shall agree to  
4           maintain its status as an eligible institu-  
5           tion; and

6           “(ii) such additional assurances as the  
7           Secretary may reasonably require consist-  
8           ent with the purposes of this section.

9           “(3) PAYMENT FOR COSTS INCURRED BY ELIGI-  
10          BLE INSTITUTIONS.—

11           “(A) NON-COMPARABLE COSTS OF ACA-  
12          DEMIC HEALTH CENTERS AND OTHER TEACH-  
13          ING HOSPITALS.—With respect to an eligible in-  
14          stitution that is a qualified academic health  
15          center or a qualified teaching hospital, the pur-  
16          pose of payments under paragraph (1) is to as-  
17          sist such institutions with costs that are not  
18          routinely incurred by other entities in providing  
19          health services, but are incurred by such insti-  
20          tutions in providing health services. Such costs  
21          include—

22           “(i) with respect to productivity in the  
23           provision of health services, costs resulting  
24           from the reduced rate of productivity of  
25           faculty due to teaching responsibilities;

1           “(ii) the uncompensated costs of clinical  
2           research;

3           “(iii) exceptional costs associated with  
4           the treatment of health conditions with respect  
5           to which an eligible institution has  
6           specialized expertise (including treatment  
7           of rare diseases, treatment of unusually severe  
8           conditions, and providing other specialized  
9           health care); and

10          “(iv) the costs of treating a substantial  
11          number of severely ill patients.

12          “(B) OTHER COSTS.—With respect to—

13               “(i) an eligible institution that is a  
14               school of dentistry, the purpose of payments  
15               under paragraph (1) is to assist  
16               such school with the costs of training dentists,  
17               including unreimbursed oral health  
18               care costs; and

19               “(ii) an eligible institution that is a  
20               high intensity nonteaching rural hospital,  
21               the purpose of payments under paragraph  
22               (1) is to assist the institution with the  
23               costs described under subparagraph  
24               (A)(iv).

1       “(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS;  
2 ANNUAL AMOUNT OF PAYMENTS.—

3           “(1) AVAILABILITY OF FUNDS FROM TRUST  
4 FUND.—Except as provided in subsection (e), the  
5 following amounts shall be available for a calendar  
6 year for making payments under subsection (a) from  
7 the Academic Health Center Trust Fund established  
8 under section 9552(a)(2)(B) of the Internal Revenue  
9 Code of 1986:

10           “(A) In the case of calendar year 1996,  
11       \$6,280,000,000.

12           “(B) In the case of calendar year 1997,  
13       \$7,250,000,000.

14           “(C) In the case of calendar year 1998,  
15       \$8,220,000,000.

16           “(D) In the case of calendar year 1999,  
17       \$9,400,000,000.

18           “(E) In the case of calendar year 2000,  
19       \$10,640,000,000.

20           “(F) In the case of each subsequent cal-  
21 endar year, the amount specified in this para-  
22 graph in the previous calendar year (without re-  
23 gard to any reduction of such amount under  
24 subsection (e)) updated through the midpoint of  
25 the year by the estimated percentage change in

1 the general health care inflation factor (as de-  
2 fined in section 1893(d)(7)) during the 12-  
3 month period ending at that midpoint, with ap-  
4 propriate adjustments to reflect previous  
5 underestimations or overestimations under this  
6 subparagraph in the projected health care infla-  
7 tion factor.

8 “(2) SPECIAL ALLOTMENTS.—Of the amounts  
9 available for a calendar year for making payments  
10 under subsection (a) pursuant to paragraph (1)—

11 “(A) such amounts as are necessary shall  
12 be reserved to make payments to eligible insti-  
13 tutions that are high intensity nonteaching  
14 rural hospitals; and

15 “(B) after reserving the amounts described  
16 in subparagraph (A), the following amounts  
17 shall be reserved to make payments to eligible  
18 institutions that are schools of dentistry:

19 “(i) In the case of calendar year  
20 1996, \$50,000,000.

21 “(ii) In the case of each subsequent  
22 calendar year, the amount specified in this  
23 subparagraph for the previous calendar  
24 year updated through the midpoint of the  
25 year by the estimated percentage change in

1 the general health care inflation factor  
2 during the 12-month period ending at that  
3 midpoint, with appropriate adjustments to  
4 reflect previous underestimations or over-  
5 estimations under this clause in the pro-  
6 jected health care inflation factor.

7 “(3) AMOUNT OF PAYMENTS FOR ELIGIBLE IN-  
8 STITUTIONS.—

9 “(A) QUALIFIED ACADEMIC HEALTH CEN-  
10 TER OR QUALIFIED TEACHING HOSPITAL.—  
11 Subject to the annual amount available under  
12 paragraphs (1) and (2) for a calendar year, the  
13 amount of payments required under subsection  
14 (a) to be made to a qualified academic health  
15 center or qualified teaching hospital is an  
16 amount equal to—

17 “(i) the inpatient costs of the quali-  
18 fied academic health center or qualified  
19 teaching hospital for furnishing patient  
20 care for all patients for the calendar year,  
21 multiplied by

22 “(ii)  $(e \text{ raised to the power } (.405 \times$   
23  $r) - 1)$ , where ‘r’ is the ratio of the qualified  
24 academic health center’s or the qualified  
25 teaching hospital’s full-time equivalent

1 training participants (as determined under  
2 section 1893(c)) to beds for such center or  
3 institution for the calendar year and 'e' is  
4 the natural log of one.

5 “(B) SCHOOL OF DENTISTRY.—Subject to  
6 the annual amount available under paragraphs  
7 (1) and (2) for a calendar year, the amount re-  
8 quired under subsection (a) to be made to a  
9 school of dentistry is an amount equal to the  
10 sum of—

11 “(i) 75 percent of the amount avail-  
12 able pursuant to paragraph (2)(B) multi-  
13 plied by the ratio of the number of full-  
14 time equivalent training participants in the  
15 school of dentistry (determined in accord-  
16 ance with a method to be developed by the  
17 Secretary) to the national number of full-  
18 time equivalent training participants in all  
19 schools of dentistry (as determined by the  
20 Secretary); and

21 “(ii) 25 percent of the amount avail-  
22 able pursuant to paragraph (2)(B) multi-  
23 plied by the ratio of the unreimbursed oral  
24 health care costs of the school of dentistry  
25 to the national unreimbursed oral health

1 care costs of all schools of dentistry (as de-  
2 termined by the Secretary).

3 “(C) HIGH INTENSITY NONTEACHING  
4 RURAL HOSPITAL.—Subject to the annual  
5 amount available under paragraphs (1) and (2)  
6 for a calendar year, the amount required under  
7 subsection (a) to be made to a high intensity  
8 nonteaching rural hospital is an amount equal  
9 to 5 percent of the inpatient costs of patient  
10 care for all patients of the hospital.

11 “(4) LIMITATION.—If the annual amount avail-  
12 able under paragraph (1) for a calendar year is in-  
13 sufficient for providing each eligible institution that  
14 submits to the Secretary an application for such  
15 year in accordance with subsection (a)(2) with the  
16 amount of payments determined under paragraph  
17 (3) for the institution for such year or is in excess  
18 of the amount required for making such payments  
19 for such year, the Secretary shall make such pro  
20 rata reductions or increases in the amounts so deter-  
21 mined as may be necessary to ensure that the total  
22 of payments made under subsection (a) for such  
23 year equals the total of such amount.

24 “(c) REPORT ON MODIFICATIONS IN FORMULA.—  
25 Not later than July 1, 1996, the Secretary shall submit

1 to the Congress a report containing any recommendations  
2 of the Secretary regarding policies for allocating amounts  
3 under subsection (b)(3) among eligible institutions. In  
4 making such recommendations, the Secretary shall con-  
5 sider the costs described in subsection (a)(3) (including  
6 outpatient costs) that are incurred by such institutions.

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

8 “(1) QUALIFIED ACADEMIC HEALTH CENTER.—

9 The term ‘qualified academic health center’ means  
10 an entity that—

## 11 **Subtitle C—Home and Community-** 12 **Based Services**

### 13 **SEC. 667. STATE PROGRAMS FOR HOME AND COMMUNITY-** 14 **BASED SERVICES FOR INDIVIDUALS WITH** 15 **DISABILITIES.**

16 (a) IN GENERAL.—Title XIX of the Social Security  
17 Act (42 U.S.C. 1396 et seq.), as amended by section 301,  
18 is amended by adding at the end the following new part:

1 **“PART C—STATE PROGRAMS FOR HOME AND**  
2 **COMMUNITY-BASED SERVICES FOR INDIVID-**  
3 **UALS WITH DISABILITIES**

4 **“SEC. 1971. STATE PROGRAMS FOR HOME AND COMMU-**  
5 **NITY-BASED SERVICES FOR INDIVIDUALS**  
6 **WITH DISABILITIES.**

7 “(a) IN GENERAL.—Each State that has a plan for  
8 home and community-based services for individuals with  
9 disabilities submitted to and approved by the Secretary  
10 under section 1972(b) is entitled to payment in accordance  
11 with section 1978.

12 “(b) ENTITLEMENT TO SERVICES.—Nothing in this  
13 part shall be construed to create a right to services for  
14 individuals or a requirement that a State with an approved  
15 plan expend the entire amount of funds to which it is enti-  
16 tled under this part.

17 “(c) DESIGNATION OF AGENCY.—Not later than 6  
18 months after the date of enactment of this part, the Sec-  
19 retary shall designate an agency responsible for program  
20 administration under this part.

21 **“SEC. 1972. STATE PLANS.**

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

26 “(1) ELIGIBILITY.—

1           “(A) IN GENERAL.—Within the amounts  
2 provided by the State and under section 1978  
3 for such plan, the plan shall provide that serv-  
4 ices under the plan will be available to individ-  
5 uals with disabilities (as defined in section  
6 1973(a)) in the State.

7           “(B) INITIAL SCREENING.—The plan shall  
8 provide a process for the initial screening of an  
9 individual who has some reasonable probability  
10 of being an individual with disabilities. Any  
11 such process shall require the provision of as-  
12 sistance to individuals who wish to apply but  
13 whose disability limits their ability to apply.  
14 The initial screening and the determination of  
15 disability (as defined under section 1973(b)(1))  
16 shall be conducted by a public agency.

17           “(C) RESTRICTIONS.—The plan may not  
18 limit the eligibility of individuals with disabil-  
19 ities based on—

20                   “(i) income,

21                   “(ii) age,

22                   “(iii) geography,

23                   “(iv) nature or category of disability,

24                   “(v) residential setting (other than an  
25 institutional setting), or

1                   “(vi) other grounds specified by the  
2                   Secretary;  
3                   except that the Secretary may permit a State to  
4                   limit eligibility based on level of disability.

5                   “(D) CONTINUATION OF SERVICES.—The  
6                   plan must provide assurances that, in the case  
7                   of an individual receiving medical assistance for  
8                   home and community-based services under the  
9                   State medicaid plan as of the date the first  
10                  State plan is approved under this part, the  
11                  State will continue to make available (either  
12                  under this plan, under the State medicaid plan,  
13                  or otherwise) to such individual an appropriate  
14                  level of assistance for home and community-  
15                  based services, taking into account the level of  
16                  assistance provided as of such date and the in-  
17                  dividual’s need for home and community-based  
18                  services.

19                  “(2) SERVICES.—

20                  “(A) NEEDS ASSESSMENT.—Not later than  
21                  the end of the second year of implementation,  
22                  the plan or its amendments shall include the re-  
23                  sults of a statewide assessment of the needs of  
24                  individuals with disabilities in a format required  
25                  by the Secretary. The needs assessment shall

1 include demographic data concerning the num-  
2 ber of individuals within each category of dis-  
3 ability described in this part, and the services  
4 available to meet the needs of such individuals.

5 “(B) SPECIFICATION.—Consistent with  
6 section 1974, the plan shall specify—

7 “(i) the services made available under  
8 the plan,

9 “(ii) the extent and manner in which  
10 such services are allocated and made avail-  
11 able to individuals with disabilities, and

12 “(iii) the manner in which services  
13 under the plan are coordinated with each  
14 other and with health and long-term care  
15 services available outside the plan for indi-  
16 viduals with disabilities.

17 “(C) TAKING INTO ACCOUNT INFORMAL  
18 CARE.—A State plan may take into account, in  
19 determining the amount and array of services  
20 made available to covered individuals with dis-  
21 abilities, the availability of informal care.

22 “(D) ALLOCATION.—The State plan—

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

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

4           “(iii) shall include services that assist  
5 all categories of individuals with disabili-  
6 ties, regardless of their age or the nature  
7 of their disabling conditions,

8           “(iv) shall demonstrate that services  
9 are allocated equitably, in accordance with  
10 the needs assessment required under sub-  
11 paragraph (A), and

12           “(v) shall ensure that—

13           “(I) the proportion of the popu-  
14 lation of low-income individuals with  
15 disabilities in the State that rep-  
16 resents individuals with disabilities  
17 who are provided home and commu-  
18 nity-based services either under the  
19 plan, under the State medicaid plan,  
20 or under both, is not less than,

21           “(II) the proportion of the popu-  
22 lation of the State that represents in-  
23 dividuals who are low-income individ-  
24 uals.

1           “(E) LIMITATION ON LICENSURE OR CER-  
2           TIFICATION.—The State may not subject  
3           consumer-directed providers of personal assist-  
4           ance services to licensure, certification, or other  
5           requirements which the Secretary finds not to  
6           be necessary for the health and safety of indi-  
7           viduals with disabilities.

8           “(F) CONSUMER CHOICE.—To the extent  
9           feasible, the State shall follow the choice of an  
10          individual with disabilities (or that individual’s  
11          designated representative who may be a family  
12          member) regarding which covered services to re-  
13          ceive and the providers who will provide such  
14          services.

15          “(3) COST SHARING.—The plan shall impose  
16          cost sharing with respect to covered services in ac-  
17          cordance with section 1975.

18          “(4) TYPES OF PROVIDERS AND REQUIRE-  
19          MENTS FOR PARTICIPATION.—The plan shall speci-  
20          fy—

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

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

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

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

9           “(5) PROVIDER REIMBURSEMENT.—

10           “(A) PAYMENT METHODS.—The plan shall  
11           specify the payment methods to be used to re-  
12           imburse providers for services furnished under  
13           the plan. Such methods may include retrospec-  
14           tive reimbursement on a fee-for-service basis,  
15           prepayment on a capitation basis, payment by  
16           cash or vouchers to individuals with disabilities,  
17           or any combination of these methods. In the  
18           case of payment to consumer-directed providers  
19           of personal assistance services, including pay-  
20           ment through the use of cash or vouchers, the  
21           plan shall specify how the plan will assure com-  
22           pliance with applicable employment tax and  
23           health care coverage provisions.

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

4                   “(i) agency administered services fur-  
5 nished under the plan; and

6                   “(ii) consumer-directed personal as-  
7 sistance services furnished under the plan,  
8 including cash payments or vouchers to in-  
9 dividuals with disabilities, except that such  
10 payments shall be adequate to cover  
11 amounts required under applicable employ-  
12 ment tax and health care coverage provi-  
13 sions.

14           “(C) PLAN PAYMENT AS PAYMENT IN  
15 FULL.—The plan shall restrict payment under  
16 the plan for covered services to those providers  
17 that agree to accept the payment under the  
18 plan (at the rates established pursuant to sub-  
19 paragraph (B)) and any cost sharing permitted  
20 or provided for under section 1975 as payment  
21 in full for services furnished under the plan.

22           “(7) QUALITY ASSURANCE AND SAFEGUARDS.—  
23 The State plan shall provide for quality assurance  
24 and safeguards for applicants and beneficiaries in  
25 accordance with section 1976.

1           “(8) ADVISORY GROUP.—The State plan  
2 shall—

3           “(A) assure the establishment and mainte-  
4 nance of an advisory group under section  
5 1977(b), and

6           “(B) include the documentation prepared  
7 by the group under section 1977(b)(4).

8           “(9) ADMINISTRATION AND ACCESS.—

9           “(A) STATE AGENCY.—The plan shall des-  
10 ignate a State agency or agencies to administer  
11 (or to supervise the administration of) the plan.

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

14           “(i) coordinate services provided  
15 under the plan, including eligibility  
16 prescreening, service coordination, and re-  
17 ferrals for individuals with disabilities who  
18 are ineligible for services under this part  
19 with the State medicaid plan, titles V and  
20 XX, programs under the Older Americans  
21 Act of 1965, programs under the Devel-  
22 opmental Disabilities Assistance and Bill  
23 of Rights Act, the Individuals with Disabil-  
24 ities Education Act, and any other Federal  
25 or State programs that provide services or

1 assistance targeted to individuals with dis-  
2 abilities, and

3 “(ii) coordinate with health plans.

4 “(C) ADMINISTRATIVE EXPENDITURES.—  
5 Effective beginning with fiscal year 2003, the  
6 plan shall contain assurances that not more  
7 than 10 percent of expenditures under the plan  
8 for all quarters in any fiscal year shall be for  
9 administrative costs.

10 “(10) REPORTS AND INFORMATION TO SEC-  
11 RETARY; AUDITS.—The plan shall provide that the  
12 State will furnish to the Secretary—

13 “(A) such reports, and will cooperate with  
14 such audits, as the Secretary determines are  
15 needed concerning the State’s administration of  
16 its plan under this part, including the process-  
17 ing of claims under the plan, and

18 “(B) such data and information as the  
19 Secretary may require in a uniform format as  
20 specified by the Secretary.

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

1           “(12) HEALTH CARE WORKER REDEPLOY-  
2           MENT.—The plan shall provide for the following:

3           “(A) Before initiating the process of imple-  
4           menting the State program under such plan,  
5           negotiations will be commenced with labor  
6           unions representing the employees of the af-  
7           fected hospitals or other facilities.

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

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

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

15           “(C) The plan will provide evidence that  
16           there has been compliance with subparagraphs  
17           (A) and (B), including a description of the re-  
18           sults of the negotiations.

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

22           “(b) APPROVAL OF PLANS.—The Secretary shall ap-  
23           prove a plan submitted by a State if the Secretary deter-  
24           mines that the plan—

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

3           “(2) meets the requirements of subsection (a).  
4           The approval of such a plan shall take effect as of the  
5           first day of the first fiscal year beginning after the date  
6           of such approval (except that any approval made before  
7           January 1, 1998, shall be effective as of January 1, 1998).

8           In order to budget funds allotted under this part, the Sec-  
9           retary shall establish a deadline for the submission of such  
10          a plan before the beginning of a fiscal year as a condition  
11          of its approval effective with that fiscal year. Any signifi-  
12          cant changes to the State plan shall be submitted to the  
13          Secretary in the form of plan amendments and shall be  
14          subject to approval by the Secretary.

15          “(c) MONITORING.—The Secretary shall annually  
16          monitor the compliance of State plans with the require-  
17          ments of this part according to specified performance  
18          standards. States that fail to comply with such require-  
19          ments may be subject to the withholding of Federal funds  
20          for services or administration until such time as compli-  
21          ance is achieved.

22          “(d) TECHNICAL ASSISTANCE.—The Secretary shall  
23          ensure the availability of ongoing technical assistance to  
24          States under this section. Such assistance shall include

1 serving as a clearinghouse for information regarding suc-  
2 cessful practices in providing long-term care services.

3 “(e) REGULATIONS.—The Secretary shall issue such  
4 regulations as may be appropriate to carry out this part  
5 on a timely basis.

6 **“SEC. 1973. INDIVIDUALS WITH DISABILITIES DEFINED.**

7 “(a) IN GENERAL.—For purposes of this part, the  
8 term ‘individual with disabilities’ means any individual  
9 within one or more of the following categories of individ-  
10 uals:

11 “(1) INDIVIDUALS REQUIRING HELP WITH AC-  
12 TIVITIES OF DAILY LIVING.—An individual of any  
13 age who—

14 “(A) requires hands-on or standby assist-  
15 ance, supervision, or cueing (as defined in regu-  
16 lations) to perform three or more activities of  
17 daily living (as defined in subsection (d)), and

18 “(B) is expected to require such assistance,  
19 supervision, or cueing over a period of at least  
20 90 days.

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

23 “(A) whose score, on a standard mental  
24 status protocol (or protocols) appropriate for  
25 measuring the individual’s particular condition

1 specified by the Secretary, indicates either se-  
2 vere cognitive impairment or severe mental im-  
3 pairment, or both;

4 “(B) who—

5 “(i) requires hands-on or standby as-  
6 sistance, supervision, or cueing with one or  
7 more activities of daily living,

8 “(ii) requires hands-on or standby as-  
9 sistance, supervision, or cueing with at  
10 least such instrumental activity (or activi-  
11 ties) of daily living related to cognitive or  
12 mental impairment as the Secretary speci-  
13 fies, or

14 “(iii) displays symptoms of one or  
15 more serious behavioral problems (that is  
16 on a list of such problems specified by the  
17 Secretary) which create a need for super-  
18 vision to prevent harm to self or others;  
19 and

20 “(C) who is expected to meet the require-  
21 ments of subparagraphs (A) and (B) over a pe-  
22 riod of at least 90 days.

23 Not later than 2 years after the date of enactment  
24 of this part, the Secretary shall make recommenda-

1 tions regarding the most appropriate duration of dis-  
2 ability under this paragraph.

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

8 “(4) YOUNG CHILDREN WITH SEVERE DISABIL-  
9 ITIES.—An individual under 6 years of age who—

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

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

18 “(b) DETERMINATION.—

19 “(1) IN GENERAL.—In formulating eligibility  
20 criteria under subsection (a), the Secretary shall es-  
21 tablish criteria for assessing the functional level of  
22 disability among all categories of individuals with  
23 disabilities that are comparable in severity, regard-  
24 less of the age or the nature of the disabling condi-  
25 tion of the individual. The determination of whether

1 an individual is an individual with disabilities shall  
2 be made by a public or nonprofit agency that is  
3 specified under the State plan and that is not a pro-  
4 vider of home and community-based services under  
5 this part and by using a uniform protocol consisting  
6 of an initial screening and a determination of dis-  
7 ability specified by the Secretary. A State may not  
8 impose cost sharing with respect to a determination  
9 of disability. A State may collect additional informa-  
10 tion, at the time of obtaining information to make  
11 such determination, in order to provide for the as-  
12 sessment and plan described in section 1974(b) or  
13 for other purposes.

14 “(2) PERIODIC REASSESSMENT.—The deter-  
15 mination that an individual is an individual with dis-  
16 abilities shall be considered to be effective under the  
17 State plan for a period of not more than 6 months  
18 (or for such longer period in such cases as a signifi-  
19 cant change in an individual’s condition that may af-  
20 fect such determination is unlikely). A reassessment  
21 shall be made if there is a significant change in an  
22 individual’s condition that may affect such deter-  
23 mination.

24 “(c) ELIGIBILITY CRITERIA.—The Secretary shall re-  
25 assess the validity of the eligibility criteria described in

1 subsection (a) as new knowledge regarding the assess-  
2 ments of functional disabilities becomes available. The  
3 Secretary shall report to the Committee on Finance of the  
4 Senate and the Committees on Ways and Means and En-  
5 ergy and Commerce of the House of Representatives on  
6 its findings under the preceding sentence as determined  
7 appropriate by the Secretary.

8 “(d) ACTIVITY OF DAILY LIVING DEFINED.—For  
9 purposes of this part, the term ‘activity of daily living’  
10 means any of the following: eating, toileting, dressing,  
11 bathing, and transferring.

12 **“SEC. 1974. HOME AND COMMUNITY-BASED SERVICES COV-  
13 ERED UNDER STATE PLAN.**

14 “(a) SPECIFICATION.—

15 “(1) IN GENERAL.—Subject to the succeeding  
16 provisions of this section, the State plan under this  
17 part shall specify—

18 “(A) the home and community-based serv-  
19 ices available under the plan to individuals with  
20 disabilities (or to such categories of such indi-  
21 viduals), and

22 “(B) any limits with respect to such serv-  
23 ices.

24 “(2) FLEXIBILITY IN MEETING INDIVIDUAL  
25 NEEDS.—Subject to subsection (e)(2), such services

1       may be delivered in an individual’s home, a range of  
2       community residential arrangements, or outside the  
3       home.

4       “(b) REQUIREMENT FOR CARE MANAGEMENT.—

5             “(1) IN GENERAL.—The State shall make avail-  
6       able to each category of individuals with disabilities  
7       care management services that at a minimum in-  
8       clude—

9             “(A) a comprehensive assessment of the in-  
10       dividual’s need for home and community-based  
11       services (regardless of whether all needed serv-  
12       ices are available under the plan),

13            “(B) an individualized plan of care based  
14       on such assessment,

15            “(C) arrangements for the provision of  
16       such services, and

17            “(D) monitoring of the delivery of services.

18       “(2) CARE MANAGEMENT SERVICES.—

19            “(A) IN GENERAL.—Except as provided in  
20       subparagraph (B), the care management serv-  
21       ices described in paragraph (1) shall be pro-  
22       vided by a public or private entity that is not  
23       providing home and community-based services  
24       under this part.

1           “(B) EXCEPTION.—A person who provides  
2 home and community-based services under this  
3 part may provide care management services  
4 if—

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

11           “(ii) the State plan specifies proce-  
12 dures that the State will implement in  
13 order to avoid conflicts of interest.

14           “(3) COMPREHENSIVE ASSESSMENTS.—The  
15 Secretary shall develop a uniform comprehensive as-  
16 sessment tool that shall be used by the States under  
17 paragraph (1)(A). Alternative comprehensive assess-  
18 ment tools may be used by the States only with the  
19 approval of the Secretary. The Secretary shall pro-  
20 vide guidance to the States with regard to the ap-  
21 propriate qualifications for individuals who conduct  
22 comprehensive assessments.

23           “(4) INDIVIDUALIZED PLAN OF CARE.—

24           “(A) IN GENERAL.—The plan of care  
25 under paragraph (1)(B) shall—

1           “(i) specify which services included  
2           under the individual plan will be provided  
3           under the State plan under this part,

4           “(ii) identify (to the extent possible)  
5           how the individual will be provided any  
6           services specified under the plan of care  
7           and not provided under the State plan,

8           “(iii) specify how the provision of  
9           services to the individual under the plan  
10          will be coordinated with the provision of  
11          other health care services to the individual,  
12          and

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

16          The State shall make reasonable efforts to iden-  
17          tify and arrange for services described in clause  
18          (ii). Nothing in this subsection shall be con-  
19          strued as requiring a State (under the State  
20          plan or otherwise) to provide all the services  
21          specified in such a plan.

22          “(B) INVOLVEMENT OF INDIVIDUALS.—  
23          The individualized plan of care under para-  
24          graph (1)(B) for an individual with disabilities  
25          shall—

1           “(i) be developed by qualified individ-  
2           uals (specified under the State plan),

3           “(ii) be developed and implemented in  
4           close consultation with the individual or  
5           the individual’s designated representative,  
6           and

7           “(iii) be approved by the individual  
8           (or the individual’s designated representa-  
9           tive).

10       “(c) MANDATORY COVERAGE OF PERSONAL ASSIST-  
11       ANCE SERVICES.—The State plan shall include, in the  
12       array of services made available to each category of indi-  
13       viduals with disabilities, both agency-administered and  
14       consumer-directed personal assistance services (as defined  
15       in subsection (g)).

16       “(d) ADDITIONAL SERVICES.—

17           “(1) TYPES OF SERVICES.—Subject to sub-  
18           section (e), services available under a State plan  
19           under this part may include any (or all) of the fol-  
20           lowing:

21           “(A) Homemaker and chore assistance.

22           “(B) Home modifications.

23           “(C) Respite services.

1           “(D) Assistive devices, as defined in the  
2           Technology Related Assistance for Individuals  
3           with Disabilities Act.

4           “(E) Adult day services.

5           “(F) Habilitation and rehabilitation.

6           “(G) Supported employment.

7           “(H) Home health services.

8           “(I) Transportation.

9           “(J) Any other care or assistive services  
10           specified by the State and approved by the Sec-  
11           retary that will help individuals with disabilities  
12           to remain in their homes and communities.

13           “(2) CRITERIA FOR SELECTION OF SERVICES.—  
14           The State electing services under paragraph (1)  
15           shall specify in the State plan—

16           “(A) the methods and standards used to  
17           select the types, and the amount, duration, and  
18           scope, of services to be covered under the plan  
19           and to be available to each category of individ-  
20           uals with disabilities, and

21           “(B) how the types, and the amount, dura-  
22           tion, and scope, of services specified, within the  
23           limits of available funding, provide substantial  
24           assistance in living independently to individuals

1           within each of the categories of individuals with  
2           disabilities.

3           “(e) EXCLUSIONS AND LIMITATIONS.—

4           “(1) IN GENERAL.—A State plan may not pro-  
5           vide for coverage of—

6                   “(A) room and board,

7                   “(B) services furnished in a hospital, nurs-  
8           ing facility, intermediate care facility for the  
9           mentally retarded, or other institutional setting  
10          specified by the Secretary,

11                   “(C) items and services to the extent cov-  
12          erage is provided for the individual under a  
13          health plan or the medicare program, or

14                   “(D) the services described in paragraph  
15          (2) with respect to an individual who is eligible  
16          for medical assistance consisting of such serv-  
17          ices under the State plan under part A.

18          “(2) MEDICAID SERVICES DESCRIBED.—The  
19          services described in this paragraph are the follow-  
20          ing:

21                   “(A) Personal care services (as described  
22          in section 1905(a)(24)).

23                   “(B) Private duty nursing services (as re-  
24          ferred to in section 1905(a)(8)).

1           “(C) Home or community-based services  
2 furnished under a waiver granted under sub-  
3 section (c), (d), or (e) of section 1915.

4           “(D) Home and community care furnished  
5 to functionally disabled elderly individuals  
6 under section 1929.

7           “(E) Community supported living arrange-  
8 ments services under section 1930.

9           “(F) Case-management services (as de-  
10 scribed in section 1915(g)(2)).

11           “(G) Home health care services (as re-  
12 ferred to in section 1905(a)(7)).

13           “(H) Clinic services and rehabilitation  
14 services that are furnished to an individual who  
15 has a condition or disability that qualifies the  
16 individual to receive any of the services de-  
17 scribed in subparagraph (F).

18           “(3) STATE MAINTENANCE OF EFFORT RE-  
19 GARDING MEDICAID ELIGIBILITY AND COVERED  
20 SERVICES.—

21           “(A) IN GENERAL.—A State plan under  
22 this part shall provide that the State will, dur-  
23 ing the time that the State is furnishing home  
24 and community-based services under this part,  
25 continue to make available under the State plan

1 under part A to the classes or categories of in-  
2 dividuals described in subparagraph (B) any of  
3 the services described in paragraph (2) that  
4 were available to such classes or categories of  
5 individuals during the fiscal year immediately  
6 preceding the fiscal year in which the State  
7 first submits a State plan for approval under  
8 this part.

9 “(B) CLASSES OR CATEGORIES OF INDI-  
10 VIDUALS.—The classes or categories of individ-  
11 uals described in this subparagraph are any  
12 classes or categories of individuals who were eli-  
13 gible for medical assistance consisting of any of  
14 the services described in paragraph (2) during  
15 the fiscal year immediately preceding the fiscal  
16 year in which the State first submits a State  
17 plan for approval under this part.

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

20 “(1) vouchers,

21 “(2) cash payments directly to individuals with  
22 disabilities,

23 “(3) capitation payments to health plans, and

24 “(4) payment to providers.

25 “(g) PERSONAL ASSISTANCE SERVICES.—

1           “(1) IN GENERAL.—For purposes of this part,  
2           the term ‘personal assistance services’ means those  
3           services specified under the State plan as personal  
4           assistance services and shall include at least hands-  
5           on and standby assistance, supervision, and cueing  
6           with activities of daily living, whether agency-admin-  
7           istered or consumer-directed (as defined in para-  
8           graph (2)).

9           “(2) CONSUMER-DIRECTED.—For purposes of  
10          this part:

11                 “(A) IN GENERAL.—The term ‘consumer-  
12                 directed’ means, with reference to personal as-  
13                 sistance services or the provider of such serv-  
14                 ices, services that are provided by an individual  
15                 who is selected and managed (and, at the op-  
16                 tion of the service recipient, trained) by the in-  
17                 dividual receiving the services.

18                 “(B) STATE RESPONSIBILITIES.—A State  
19                 plan shall ensure that where services are pro-  
20                 vided in a consumer-directed manner, the State  
21                 shall create or contract with an entity, other  
22                 than the consumer or the individual provider,  
23                 to—

1           “(i) inform both recipients and provid-  
2           ers of rights and responsibilities under all  
3           applicable Federal labor and tax law; and

4           “(ii) assume responsibility for provid-  
5           ing effective billing, payments for services,  
6           tax withholding, unemployment insurance,  
7           and workers’ compensation coverage, and  
8           act as the employer of the home care pro-  
9           vider.

10           “(C) RIGHT OF CONSUMERS.—Notwith-  
11           standing the State responsibilities described in  
12           subparagraph (B), service recipients, and,  
13           where appropriate, their designated representa-  
14           tive, shall retain the right to independently se-  
15           lect, hire, terminate, and direct (including man-  
16           age, train, schedule, and verify services pro-  
17           vided) the work of a home care provider.

18           “(3) AGENCY ADMINISTERED.—For purposes of  
19           this part, the term ‘agency-administered’ means,  
20           with respect to such services, services that are not  
21           consumer-directed.

22   **“SEC. 1975. COST SHARING.**

23           “(a) NO COST SHARING FOR POOREST.—

24           “(1) IN GENERAL.—The State plan may not  
25           impose any cost sharing for individuals with income

1 (as determined under subsection (d)) less than 125  
2 percent of the official poverty level (referred to in  
3 paragraph (2)) applicable to a family of the size in-  
4 volved.

5 “(2) OFFICIAL POVERTY LEVEL.—The term  
6 ‘applicable poverty level’ means, for a family for a  
7 year, the official poverty line (as defined by the Of-  
8 fice of Management and Budget, and revised annu-  
9 ally in accordance with section 673(2) of the Omni-  
10 bus Budget Reconciliation Act of 1981) applicable to  
11 a family of the size involved.

12 “(b) SLIDING SCALE FOR REMAINDER.—

13 “(1) REQUIRED COINSURANCE.—The State  
14 plan shall impose cost sharing in the form of coin-  
15 surance (based on the amount paid under the State  
16 plan for a service)—

17 “(A) at a rate of 10 percent for individuals  
18 with disabilities with income not less than 125  
19 percent, and less than 175 percent, of such offi-  
20 cial poverty line (as so applied);

21 “(B) at a rate of 15 percent for such indi-  
22 viduals with income not less than 175 percent,  
23 and less than 225 percent, of such official pov-  
24 erty line (as so applied);

1           “(C) at a rate of 25 percent for such indi-  
2           viduals with income not less than 225 percent,  
3           and less than 275 percent, of such official pov-  
4           erty line (as so applied);

5           “(D) at a rate of 30 percent for such indi-  
6           viduals with income not less than 275 percent,  
7           and less than 325 percent, of such official pov-  
8           erty line (as so applied); and

9           “(E) at a rate of 35 percent for such indi-  
10          viduals with income equal to at least 325 per-  
11          cent of such official poverty line (as so applied).

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

15               “(A) of \$100 for individuals with disabil-  
16               ities with income not less than 125 percent, and  
17               less than 175 percent, of such official poverty  
18               line (as so applied);

19               “(B) of \$200 for such individuals with in-  
20               come not less than 175 percent, and less than  
21               225 percent, of such official poverty line (as so  
22               applied);

23               “(C) of \$300 for such individuals with in-  
24               come not less than 225 percent, and less than

1           275 percent, of such official poverty line (as so  
2           applied);

3           “(D) of \$400 for such individuals with in-  
4           come not less than 275 percent, and less than  
5           325 percent, of such official poverty line (as so  
6           applied); and

7           “(E) of \$500 for such individuals with in-  
8           come equal to at least 325 percent of such offi-  
9           cial poverty line (as so applied).

10          “(c) RECOMMENDATION OF THE SECRETARY.—The  
11 Secretary shall make recommendations to the States as  
12 to how to reduce cost-sharing for individuals with extraor-  
13 dinary out-of-pocket costs for whom the cost-sharing pro-  
14 visions of this section could jeopardize their ability to take  
15 advantage of the services offered under this part. The Sec-  
16 retary shall establish a methodology for reducing the cost-  
17 sharing burden for individuals with exceptionally high out-  
18 of-pocket costs under this part.

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

1 **“SEC. 1976. QUALITY ASSURANCE AND SAFEGUARDS.**

2 “(a) QUALITY ASSURANCE.—

3 “(1) IN GENERAL.—The State plan shall speci-  
4 fy how the State will ensure and monitor the quality  
5 of services, including—

6 “(A) safeguarding the health and safety of  
7 individuals with disabilities,

8 “(B) setting the minimum standards for  
9 agency providers and how such standards will  
10 be enforced,

11 “(C) setting the minimum competency re-  
12 quirements for agency provider employees who  
13 provide direct services under this part and how  
14 the competency of such employees will be en-  
15 forced,

16 “(D) setting minimum competency require-  
17 ments for consumer directed providers of per-  
18 sonal assistance services and how such com-  
19 petency requirements will be demonstrated,

20 “(E) obtaining meaningful consumer input,  
21 including consumer surveys that measure the  
22 extent to which participants receive the services  
23 described in the plan of care and participant  
24 satisfaction with such services,

1           “(F) establishing a process to receive, in-  
2           vestigate, and resolve allegations of neglect and/  
3           or abuse,

4           “(G) establishing optional training pro-  
5           grams for individuals with disabilities in the use  
6           and direction of consumer directed providers of  
7           personal assistance services,

8           “(H) establishing an appeals procedure for  
9           eligibility denials and a grievance procedure for  
10          disagreements with the terms of an individual-  
11          ized plan of care;

12          “(I) providing for participation in quality  
13          assurance activities, and

14          “(J) specifying the role of the long-term  
15          care ombudsman (under the Older Americans  
16          Act of 1965) and the Protection and Advocacy  
17          Agency (under the Developmental Disabilities  
18          Assistance and Bill of Rights Act) in assuring  
19          quality of services and protecting the rights of  
20          individuals with disabilities.

21          “(2) ISSUANCE OF REGULATIONS.—Not later  
22          than 1 year after the date of enactment of this part,  
23          the Secretary shall issue regulations implementing  
24          the quality provisions of this subsection.

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

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

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

7           “(3) The development of a registry of provider  
8 agencies or home care workers and consumer di-  
9 rected providers of personal assistance services  
10 against whom any complaints have been sustained,  
11 which shall be available to the public.

12           “(4) Sanctions to be imposed on States or pro-  
13 viders, including disqualification from the program,  
14 if minimum standards are not met.

15           “(5) Surveys of client satisfaction.

16           “(6) State optional training programs for infor-  
17 mal caregivers.

18       “(c) SAFEGUARDS.—

19           “(1) CONFIDENTIALITY.—The State plan shall  
20 provide safeguards which restrict the use or disclo-  
21 sure of information concerning applicants and bene-  
22 ficiaries to purposes directly connected with the ad-  
23 ministration of the plan.

24           “(2) SAFEGUARDS AGAINST ABUSE.—The State  
25 plans shall provide safeguards against physical, emo-

1 tional, or financial abuse or exploitation (specifically  
2 including appropriate safeguards in cases where pay-  
3 ment for program benefits is made by cash pay-  
4 ments or vouchers given directly to individuals with  
5 disabilities). All providers of services shall be re-  
6 quired to register with the State agency.

7 “(d) SPECIFIED RIGHTS.—The State plan shall pro-  
8 vide that in furnishing home and community-based serv-  
9 ices under the plan the following individual rights are pro-  
10 tected:

11 “(1) The right to be fully informed in advance,  
12 orally and in writing, of the care to be provided, to  
13 be fully informed in advance of any changes in care  
14 to be provided, and (except with respect to an indi-  
15 vidual determined incompetent) to participate in  
16 planning care or changes in care.

17 “(2) The right to—

18 “(A) voice grievances with respect to serv-  
19 ices that are (or fail to be) furnished without  
20 discrimination or reprisal for voicing grievances,

21 “(B) be told how to complain to State and  
22 local authorities, and

23 “(C) prompt resolution of any grievances  
24 or complaints.

1           “(3) The right to confidentiality of personal  
2           and clinical records and the right to have access to  
3           such records.

4           “(4) The right to privacy and to have one’s  
5           property treated with respect.

6           “(5) The right to refuse all or part of any care  
7           and to be informed of the likely consequences of  
8           such refusal.

9           “(6) The right to education or training for one-  
10          self and for members of one’s family or household on  
11          the management of care.

12          “(7) The right to be free from physical or men-  
13          tal abuse, corporal punishment, and any physical or  
14          chemical restraints imposed for purposes of dis-  
15          cipline or convenience and not included in an indi-  
16          vidual’s plan of care.

17          “(8) The right to be fully informed orally and  
18          in writing of the individual’s rights.

19          “(9) The right to a free choice of providers.

20          “(10) The right to direct provider activities  
21          when an individual is competent and willing to direct  
22          such activities.

23   **“SEC. 1977. ADVISORY GROUPS.**

24          “(a) FEDERAL ADVISORY GROUP.—

1           “(1) ESTABLISHMENT.—The Secretary shall es-  
2           tablish an advisory group, to advise the Secretary  
3           and States on all aspects of the program under this  
4           part.

5           “(2) COMPOSITION.—The group shall be com-  
6           posed of individuals with disabilities and their rep-  
7           resentatives, providers, Federal and State officials,  
8           and local community implementing agencies. A ma-  
9           jority of its members shall be individuals with dis-  
10          abilities and their representatives.

11          “(b) STATE ADVISORY GROUPS.—

12           “(1) IN GENERAL.—Each State plan shall pro-  
13          vide for the establishment and maintenance of an  
14          advisory group to advise the State on all aspects of  
15          the State plan under this part.

16           “(2) COMPOSITION.—Members of each advisory  
17          group shall be appointed by the Governor (or other  
18          chief executive officer of the State) and shall include  
19          individuals with disabilities and their representa-  
20          tives, providers, State officials, and local community  
21          implementing agencies. A majority of its members  
22          shall be individuals with disabilities and their rep-  
23          resentatives. The members of the advisory group  
24          shall be selected from the those nominated as de-  
25          scribed in paragraph (3).

1           “(3) SELECTION OF MEMBERS.—Each State  
2 shall establish a process whereby all residents of the  
3 State, including individuals with disabilities and  
4 their representatives, shall be given the opportunity  
5 to nominate members to the advisory group.

6           “(4) PARTICULAR CONCERNS.—Each advisory  
7 group shall—

8           “(A) before the State plan is developed,  
9 advise the State on guiding principles and val-  
10 ues, policy directions, and specific components  
11 of the plan,

12           “(B) meet regularly with State officials in-  
13 volved in developing the plan, during the devel-  
14 opment phase, to review and comment on all as-  
15 pects of the plan,

16           “(C) participate in the public hearings to  
17 help assure that public comments are addressed  
18 to the extent practicable,

19           “(D) report to the Governor and make  
20 available to the public any differences between  
21 the group’s recommendations and the plan,

22           “(E) report to the Governor and make  
23 available to the public specifically the degree to  
24 which the plan is consumer-directed, and

1           “(F) meet regularly with officials of the  
2           designated State agency (or agencies) to pro-  
3           vide advice on all aspects of implementation and  
4           evaluation of the plan.

5   **“SEC. 1978. PAYMENTS TO STATES.**

6           “(a) IN GENERAL.—Subject to section 1972(a)(9)(C)  
7 (relating to limitation on payment for administrative  
8 costs), the Secretary, in accordance with the Cash Man-  
9 agement Improvement Act, shall authorize payment to  
10 each State with a plan approved under this part, for each  
11 quarter (beginning on or after January 1, 1998), from its  
12 allotment under section 1979(b), an amount equal to—

13           “(1) the Federal home and community-based  
14           services matching percentage (as defined in sub-  
15           section (b)) of amount demonstrated by State claims  
16           to have been expended during the quarter for home  
17           and community-based services under the plan for in-  
18           dividuals with disabilities; plus

19           “(2) an amount equal to 90 percent of the  
20           amount demonstrated by the State to have been ex-  
21           pended during the quarter for quality assurance ac-  
22           tivities under the plan; plus

23           “(3) an amount equal to 90 percent of amount  
24           expended during the quarter under the plan for ac-  
25           tivities (including preliminary screening) relating to

1 determination of eligibility and performance of needs  
2 assessment; plus

3 “(4) an amount equal to 90 percent (or, begin-  
4 ning with quarters in fiscal year 2003, 75 percent)  
5 of the amount expended during the quarter for the  
6 design, development, and installation of mechanical  
7 claims processing systems and for information re-  
8 trieval; plus

9 “(5) an amount equal to 50 percent of the re-  
10 mainder of the amounts expended during the quar-  
11 ter as found necessary by the Secretary for the prop-  
12 er and efficient administration of the State plan.

13 “(b) FEDERAL HOME AND COMMUNITY-BASED  
14 SERVICES MATCHING PERCENTAGE.—In subsection (a),  
15 the term ‘Federal home and community-based services  
16 matching percentage’ means, with respect to a State, the  
17 State’s Federal medical assistance percentage (as defined  
18 in section 1905(b)) increased by 15 percentage points, ex-  
19 cept that the Federal home and community-based services  
20 matching percentage shall in no case be less than 65 per-  
21 cent or more than 90 percent.

22 “(c) PAYMENTS ON ESTIMATES WITH RETROSPEC-  
23 TIVE ADJUSTMENTS.—The method of computing and  
24 making payments under this section shall be as follows:

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

8           “(2) From the allotment available therefore, the  
9 Secretary shall provide for payment of the amount  
10 so estimated, reduced or increased, as the case may  
11 be, by any sum (not previously adjusted under this  
12 section) by which the Secretary finds that the esti-  
13 mate of the amount to be paid the State for any  
14 prior period under this section was greater or less  
15 than the amount which should have been paid.

16           “(d) APPLICATION OF RULES REGARDING LIMITA-  
17 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH  
18 CARE RELATED TAXES.—The provisions of section  
19 1903(w) shall apply to payments to States under this sec-  
20 tion in the same manner as they apply to payments to  
21 States under section 1903(a).

22           “(e) FAILURE TO COMPLY WITH STATE PLAN.—If  
23 a State furnishing home and community-based services  
24 under this part fails to comply with the State plan ap-  
25 proved under this part, the Secretary may withhold an

1 amount of funds determined appropriate by the Secretary  
2 from any payment to the State under this section.

3 **“SEC. 1979. TOTAL FEDERAL BUDGET; ALLOTMENTS TO**  
4 **STATES.**

5 “(a) TOTAL FEDERAL BUDGET.—The total Federal  
6 budget for State plans under this part for any fiscal year  
7 beginning on or after October 1, 1997, is an amount equal  
8 to the sum of—

9 “(1) the amount of funds deposited in the  
10 Long-Term Care Account of the Health Security  
11 Trust Fund established under section 9551 of the  
12 Internal Revenue Code of 1986 for such fiscal year;  
13 and

14 “(2) any funds in such account that were not  
15 expended in any preceding fiscal year.

16 “(b) ALLOTMENTS TO STATES.—

17 “(1) IN GENERAL.—The Secretary shall allot to  
18 each State for each fiscal year an amount that bears  
19 the same ratio to the total Federal budget for the  
20 fiscal year (specified under subsection (a)) as the  
21 State allotment factor (under paragraph (2) for the  
22 State for the fiscal year) bears to the sum of such  
23 factors for all States for that fiscal year.

24 “(2) STATE ALLOTMENT FACTOR.—

1           “(A) IN GENERAL.—For each State for  
2 each fiscal year, the Secretary shall compute a  
3 State allotment factor equal to the sum of—

4           “(i) the base allotment factor (speci-  
5 fied in subparagraph (B)), and

6           “(ii) the low income allotment factor  
7 (specified in subparagraph (C)).

8           “(B) BASE ALLOTMENT FACTOR.—The  
9 base allotment factor, specified in this subpara-  
10 graph, for a State for a fiscal year is equal to  
11 the product of the following:

12           “(i) NUMBER OF INDIVIDUALS WITH  
13 DISABILITIES.—The number of individuals  
14 with disabilities in the State (determined  
15 under paragraph (3)) for the fiscal year.

16           “(ii) 80 PERCENT OF THE NATIONAL  
17 PER CAPITA BUDGET.—80 percent of the  
18 national average per capita budget amount  
19 (determined under paragraph (4)) for the  
20 fiscal year.

21           “(iii) WAGE ADJUSTMENT FACTOR.—  
22 The wage adjustment factor (determined  
23 under paragraph (5)) for the State for the  
24 fiscal year.

1           “(iv) FEDERAL HOME AND COMMU-  
2           NITY-BASED SERVICES MATCHING PER-  
3           CENTAGE.—The Federal home and com-  
4           munity-based services matching percentage  
5           (determined under section 1978(b)) for the  
6           fiscal year.

7           “(C) LOW INCOME ALLOTMENT FACTOR.—  
8           The low income allotment factor, specified in  
9           this subparagraph, for a State for a fiscal year  
10          is equal to the product of the following:

11           “(i) NUMBER OF INDIVIDUALS WITH  
12           DISABILITIES.—The number of individuals  
13           with disabilities in the State (determined  
14           under paragraph (3)) for the fiscal year.

15           “(ii) 10 PERCENT OF THE NATIONAL  
16           PER CAPITA BUDGET.—10 percent of the  
17           national average per capita budget amount  
18           (determined under paragraph (4)) for the  
19           fiscal year.

20           “(iii) WAGE ADJUSTMENT FACTOR.—  
21           The wage adjustment factor (determined  
22           under paragraph (5)) for the State for the  
23           fiscal year.

24           “(iv) FEDERAL HOME AND COMMU-  
25           NITY-BASED SERVICES MATCHING PER-

1           CENTAGE.—The Federal home and com-  
2           munity-based services matching percentage  
3           (determined under section 1978(b)) for the  
4           fiscal year.

5           “(v) LOW INCOME INDEX.—The low  
6           income index (determined under paragraph  
7           (6)) for the State for the preceding fiscal  
8           year.

9           “(3) NUMBER OF INDIVIDUALS WITH DISABIL-  
10          ITIES.—The number of individuals with disabilities  
11          in a State for a fiscal year shall be determined as  
12          follows:

13               “(A) BASE.—The Secretary shall deter-  
14               mine the number of individuals in the State by  
15               age, sex, and income category, based on the  
16               1990 decennial census, adjusted (as appro-  
17               priate) by the March 1996 current population  
18               survey.

19               “(B) DISABILITY PREVALENCE LEVEL BY  
20               POPULATION CATEGORY.—The Secretary shall  
21               determine, for each such age, sex, and income  
22               category, the national average proportion of the  
23               population of such category that represents in-  
24               dividuals with disabilities. The Secretary may

1           conduct periodic surveys in order to determine  
2           such proportions.

3           “(C) BASE DISABLED POPULATION IN A  
4           STATE.—The number of individuals with dis-  
5           abilities in a State in 1996 is equal to the sum  
6           of the products, for such each age, sex, and in-  
7           come category, of—

8                   “(i) the population of individuals in  
9                   the State in the category (determined  
10                  under subparagraph (A)), and

11                   “(ii) the national average proportion  
12                   for such category (determined under sub-  
13                  paragraph (B)).

14           “(D) UPDATE.—The Secretary shall deter-  
15           mine the number of individuals with disabilities  
16           in a State in a fiscal year equal to the number  
17           determined under subparagraph (C) for the  
18           State increased (or decreased) by the percent-  
19           age increase (or decrease) in the disabled popu-  
20           lation of the State as determined under the cur-  
21           rent population survey from 1996 to the year  
22           before the fiscal year involved.

23           “(4) NATIONAL PER CAPITA BUDGET  
24           AMOUNT.—The national average per capita budget  
25           amount, for a fiscal year, is—

1           “(A) the total Federal budget specified  
2           under subsection (a) for the fiscal year; divided  
3           by

4           “(B) the sum, for the fiscal year, of the  
5           numbers of individuals with disabilities (deter-  
6           mined under paragraph (3)) for all the States  
7           for the fiscal year.

8           “(5) WAGE ADJUSTMENT FACTOR.—The wage  
9           adjustment factor, for a State for a fiscal year, is  
10          equal to the ratio of—

11           “(A) the average hourly wages for service  
12           workers (other than household or protective  
13           services) in the State, to

14           “(B) the national average hourly wages for  
15           service workers (other than household or protec-  
16           tive services).

17          The hourly wages shall be determined under this  
18          paragraph based on data from the most recent de-  
19          cennial census for which such data are available.

20           “(6) LOW INCOME INDEX.—The low income  
21           index for each State for a fiscal year is the ratio, de-  
22           termined for the preceding fiscal year, of—

23           “(A) the percentage of the State’s popu-  
24           lation that has income below 150 percent of the  
25           poverty level, to

1           “(B) the percentage of the population of  
2           the United States that has income below 150  
3           percent of the poverty level.

4           Such percentages shall be based on data from the  
5           most recent decennial census for which such data  
6           are available, adjusted by data from the most recent  
7           current population survey as determined appropriate  
8           by the Secretary.

9           “(7) NO DUPLICATE PAYMENT.—No payment  
10          may be made to a State under this section for any  
11          services provided to an individual to the extent that  
12          the State received payment for such services under  
13          section 1903(a).

14          “(c) CARRY-OVER.—With respect to fiscal years  
15          1998 through 2005, a State shall be permitted to carry-  
16          over not more than 25 percent of the allotment of such  
17          State for expenditures in the subsequent year.

18          “(d) STATE ENTITLEMENT.—This part constitutes  
19          budget authority in advance of appropriations Acts, and  
20          represents the obligation of the Federal Government to  
21          provide for the payment to States of amounts described  
22          in subsection (a).

23          **“SEC. 1980. FEDERAL EVALUATIONS.**

24          “Not later than December 31, 2003, December 31,  
25          2006, and each December 31 thereafter, the Secretary

1 shall provide to Congress analytical reports that evalu-  
2 ate—

3           “(1) the extent to which individuals with low in-  
4 comes and disabilities are equitably served;

5           “(2) the adequacy and equity of service plans to  
6 individuals with similar levels of disability across  
7 States;

8           “(3) the comparability of program participation  
9 across States, described by level and type of disabil-  
10 ity; and

11           “(4) the ability of service providers to suffi-  
12 ciently meet the demand for services.”.

13       (b) CONFORMING AMENDMENT.—Title XIX of the  
14 Social Security Act (42 U.S.C. 1396 et seq.), as amended  
15 by section 301, is amended by striking the title inserting  
16 the following:

1 **“TITLE XIX—MEDICAL ASSIST-**  
2 **ANCE PROGRAMS, STATE**  
3 **PROGRAMS FOR PREMIUM**  
4 **AND COST-SHARING ASSIST-**  
5 **ANCE, AND STATE PROGRAMS**  
6 **FOR HOME AND COMMUNITY-**  
7 **BASED SERVICES”.**

8 **Subtitle D—Medicaid Program**

9 **PART I—INTEGRATION OF CERTAIN MEDICAID**  
10 **ELIGIBLES INTO REFORMED HEALTH CARE**  
11 **SYSTEM**

12 **SEC. 671. LIMITING COVERAGE UNDER MEDICAID OF ITEMS**  
13 **AND SERVICES COVERED UNDER STANDARD**  
14 **BENEFITS PACKAGE.**

15 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et  
16 seq.) is amended by redesignating section 1931 as section  
17 1932 and by inserting after section 1930 the following new  
18 section:

19 “TREATMENT OF ITEMS AND SERVICES IN THE  
20 STANDARD BENEFITS PACKAGE

21 “SEC. 1931. (a) ITEMS AND SERVICES COVERED  
22 UNDER STANDARD BENEFITS PACKAGE.—Except as pro-  
23 vided in subsection (c), a State plan under this part shall  
24 not provide medical assistance consisting of payment for

1 items and services in the standard benefits package de-  
2 scribed in section 21201(a).

3 “(b) MEDICAL ASSISTANCE NOT AFFECTED.—Sub-  
4 section (a) shall not be construed as—

5 “(1) affecting the eligibility of any individual  
6 for medical assistance consisting of payment for  
7 items and services not covered under the standard  
8 benefits package;

9 “(2) affecting the amount, duration, and scope  
10 of any medical assistance consisting of payment for  
11 the items and services described in paragraph (1); or

12 “(3) prohibiting payment of medical assistance  
13 for items and services covered under the standard  
14 benefits package to the extent that the items and  
15 services under this part exceed the items and serv-  
16 ices covered under such package with respect to  
17 amount, duration, and scope.

18 “(c) EXCEPTIONS.—

19 “(1) IN GENERAL.—Subsection (a) shall not af-  
20 fect the provision of medical assistance consisting of  
21 payment for items and services in the standard ben-  
22 efits package—

23 “(A) which are provided to—

24 “(i) except as provided in paragraph  
25 (2), an individual eligible for medical as-

1 assistance under the State plan who is not a  
2 premium subsidy eligible individual (as de-  
3 fined in section 1952(a)(2));

4 “(ii) an individual with respect to  
5 whom supplemental security income bene-  
6 fits are being paid under title XVI; and

7 “(iii) an individual who is eligible for  
8 benefits under part A of title XVIII; or

9 “(B) which consist of emergency services  
10 to certain aliens under section 1903(v)(2).

11 “(2) SPECIAL RULE.—With respect to the first  
12 year in which the eligibility percentage for premium  
13 assistance under section 1952(a)(2)(B) equals 200  
14 percent and any succeeding year, subsection (a) shall  
15 apply to an individual who is not a premium subsidy  
16 eligible individual because the individual’s family in-  
17 come determined under section 1958(2) exceeds 200  
18 percent of the poverty line (as defined in section  
19 1958(5)).

20 “(d) STATE MAINTENANCE OF EFFORT.—

21 “(1) IN GENERAL.—

22 “(A) REDUCTION IN QUARTERLY PAY-  
23 MENTS.—For any calendar quarter in an appli-  
24 cable year (as defined in subparagraph (B)),  
25 the amount otherwise payable to a State under

1 section 1903 for the quarter shall be reduced by  
2 the State maintenance of effort amount for the  
3 quarter determined under paragraph (2).

4 “(B) APPLICABLE YEAR.—For purposes of  
5 this paragraph, the term ‘applicable year’  
6 means 1996 and any succeeding year.

7 “(2) MAINTENANCE OF EFFORT AMOUNT.—

8 “(A) IN GENERAL.—The maintenance of  
9 effort amount for a State for a calendar quarter  
10 in an applicable year shall be equal to 25 per-  
11 cent of the State’s base payment amount (de-  
12 termined under subparagraph (B)), multiplied  
13 by the inflation index (described in subpara-  
14 graph (C)(i)) and the State population index  
15 (described in subparagraph (C)(ii)).

16 “(B) STATE BASE PAYMENT AMOUNT.—  
17 The base payment amount for a State for an  
18 applicable year shall be an amount, as deter-  
19 mined by the Secretary, equal to the total ex-  
20 penditures from State funds made under the  
21 State plan during fiscal year 1994 with respect  
22 to medical assistance consisting of items and  
23 services of the type included in the standard  
24 benefits package for individuals who would not  
25 have received such medical assistance if the

1 provisions of this section and part B (as in ef-  
2 fect in the applicable year) had been in effect  
3 in fiscal year 1994.

4 “(C) INDEXES.—

5 “(i) INFLATION INDEX.—

6 “(I) IN GENERAL.—For purposes  
7 of this paragraph, the Secretary shall  
8 establish a cumulative inflation index  
9 for the applicable year which equals 1  
10 plus the product of—

11 “(aa) the percentage change  
12 in the national per capita health  
13 expenditures plus the applicable  
14 percentage points (determined  
15 under subclause (II)); multiplied  
16 by

17 “(bb) the cumulative level of  
18 the index for the preceding year.

19 “(II) APPLICABLE PERCENTAGE  
20 POINTS.—For purposes of subclause  
21 (I), the applicable percentage points  
22 are—

23 “(aa) for each of years 1995  
24 through 1997, 1;

25 “(bb) for 1998, .8;

1                   “(cc) for 1999, .6;  
2                   “(dd) for 2000, .4;  
3                   “(ee) for 2001, .2; and  
4                   “(ff) for succeeding years, 0.

5                   “(III) BASE YEAR.—The base  
6                   year for the inflation index under this  
7                   clause is 1994.

8                   “(ii) STATE POPULATION INDEX.—  
9                   For purposes of this paragraph, the Sec-  
10                  retary shall establish a State population  
11                  index where the level of the index is equal  
12                  to 1 plus the cumulative percentage change  
13                  in the number of individuals residing in a  
14                  State from 1994 through December 31 of  
15                  the year preceding the applicable year.”.

16                  (b) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-  
17                  tion 1903(i) (42 U.S.C. 1396b(i)) is amended—

18                   (1) by striking “or” at the end of paragraph  
19                   (14),

20                   (2) by striking the period at the end of para-  
21                   graph (15) and inserting “; or”, and

22                   (3) by inserting after paragraph (15) the fol-  
23                   lowing new paragraph:

24                   “(16) with respect to items and services covered  
25                   under the standard benefits package described in

1 section 21201(a) for individuals to whom section  
2 1931(a) applies.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply with respect to items or services  
5 furnished in a State on or after January 1, 1996.

6 **PART II—COORDINATED CARE SERVICES FOR**  
7 **DISABLED MEDICAID ELIGIBLES**

8 **SEC. 672. COORDINATED CARE SERVICES FOR DISABLED**  
9 **MEDICAID ELIGIBLES.**

10 (a) STATE EXPENDITURES LIMITED TO CERTIFIED  
11 HEALTH PLANS.—Section 1903(m) (42 U.S.C. 1396b) is  
12 amended by adding at the end the following new para-  
13 graph:

14 “(7) No payment shall be made under this part  
15 to a State with respect to expenditures incurred by  
16 the State for payment for services provided by an  
17 entity with a contract under this subsection unless  
18 such entity is a certified standard health plan (as  
19 defined in section 21011(a)(2)).”.

20 (b) MODIFICATION TO 75/25 RULE.—Section  
21 1903(m)(2)(A)(ii) (42 U.S.C. 1396b(m)(2)(A)(ii)) is  
22 amended by striking “75 percent” and inserting “50 per-  
23 cent”.

24 (c) EFFECTIVE DATE.—The amendments made by  
25 this section shall become effective with respect to pay-

1 ments for calendar quarters beginning on or after January  
2 1, 1996.

3 **PART III—PAYMENTS TO HOSPITALS SERVING**  
4 **VULNERABLE POPULATIONS**

5 **SEC. 673. REPLACEMENT OF DSH PAYMENT PROVISIONS**  
6 **WITH PROVISIONS RELATING TO PAYMENTS**  
7 **TO HOSPITALS SERVING VULNERABLE POPU-**  
8 **LATIONS.**

9 (a) AMENDMENTS TO PROVISIONS REQUIRING  
10 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—

11 (1) ADJUSTMENTS TO NATIONAL DSH PAYMENT  
12 LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r-  
13 4(f)(1)(B)) is amended to read as follows:

14 “(B) NATIONAL DSH PAYMENT LIMIT.—

15 “(i) IN GENERAL.—Except as pro-  
16 vided in clause (ii), the national DSH pay-  
17 ment limit for a fiscal year is equal to 12  
18 percent of the total amount of expenditures  
19 under the State plans under this part for  
20 medical assistance during the fiscal year.

21 “(ii) REDUCTION IN LIMIT.—For fis-  
22 cal years during which the eligibility per-  
23 centage for premium assistance under sec-  
24 tion 1952(a)(2)(B)—

1           “(I) equals or exceeds 125 per-  
2 cent but is less than 150 percent, ‘10  
3 percent’ shall be substituted for ‘12  
4 percent’ in clause (i);

5           “(II) equals or exceeds 150 per-  
6 cent but is less than 175 percent, ‘8  
7 percent’ shall be substituted for ‘12  
8 percent’ in clause (i);

9           “(III) equals or exceeds 175 per-  
10 cent but is less than 200 percent, ‘6  
11 percent’ shall be substituted for ‘12  
12 percent’ in clause (i); and

13           “(IV) equals 200 percent, ‘4 per-  
14 cent’ shall be substituted for ‘12 per-  
15 cent’ in clause (i).

16           (2) ADJUSTMENTS TO STATE ALLOTMENT LIM-  
17 ITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r-  
18 4(f)(2)(B)) is amended to read as follows:

19           “(B) EXCEPTIONS.—

20           “(i) IN GENERAL.—Except as pro-  
21 vided in clause (ii), a State DSH allotment  
22 under subparagraph (A) for a fiscal year  
23 shall not exceed 12 percent of the total  
24 amount of expenditures under the State

1 plan for medical assistance during the fis-  
2 cal year.

3 “(ii) REDUCTION IN LIMIT.—For fis-  
4 cal years during which the eligibility per-  
5 centage for premium assistance under sec-  
6 tion 1952(a)(2)(B)—

7 “(I) equals or exceeds 125 per-  
8 cent but is less than 150 percent, ‘10  
9 percent’ shall be substituted for ‘12  
10 percent’ in clause (i);

11 “(II) equals or exceeds 150 per-  
12 cent but is less than 175 percent, ‘8  
13 percent’ shall be substituted for ‘12  
14 percent’ in clause (i);

15 “(III) equals or exceeds 175 per-  
16 cent but is less than 200 percent, ‘6  
17 percent’ shall be substituted for ‘12  
18 percent’ in clause (i); and

19 “(IV) equals 200 percent, ‘4 per-  
20 cent’ shall be substituted for ‘12 per-  
21 cent’ in clause (i).

22 (3) ELIMINATION OF HIGH DSH STATES AND  
23 STATE SUPPLEMENTAL AMOUNTS.—

1           (A) IN GENERAL.—Section 1923(f)(2)(A)  
2           (42 U.S.C. 1396r-4(f)(2)(A)) is amended to  
3           read as follows:

4           “(A) IN GENERAL.—Subject to subpara-  
5           graph (B), the State DSH allotment for a fiscal  
6           year is equal to the State DSH allotment for  
7           the previous fiscal year increased by the State  
8           growth factor (as defined in paragraph (3)(B))  
9           for the fiscal year.”.

10           (B) CONFORMING AMENDMENTS.—(i) Sec-  
11           tion 1923(f) (42 U.S.C. 1396r-4(f)) is amended  
12           by striking paragraph (3) and redesignating  
13           paragraph (4) as paragraph (3).

14           (ii) Section 1923(f)(3) (42 U.S.C. 1396r-  
15           4(f)(3)), as redesignated by clause (i), is  
16           amended by striking subparagraphs (A) and  
17           (C) and redesignating subparagraphs (B), (D),  
18           and (E) as subparagraphs (A), (B), and (C).

19           (iii) Section 1923(f)(3)(B) (42 U.S.C.  
20           1396r-4(f)(3)(B)), as redesignated by clauses  
21           (i) and (ii), is amended to read as follows:

22           “(B) STATE GROWTH AMOUNT.—The term  
23           ‘State growth amount’ means, with respect to a  
24           State for a fiscal year, the product of the State

1 growth factor and the State DSH payment  
2 limit for the previous fiscal year.”.

3 (iv) Section 1923(f)(1)(A) (42 U.S.C.  
4 1396r-4(f)(1)(A) is amended by striking “(as  
5 defined in paragraph (4)(B))” and inserting  
6 “(as defined in paragraph (3)(A))”.

7 (3) TERMINATION OF REQUIREMENT ON  
8 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—  
9 Section 1923 (42 U.S.C. 1396r-4) is amended by  
10 adding at the end the following new subsection:

11 “(h) TERMINATION OF REQUIREMENT TO MAKE  
12 PAYMENT ADJUSTMENTS.—

13 “(1) IN GENERAL.—Any requirement imposed  
14 by this section on a State to increase the rate or  
15 amount of payment for inpatient hospital services  
16 provided by a hospital which serves a disproportion-  
17 ate number of low income patients with special  
18 needs shall terminate in the year described in para-  
19 graph (2).

20 “(2) YEAR DESCRIBED.—The year described in  
21 this paragraph is the first year beginning after the  
22 year in which the eligibility percentage for premium  
23 assistance under section 1952(a)(2)(B) equals 200  
24 percent.”.

1           (4) NO FEDERAL FINANCIAL PARTICIPATION.—  
2           Section 1903(i) (42 U.S.C. 1396b(i)), as amended  
3           by section 671(b), is amended—

4           (1) by striking “or” at the end of paragraph  
5           (15),

6           (2) by striking the period at the end of para-  
7           graph (16) and inserting “; or”, and

8           (3) by inserting after paragraph (16) the fol-  
9           lowing new paragraph:

10           “(17) during or after the year described in sec-  
11           tion 1923(h)(2) with respect to any payment made  
12           by a State to a hospital which serves a dispropor-  
13           tionate number of low income patients with special  
14           needs that is in excess of the payment otherwise re-  
15           quired under this part.”.

16           (5) EFFECTIVE DATE.—The amendments made  
17           by this section shall be effective for calendar quar-  
18           ters beginning on or after October 1, 1997.

19           (b) PAYMENTS TO HOSPITALS SERVING VULNER-  
20           ABLE POPULATIONS.—Title XIX, as amended by sections  
21           301 and 667, is amended by adding at the end the follow-  
22           ing new part:

1     **“PART D—PAYMENTS TO HOSPITALS SERVING**  
2                     **VULNERABLE POPULATIONS**

3     **“SEC. 1991. PAYMENTS TO HOSPITALS.**

4             “(a) ENTITLEMENT STATUS.—The Secretary shall  
5 make payments in accordance with this part to eligible  
6 hospitals described in section 1992. The preceding sen-  
7 tence constitutes budget authority in advance of appro-  
8 priations Acts and represents the obligation of the Federal  
9 Government to provide funding for such payments in the  
10 amounts, and for the fiscal years, specified in subsection  
11 (b).

12             “(b) AMOUNT OF ENTITLEMENT.—For purposes of  
13 subsection (a), the amounts and fiscal years specified in  
14 this subsection are (in the aggregate for all eligible hos-  
15 pitals) \$2,500,000,000 for the first applicable fiscal year  
16 (as defined in section 1994) and for each subsequent fiscal  
17 year.

18             “(c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-  
19 ments to an eligible hospital under this section for a year  
20 shall be made on a quarterly basis during the year.

21     **“SEC. 1992. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

22             “(a) HOSPITALS IN PARTICIPATING STATES.—In  
23 order to be an eligible hospital under this part, a hospital  
24 must be located in a State that is a participating State  
25 under title XXI.

1       “(b) STATE IDENTIFICATION.—In accordance with  
2 the criteria described in subsection (c) and such proce-  
3 dures as the Secretary may require, each State shall iden-  
4 tify the hospitals in the State that meet such criteria and  
5 provide the Secretary with a list of such hospitals.

6       “(c) CRITERIA FOR ELIGIBILITY.—A hospital meets  
7 the criteria described in this subsection if the hospital’s  
8 low-income utilization rate for the base year under section  
9 1923(b)(3) (as such section is in effect on the day before  
10 the date of the enactment of this part) is not less than  
11 25 percent.

12 **“SEC. 1993. AMOUNT OF PAYMENTS.**

13       “(a) IN GENERAL.—The total amount available for  
14 payments under this part in a year shall be allocated to  
15 hospitals for low-income assistance in accordance with this  
16 subsection.

17       “(b) DETERMINATION OF HOSPITAL PAYMENT  
18 AMOUNT.—The amount of payment to an eligible hospital  
19 during a year shall be the equal to the hospital’s low-in-  
20 come percentage (as defined in subsection (c)) of the total  
21 amount available for payments under this part for the  
22 year.

23       “(c) LOW-INCOME PERCENTAGE DEFINED.—

24               “(1) IN GENERAL.—For purposes of this sec-  
25 tion, an eligible hospital’s ‘low-income percentage’

1 for a year is equal to the amount (expressed as a  
2 percentage) of the total low-income days for all eligi-  
3 ble hospitals for the year that are attributable to the  
4 hospital.

5 “(2) LOW-INCOME DAYS DESCRIBED.—For pur-  
6 poses of paragraph (1), an eligible hospital’s low-in-  
7 come days for a year shall be equal to the product  
8 of—

9 “(A) the total number of inpatient days for  
10 the hospital for the year (as reported to the  
11 Secretary by the State in which the hospital is  
12 located, in accordance with a reporting schedule  
13 and procedures established by the Secretary);  
14 and

15 “(B) the hospital’s low-income utilization  
16 rate for the base year under section 1923(b)(3)  
17 (as such section is in effect on the day before  
18 the date of the enactment of this part).

19 **“SEC. 1994. DEFINITIONS.**

20 “For purposes of this part:

21 “(1) BASE YEAR.—The term ‘base year’ means  
22 1995.

23 “(2) FIRST APPLICABLE FISCAL YEAR.—The  
24 term ‘first applicable fiscal year’ means first fiscal  
25 year that begins after the fiscal year in which the

1 eligibility percentage for premium assistance under  
2 section 1952(a)(2)(B) equals 200 percent.”

3 (c) CONFORMING AMENDMENT.—Title XIX (42  
4 U.S.C. 1396 et seq.), as amended by sections 301 and  
5 667, is amended by striking the title inserting the follow-  
6 ing:

7 **“TITLE XIX—MEDICAL ASSIST-**  
8 **ANCE PROGRAMS, PROGRAMS**  
9 **FOR PREMIUM AND COST-**  
10 **SHARING ASSISTANCE, PRO-**  
11 **GRAMS FOR HOME AND COM-**  
12 **MUNITY-BASED SERVICES,**  
13 **AND PAYMENTS TO HOS-**  
14 **PITALS SERVING VULNER-**  
15 **ABLE POPULATIONS”.**

16 **PART IV—MEDICAID LONG-TERM CARE**  
17 **PROVISIONS**

18 **SEC. 674. PAYMENTS FOR HOME OR COMMUNITY-BASED**  
19 **CARE, PERSONAL CARE SERVICES, AND**  
20 **FRAIL ELDERLY SERVICES.**

21 (a) IN GENERAL.—

22 (1) PAYMENT.—Section 1903(a) (42 U.S.C.  
23 1396b(a)) is amended—

24 (A) by striking the period at the end of  
25 paragraph (7) and inserting “; plus”; and

1 (B) by adding at the end the following new  
2 paragraph:

3 “(8) an amount equal to the Federal home or  
4 community-based care matching percentage (as de-  
5 fined in section 1905(t)) of the total amount ex-  
6 pended during such quarter for home or community-  
7 based services furnished under a waiver under sub-  
8 section (c) or (d) of section 1915, personal care serv-  
9 ices described in section 1905(a)(24), and home and  
10 community care for functionally disabled elderly in-  
11 dividuals under section 1929.”.

12 (2) FEDERAL HOME OR COMMUNITY-BASED  
13 CARE MATCHING PERCENTAGE.—Section 1905 (42  
14 U.S.C. 1396d) is amended by adding at the end the  
15 following new subsection:

16 “(t) The term ‘Federal home or community-based  
17 care matching percentage’ means, with respect to a State,  
18 the State’s Federal medical assistance percentage (as de-  
19 fined in subsection (b)) increased by 10 percentage  
20 points.”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 subsection (a) shall apply to payments for medical assist-  
23 ance for calendar quarters beginning on or after January  
24 1, 1995.

1 **SEC. 675. INCREASED RESOURCE DISREGARD FOR INDIVID-**  
2 **UALS RECEIVING CERTAIN SERVICES.**

3 (a) IN GENERAL.—Section 1902(a)(10) (42 U.S.C.  
4 1396a(a)(10)) is amended—

5 (1) by striking “and” at the end of subpara-  
6 graph (E);

7 (2) by adding “and” at the end of subpara-  
8 graph (F); and

9 (3) by adding at the end the following new sub-  
10 paragraph:

11 “(G) provide that, in determining the eligi-  
12 bility of any unmarried individual who has ap-  
13 plied for or is receiving medical assistance con-  
14 sisting of community-based services furnished  
15 under a waiver under subsection (c) or (d) of  
16 section 1915, personal care services described in  
17 section 1905(a)(24), or home and community  
18 care for functionally disabled elderly individuals  
19 under section 1929, the first \$4,000 of re-  
20 sources may, at the option of the State, be dis-  
21 regarded.”.

22 (b) EFFECTIVE DATE.—The amendments made by  
23 subsection (a) shall apply to payments for medical assist-  
24 ance for calendar quarters beginning on or after January  
25 1, 1995.

1 **SEC. 676. FRAIL ELDERLY DEMONSTRATION PROJECT**  
2 **WAIVERS.**

3 (a) EXPANSION OF NUMBER OF WAIVERS.—Section  
4 9412(b)(1) of the Omnibus Budget Reconciliation Act of  
5 1986 is amended by striking “15” and inserting “40”.

6 (b) DEVELOPMENT OF PROTOCOLS AND MODEL  
7 CERTIFICATION GUIDELINES.—Section 9412(b) of the  
8 Omnibus Budget Reconciliation Act of 1986 is amended  
9 by adding at the end the following new paragraphs:

10 “(5) The Secretary, in consultation with the  
11 States and organizations operating projects in ac-  
12 cordance with waivers under this subsection shall de-  
13 velop and publish a waiver protocol that will estab-  
14 lish minimum standard requirements that an organi-  
15 zation must meet to be eligible for a waiver under  
16 this subsection. In developing the protocol under the  
17 preceding sentence, the Secretary shall incorporate  
18 standards for organizations to deliver integrated  
19 acute and long-term care services for the elderly,  
20 children, and young adults.

21 “(6) The Secretary shall develop model guide-  
22 lines that shall be available to States that choose to  
23 establish a comprehensive procedure for the licen-  
24 sure and certification of an organization operating a  
25 demonstration project under a waiver granted pursu-  
26 ant to this subsection. Such guidelines shall encom-

1 pass the range of services provided by such an orga-  
2 nization.

3 (c) EVALUATIONS AND REPORTS.—Section 9412(b)  
4 of the Omnibus Budget Reconciliation Act of 1986, as  
5 amended by subsection (b), is amended by adding at the  
6 end the following new paragraph:

7 “(7)(A) The Secretary shall develop standard  
8 evaluation protocols to assess the cost-effectiveness  
9 and quality of service provided under—

10 “(i) demonstration projects operating on  
11 the date of the enactment of this paragraph  
12 under waivers granted pursuant to this sub-  
13 section; and

14 “(ii) demonstration projects granted waiv-  
15 ers after the date of the enactment of this para-  
16 graph.

17 “(B) The Secretary shall conduct evaluations of  
18 the demonstration projects in accordance with the  
19 protocols developed under subparagraph (A) and  
20 based on the results of such evaluations, report to  
21 the Committee on Finance of the Senate, the Com-  
22 mittee on Ways and Means of the House of Rep-  
23 resentatives, and the Subcommittee on Health and  
24 the Environment of the Committee on Energy and  
25 Commerce of the House of Representatives by—



1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to services furnished on or after  
3 January 1, 1995.

4 **SEC. 678. ELIMINATION OF RULE REGARDING AVAILABIL-**  
5 **ITY OF BEDS IN CERTAIN INSTITUTIONS.**

6 (a) IN GENERAL.—The first sentence of section  
7 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by insert-  
8 ing the following before the end period: “(at the option  
9 of the State, such determination may be made without re-  
10 gard to the availability of beds in such a hospital, nursing  
11 facility, or intermediate care facility for the mentally re-  
12 tarded located in the State)”.

13 (b) EFFECTIVE DATE.—The amendment made by  
14 subsection (a) shall be effective with respect to waivers  
15 granted or renewed on or after January 1, 1995.

16 **PART V—MISCELLANEOUS**

17 **SEC. 679. MEDICAID COVERAGE OF ALL CERTIFIED NURSE**  
18 **PRACTITIONER AND CLINICAL NURSE SPE-**  
19 **CIALIST SERVICES.**

20 (a) IN GENERAL.—Paragraph (21) of section  
21 1905(a) (42 U.S.C. 1396d(a)) is amended to read as fol-  
22 lows:

23 “(21) services furnished by all certified nurse  
24 practitioners (as defined by the Secretary) or clinical  
25 nurse specialists (as defined in subsection (u)) which

1 the certified nurse practitioner or clinical nurse spe-  
2 cialist is legally authorized to perform under State  
3 law (or the State regulatory mechanism provided by  
4 State law), whether or not the certified nurse practi-  
5 tioner or clinical nurse specialist is under the super-  
6 vision of, or associated with, a physician or other  
7 health care provider;”.

8 (b) CLINICAL NURSE SPECIALIST DEFINED.—Sec-  
9 tion 1905 (42 U.S.C. 1396), as amended by section 674,  
10 is amended by adding at the end the following new sub-  
11 section:

12 “(u) The term ‘clinical nurse specialist’ means an in-  
13 dividual who—

14 “(1) is a registered nurse and is licensed to  
15 practice nursing in the State in which the clinical  
16 nurse specialist services are performed; and

17 “(2) holds a master’s degree in a defined clini-  
18 cal area of nursing from an accredited educational  
19 institution.”.

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section shall become effective with respect to pay-  
22 ments for calendar quarters beginning on or after January  
23 1, 1995.

1                   **TITLE VII—REVENUE**  
2                                   **PROVISIONS**

3 **SEC. 700. AMENDMENT OF 1986 CODE.**

4           Except as otherwise expressly provided, whenever in  
5 this title an amendment or repeal is expressed in terms  
6 of an amendment to, or repeal of, a section or other provi-  
7 sion, the reference shall be considered to be made to a  
8 section or other provision of the Internal Revenue Code  
9 of 1986.

10           **Subtitle A—Financing Provisions**

11                   **PART I—INCREASE IN TAX ON TOBACCO**

12                                   **PRODUCTS**

13 **SEC. 701. INCREASE IN EXCISE TAXES ON TOBACCO**  
14                                   **PRODUCTS.**

15           (a) CIGARETTES.—Subsection (b) of section 5701 is  
16 amended—

17                   (1) by striking “\$12 per thousand (\$10 per  
18 thousand on cigarettes removed during 1991 or  
19 1992)” in paragraph (1) and inserting “\$62 per  
20 thousand”, and

21                   (2) by striking “\$25.20 per thousand (\$21 per  
22 thousand on cigarettes removed during 1991 or  
23 1992)” in paragraph (2) and inserting “\$130.20 per  
24 thousand”.

1 (b) CIGARS.—Subsection (a) of section 5701 is  
2 amended—

3 (1) by striking “\$1.125 cents per thousand  
4 (93.75 cents per thousand on cigars removed during  
5 1991 or 1992)” in paragraph (1) and inserting  
6 “\$51.13 per thousand”, and

7 (2) by striking “equal to” and all that follows  
8 in paragraph (2) and inserting “equal to 66 percent  
9 of the price for which sold but not more than \$155  
10 per thousand.”

11 (c) CIGARETTE PAPERS.—Subsection (c) of section  
12 5701 is amended by striking “0.75 cent (0.625 cent on  
13 cigarette papers removed during 1991 or 1992)” and in-  
14 serting “3.88 cents”.

15 (d) CIGARETTE TUBES.—Subsection (d) of section  
16 5701 is amended by striking “1.5 cents (1.25 cents on  
17 cigarette tubes removed during 1991 or 1992)” and in-  
18 serting “7.76 cents”.

19 (e) SMOKELESS TOBACCO.—Subsection (e) of section  
20 5701 is amended—

21 (1) by striking “36 cents (30 cents on snuff re-  
22 moved during 1991 or 1992)” in paragraph (1) and  
23 inserting “\$13.69”, and

1           (2) by striking “12 cents (10 cents on chewing  
2 tobacco removed during 1991 or 1992)” in para-  
3 graph (2) and inserting “\$5.45”.

4           (f) PIPE TOBACCO.—Subsection (f) of section 5701  
5 is amended by striking “67.5 cents (56.25 cents on pipe  
6 tobacco removed during 1991 or 1992)” and inserting  
7 “\$17.35”.

8           (g) APPLICATION OF TAX INCREASE TO PUERTO  
9 RICO.—Section 5701 is amended by adding at the end the  
10 following new subsection:

11           “(h) APPLICATION TO TAXES TO PUERTO RICO.—  
12 Notwithstanding subsections (b) and (c) of section 7653  
13 and any other provision of law—

14           “(1) IN GENERAL.—On tobacco products and  
15 cigarette papers and tubes, manufactured or im-  
16 ported into the Commonwealth of Puerto Rico, there  
17 is hereby imposed a tax at the rate equal to the ex-  
18 cess of—

19           “(A) the rate of tax applicable under this  
20 section to like articles manufactured in the  
21 United States, over

22           “(B) the rate referred to in subparagraph  
23 (A) as in effect on the day before the date of  
24 the enactment of the Health Security Act.

1           “(2) SHIPMENTS TO PUERTO RICO FROM THE  
2 UNITED STATES.—Only the rates of tax in effect on  
3 the day before the date of the enactment of this sub-  
4 section shall be taken into account in determining  
5 the amount of any exemption from, or credit or  
6 drawback of, any tax imposed by this section on any  
7 article shipped to the Commonwealth of Puerto Rico  
8 from the United States.

9           “(3) SHIPMENTS FROM PUERTO RICO TO THE  
10 UNITED STATES.—The rates of tax taken into ac-  
11 count under section 7652(a) with respect to tobacco  
12 products and cigarette papers and tubes coming into  
13 the United States from the Commonwealth of Puer-  
14 to Rico shall be the rates of tax in effect on the day  
15 before the date of the enactment of the Health Secu-  
16 rity Act.

17           “(4) DISPOSITION OF REVENUES.—The provi-  
18 sions of section 7652(a)(3) shall not apply to any  
19 tax imposed by reason of this subsection.”

20           (h) FUNDING OF SUBSIDIES FOR CHILDREN AND  
21 PREGNANT WOMEN.—Section 5701 is amended by adding  
22 at the end the following new subsection:

23           “(i) FUNDING OF SUBSIDIES FOR CHILDREN AND  
24 PREGNANT WOMEN.—In the case of articles removed after  
25 June 30, 1996, and before January 1, 2002—

1           “(1) each of the following rates of tax shall be  
2           increased by the amount determined in accordance  
3           with the following table:

<b>“For the tax under subsection:</b>	<b>The increase is:</b>
(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,

4           “(2) the rate of tax under subsection (c) shall  
5           be increased by 0.93 cent,

6           “(3) the rate of tax under subsection (d) shall  
7           be increased by 1.86 cents, and

8           “(4) subsection (a)(2) shall be applied by sub-  
9           stituting ‘81.81 percent’ for ‘66 percent.’”

10          (i) EFFECTIVE DATE.—The amendments made by  
11 this section shall apply to articles removed (as defined in  
12 section 5702(k) of the Internal Revenue Code of 1986,  
13 as amended by this Act) after December 31, 1994.

14          (j) FLOOR STOCKS TAXES.—

15           (1) IMPOSITION OF TAX.—On tobacco products  
16           and cigarette papers and tubes manufactured in or  
17           imported into the United States or the Common-  
18           wealth of Puerto Rico which are removed before any  
19           tax-increase date, and held on such date for sale by  
20           any person, there is hereby imposed a tax in an  
21           amount equal to the excess of—

1 (A) the tax which would be imposed under  
2 section 5701 of the Internal Revenue Code of  
3 1986 on the article if the article had been re-  
4 moved on such date, over

5 (B) the prior tax (if any) imposed under  
6 section 5701 or 7652 of such Code on such ar-  
7 ticle.

8 (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
9 IN VENDING MACHINES.—To the extent provided in  
10 regulations prescribed by the Secretary, no tax shall  
11 be imposed by paragraph (1) on cigarettes held for  
12 retail sale on any tax-increase date, by any person  
13 in any vending machine. If the Secretary provides  
14 such a benefit with respect to any person, the Sec-  
15 retary may reduce the \$500 amount in paragraph  
16 (3) with respect to such person.

17 (3) CREDIT AGAINST TAX.—Each person shall  
18 be allowed as a credit against the taxes imposed by  
19 paragraph (1) an amount equal to \$500. Such credit  
20 shall not exceed the amount of taxes imposed by  
21 paragraph (1) on each tax-increase date for which  
22 such person is liable.

23 (4) LIABILITY FOR TAX AND METHOD OF PAY-  
24 MENT.—

1 (A) LIABILITY FOR TAX.—A person hold-  
2 ing cigarettes on any tax-increase date, to  
3 which any tax imposed by paragraph (1) applies  
4 shall be liable for such tax.

5 (B) METHOD OF PAYMENT.—The tax im-  
6 posed by paragraph (1) shall be paid in such  
7 manner as the Secretary shall prescribe by reg-  
8 ulations.

9 (C) TIME FOR PAYMENT.—The tax im-  
10 posed by paragraph (1) shall be paid on or be-  
11 fore the date which is 3 months after the tax-  
12 increase date.

13 (5) ARTICLES IN FOREIGN TRADE ZONES.—  
14 Notwithstanding the Act of June 18, 1934 (48 Stat.  
15 998, 19 U.S.C. 81a) and any other provision of law,  
16 any article which is located in a foreign trade zone  
17 on any tax-increase date shall be subject to the tax  
18 imposed by paragraph (1) if—

19 (A) internal revenue taxes have been deter-  
20 mined, or customs duties liquidated, with re-  
21 spect to such article before such date pursuant  
22 to a request made under the 1st proviso of sec-  
23 tion 3(a) of such Act, or

1 (B) such article is held on such date under  
2 the supervision of a customs officer pursuant to  
3 the 2d proviso of such section 3(a).

4 (6) DEFINITIONS.—For purposes of this sub-  
5 section—

6 (A) IN GENERAL.—Terms used in this sub-  
7 section which are also used in section 5702 of  
8 the Internal Revenue Code of 1986 shall have  
9 the respective meanings such terms have in  
10 such section, as amended by this Act.

11 (B) SECRETARY.—The term “Secretary”  
12 means the Secretary of the Treasury or his del-  
13 egate.

14 (C) TAX-INCREASE DATE.—The term “tax-  
15 increase date” means January 1, 1995, and  
16 July 1, 1996.

17 (7) CONTROLLED GROUPS.—Rules similar to  
18 the rules of section 5061(e)(3) of such Code shall  
19 apply for purposes of this subsection.

20 (8) OTHER LAWS APPLICABLE.—All provisions  
21 of law, including penalties, applicable with respect to  
22 the taxes imposed by section 5701 of such Code  
23 shall, insofar as applicable and not inconsistent with  
24 the provisions of this subsection, apply to the floor  
25 stocks taxes imposed by paragraph (1), to the same

1 extent as if such taxes were imposed by such section  
2 5701. The Secretary may treat any person who bore  
3 the ultimate burden of the tax imposed by para-  
4 graph (1) as the person to whom a credit or refund  
5 under such provisions may be allowed or made.

6 **SEC. 702. MODIFICATIONS OF CERTAIN TOBACCO TAX PRO-**  
7 **VISIONS.**

8 (a) EXEMPTION FOR EXPORTED TOBACCO PROD-  
9 UCTS AND CIGARETTE PAPERS AND TUBES TO APPLY  
10 ONLY TO ARTICLES MARKED FOR EXPORT.—

11 (1) Subsection (b) of section 5704 is amended  
12 by adding at the end the following new sentence:  
13 “Tobacco products and cigarette papers and tubes  
14 may not be transferred or removed under this sub-  
15 section unless such products or papers and tubes  
16 bear such marks, labels, or notices as the Secretary  
17 shall by regulations prescribe.”

18 (2) Section 5761 is amended by redesignating  
19 subsections (c) and (d) as subsections (d) and (e),  
20 respectively, and by inserting after subsection (b)  
21 the following new subsection:

22 “(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE  
23 PAPERS AND TUBES FOR EXPORT.—Except as provided  
24 in subsections (b) and (d) of section 5704—

1           “(1) every person who sells, relands, or receives  
2           within the jurisdiction of the United States any to-  
3           bacco products or cigarette papers or tubes which  
4           have been labeled or shipped for exportation under  
5           this chapter,

6           “(2) every person who sells or receives such  
7           relanded tobacco products or cigarette papers or  
8           tubes, and

9           “(3) every person who aids or abets in such  
10          selling, relanding, or receiving,

11 shall, in addition to the tax and any other penalty provided  
12 in this title, be liable for a penalty equal to the greater  
13 of \$1,000 or 5 times the amount of the tax imposed by  
14 this chapter. All tobacco products and cigarette papers  
15 and tubes relanded within the jurisdiction of the United  
16 States, and all vessels, vehicles, and aircraft used in such  
17 relanding or in removing such products, papers, and tubes  
18 from the place where relanded, shall be forfeited to the  
19 United States.”

20           (3) Subsection (a) of section 5761 is amended  
21           by striking “subsection (b)” and inserting “sub-  
22           section (b) or (c)”.

23           (4) Subsection (d) of section 5761, as redesign-  
24           nated by paragraph (2), is amended by striking  
25           “The penalty imposed by subsection (b)” and insert-

1 ing “The penalties imposed by subsections (b) and  
2 (c)”.

3 (5)(A) Subpart F of chapter 52 is amended by  
4 adding at the end the following new section:

5 **“SEC. 5754. RESTRICTION ON IMPORTATION OF PRE-**  
6 **VIOUSLY EXPORTED TOBACCO PRODUCTS.**

7 “(a) IN GENERAL.—Tobacco products and cigarette  
8 papers and tubes previously exported from the United  
9 States may be imported or brought into the United States  
10 only as provided in section 5704(d). For purposes of this  
11 section, section 5704(d), section 5761, and such other pro-  
12 visions as the Secretary may specify by regulations, ref-  
13 erences to exportation shall be treated as including a ref-  
14 erence to shipment to the Commonwealth of Puerto Rico.

15 “(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).”**

16 (B) The table of sections for subpart F of chap-  
17 ter 52 is amended by adding at the end the following  
18 new item:

“Sec. 5754. Restriction on importation of previously exported to-  
bacco products.”

19 (b) IMPORTERS REQUIRED TO BE QUALIFIED.—

20 (1) Sections 5712, 5713(a), 5721, 5722,  
21 5762(a)(1), and 5763(b) and (c) are each amended  
22 by inserting “or importer” after “manufacturer”.

1           (2) The heading of subsection (b) of section  
2           5763 is amended by inserting “QUALIFIED IMPORT-  
3           ERS,” after “MANUFACTURERS,”.

4           (3) The heading for subchapter B of chapter 52  
5           is amended by inserting “**and Importers**” after  
6           “**Manufacturers**”.

7           (4) The item relating to subchapter B in the  
8           table of subchapters for chapter 52 is amended by  
9           inserting “and importers” after “manufacturers”.

10          (c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES  
11          OF CIGARETTE MANUFACTURERS.—

12           (1) Subsection (a) of section 5704 is amend-  
13           ed—

14           (A) by striking “EMPLOYEE USE OR” in  
15           the heading, and

16           (B) by striking “for use or consumption by  
17           employees or” in the text.

18           (2) Subsection (e) of section 5723 is amended  
19           by striking “for use or consumption by their employ-  
20           ees, or for experimental purposes” and inserting  
21           “for experimental purposes”.

22          (d) REPEAL OF TAX-EXEMPT SALES TO UNITED  
23          STATES.—Subsection (b) of section 5704 is amended by  
24          striking “and manufacturers may similarly remove such  
25          articles for use of the United States;”.

1 (e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS  
2 SUBJECT TO TAX.—Subsection (c) of section 5701 is  
3 amended by striking “On each book or set of cigarette  
4 papers containing more than 25 papers,” and inserting  
5 “On cigarette papers,”.

6 (f) STORAGE OF TOBACCO PRODUCTS.—Subsection  
7 (k) of section 5702 is amended by inserting “under section  
8 5704” after “internal revenue bond”.

9 (g) AUTHORITY TO PRESCRIBE MINIMUM MANUFAC-  
10 TURING ACTIVITY REQUIREMENTS.—Section 5712 is  
11 amended by striking “or” at the end of paragraph (1),  
12 by redesignating paragraph (2) as paragraph (3), and by  
13 inserting after paragraph (1) the following new paragraph:

14 “(2) the activity proposed to be carried out at  
15 such premises does not meet such minimum capacity  
16 or activity requirements as the Secretary may pre-  
17 scribe, or”.

18 (h) SPECIAL RULES RELATING TO PUERTO RICO  
19 AND THE VIRGIN ISLANDS.—Section 7652 is amended by  
20 adding at the end the following new subsection:

21 “(h) LIMITATION ON COVER OVER OF TAX ON TO-  
22 BACCO PRODUCTS.—For purposes of this section, with re-  
23 spect to taxes imposed under section 5701 or this section  
24 on any tobacco product or cigarette paper or tube, the  
25 amount covered into the treasuries of Puerto Rico and the

1 Virgin Islands shall not exceed the rate of tax under sec-  
2 tion 5701 in effect on the article on the day before the  
3 date of the enactment of the Health Security Act.”

4 (i) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to articles removed (as defined in  
6 section 5702(k) of the Internal Revenue Code of 1986,  
7 as amended by this Act) after December 31, 1994.

8 **SEC. 703. IMPOSITION OF EXCISE TAX ON MANUFACTURE**  
9 **OR IMPORTATION OF ROLL-YOUR-OWN TO-**  
10 **BACCO.**

11 (a) IN GENERAL.—Section 5701 (relating to rate of  
12 tax), as amended by section 701, is amended by redesi-  
13 gnating subsections (g) and (h) as subsections (h) and (i)  
14 and by inserting after subsection (f) the following new  
15 subsection:

16 “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own  
17 tobacco, manufactured in or imported into the United  
18 States, there shall be imposed a tax of \$17.35 per pound  
19 (and a proportionate tax at the like rate on all fractional  
20 parts of a pound).”

21 (b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (re-  
22 lating to definitions) is amended by adding at the end the  
23 following new subsection:

24 “(p) ROLL-YOUR-OWN TOBACCO.—The term ‘roll-  
25 your-own tobacco’ means any tobacco which, because of

1 its appearance, type, packaging, or labeling, is suitable for  
2 use and likely to be offered to, or purchased by, consumers  
3 as tobacco for making cigarettes.”

4 (c) TECHNICAL AMENDMENTS.—

5 (1) Subsection (c) of section 5702 is amended  
6 by striking “and pipe tobacco” and inserting “pipe  
7 tobacco, and roll-your-own tobacco”.

8 (2) Subsection (d) of section 5702 is amend-  
9 ed—

10 (A) in the material preceding paragraph  
11 (1), by striking “or pipe tobacco” and inserting  
12 “pipe tobacco, or roll-your-own tobacco”, and

13 (B) by striking paragraph (1) and insert-  
14 ing the following new paragraph:

15 “(1) a person who produces cigars, cigarettes,  
16 smokeless tobacco, pipe tobacco, or roll-your-own to-  
17 bacco solely for the person’s own personal consump-  
18 tion or use, and”.

19 (3) The chapter heading for chapter 52 is  
20 amended to read as follows:

21 **“CHAPTER 52—TOBACCO PRODUCTS AND**  
22 **CIGARETTE PAPERS AND TUBES”.**

23 (4) The table of chapters for subtitle E is  
24 amended by striking the item relating to chapter 52  
25 and inserting the following new item:

“CHAPTER 52. Tobacco products and cigarette papers and tubes.”

1 (d) EFFECTIVE DATE.—

2 (1) IN GENERAL.—The amendments made by  
3 this section shall apply to roll-your-own tobacco re-  
4 moved (as defined in section 5702(k) of the Internal  
5 Revenue Code of 1986, as amended by this Act)  
6 after December 31, 1994.

7 (2) TRANSITIONAL RULE.—Any person who—

8 (A) on the date of the enactment of this  
9 Act is engaged in business as a manufacturer of  
10 roll-your-own tobacco or as an importer of to-  
11 bacco products or cigarette papers and tubes,  
12 and

13 (B) before January 1, 1995, submits an  
14 application under subchapter B of chapter 52  
15 of such Code to engage in such business,  
16 may, notwithstanding such subchapter B, continue  
17 to engage in such business pending final action on  
18 such application. Pending such final action, all pro-  
19 visions of such chapter 52 shall apply to such appli-  
20 cant in the same manner and to the same extent as  
21 if such applicant were a holder of a permit under  
22 such chapter 52 to engage in such business.



1           “(1) HEALTH INSURANCE.—The tax imposed  
2           by subsection (a)(1) shall be paid by the issuer of  
3           the policy.

4           “(2) HEALTH-RELATED ADMINISTRATIVE SERV-  
5           ICES.—The tax imposed by subsection (a)(2) shall  
6           be paid by the person providing the health-related  
7           administrative services.

8           “(c) TAXABLE HEALTH INSURANCE POLICY.—For  
9           purposes of this section—

10           “(1) IN GENERAL.—Except as otherwise pro-  
11           vided in this section, the term ‘taxable health insur-  
12           ance policy’ means any insurance policy providing  
13           accident or health insurance with respect to individ-  
14           uals residing in the United States.

15           “(2) EXEMPTION OF CERTAIN POLICIES.—The  
16           term ‘taxable health insurance policy’ does not in-  
17           clude any insurance policy if substantially all of the  
18           coverage provided under such policy relates to—

19                   “(A) liabilities incurred under workers’  
20                   compensation laws,

21                   “(B) tort liabilities,

22                   “(C) liabilities relating to ownership or use  
23                   of property,

24                   “(D) credit insurance, or

1           “(E) such other similar liabilities as the  
2           Secretary may specify by regulations.

3           “(3) SPECIAL RULE WHERE POLICY PROVIDES  
4           OTHER COVERAGE.—In the case of any taxable  
5           health insurance policy under which amounts are  
6           payable other than for accident or health coverage,  
7           in determining the amount of the tax imposed by  
8           subsection (a)(1) on any premium paid under such  
9           policy, there shall be excluded the amount of the  
10          charge for the nonaccident or health coverage if—

11           “(A) the charge for such nonaccident or  
12          health coverage is either separately stated in  
13          the policy, or furnished to the policyholder in a  
14          separate statement, and

15           “(B) such charge is reasonable in relation  
16          to the total charges under the policy.

17          In any other case, the entire amount of the premium  
18          paid under such a policy shall be subject to tax  
19          under subsection (a)(1).

20          “(4) TREATMENT OF PREPAID HEALTH COV-  
21          ERAGE ARRANGEMENTS.—

22           “(A) IN GENERAL.—In the case of any ar-  
23          rangement described in subparagraph (B)—

24           “(i) such arrangement shall be treated  
25          as a taxable health insurance policy,

1           “(ii) the payments or premiums re-  
2           ferred to in subparagraph (B)(i) shall be  
3           treated as premiums received for a taxable  
4           health insurance policy, and

5           “(iii) the person referred to in sub-  
6           paragraph (B)(i) shall be treated as the is-  
7           suer.

8           “(B) DESCRIPTION OF ARRANGEMENTS.—  
9           An arrangement is described in this subpara-  
10          graph if under such arrangement—

11          “(i) fixed payments or premiums are  
12          received as consideration for any person’s  
13          agreement to provide or arrange for the  
14          provision of accident or health coverage to  
15          residents of the United States, regardless  
16          of how such coverage is provided or ar-  
17          ranged to be provided, and

18          “(ii) substantially all of the risks of  
19          the rates of utilization of services is as-  
20          sumed by such person or the provider of  
21          such services.

22          “(d) HEALTH-RELATED ADMINISTRATIVE SERV-  
23          ICES.—For purposes of this section, the term ‘health-re-  
24          lated administrative services’ means—

1           “(1) the processing of claims or performance of  
2           other administrative services in connection with acci-  
3           dent or health coverage under a taxable health in-  
4           surance policy if the charge for such services is not  
5           included in the premiums under such policy, and

6           “(2) processing claims, arranging for provision  
7           of accident or health coverage, or performing other  
8           administrative services in connection with an appli-  
9           cable self-insured health plan (as defined in section  
10          4502(c)) established or maintained by a person  
11          other than the person performing the services.

12 For purposes of paragraph (1), rules similar to the rules  
13 of subsection (c)(3) shall apply.

14 **“SEC. 4502. SELF-INSURED HEALTH PLANS.**

15          “(a) IMPOSITION OF TAX.—In the case of any appli-  
16 cable self-insured health plan, there is hereby imposed a  
17 tax for each month equal to 1.75 percent of the sum of—

18           “(1) the accident or health coverage expendi-  
19           tures for such month under such plan, and

20           “(2) the direct administrative expenditures for  
21           such month under such plan.

22          “(b) LIABILITY FOR TAX.—

23           “(1) IN GENERAL.—The tax imposed by sub-  
24           section (a) shall be paid by the plan sponsor.

1           “(2) PLAN SPONSOR.—For purposes of para-  
2 graph (1), the term ‘plan sponsor’ means—

3                   “(A) the employer in the case of a plan es-  
4 tablished or maintained by a single employer,

5                   “(B) the employee organization in the case  
6 of a plan established or maintained by an em-  
7 ployee organization, or

8                   “(C) in the case of—

9                           “(i) a plan established or maintained  
10 by 2 or more employers or jointly by 1 or  
11 more employers and 1 or more employee  
12 organizations,

13                           “(ii) a voluntary employees’ bene-  
14 ficiary association under section 501(c)(9),  
15 or

16                           “(iii) a plan described in subsection  
17 (c)(2)(E),

18 the association, committee, joint board of trust-  
19 ees, or other similar group of representatives of  
20 the parties who establish or maintain the plan.

21           “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—

22 For purposes of this section, the term ‘applicable self-in-  
23 sured health plan’ means any plan for providing accident  
24 or health coverage if—

1           “(1) any portion of such coverage is provided  
2 other than through an insurance policy, and

3           “(2) such plan is established or maintained—

4           “(A) by one or more employers for the  
5 benefit of their employees or former employees,

6           “(B) by one or more employee organiza-  
7 tions for the benefit of their members or former  
8 members,

9           “(C) jointly by 1 or more employers and 1  
10 or more employee organizations for the benefit  
11 of employees or former employees,

12           “(D) by a voluntary employees’ beneficiary  
13 association described in section 501(c)(9), or

14           “(E) in the case of a plan not described in  
15 the preceding subparagraphs, by a qualified as-  
16 sociation (as defined in section 21433(c) of the  
17 Social Security Act).

18           “(d) ACCIDENT OR HEALTH COVERAGE EXPENDI-  
19 TURES.—For purposes of this section—

20           “(1) IN GENERAL.—The accident or health cov-  
21 erage expenditures of any applicable self-insured  
22 health plan for any month are the aggregate expend-  
23 itures paid in such month for accident or health cov-  
24 erage provided under such plan to the extent such

1 expenditures are not subject to tax under section  
2 4501.

3 “(2) TREATMENT OF REIMBURSEMENTS.—In  
4 determining accident or health coverage expenditures  
5 during any month of any applicable self-insured  
6 health plan, reimbursements (by insurance or other-  
7 wise) received during such month shall be taken into  
8 account as a reduction in accident or health coverage  
9 expenditures.

10 “(3) CERTAIN EXPENDITURES DISREGARDED.—  
11 Paragraph (1) shall not apply to any expenditure for  
12 the acquisition or improvement of land or for the ac-  
13 quisition or improvement of any property to be used  
14 in connection with the provision of accident or  
15 health coverage which is subject to the allowance  
16 under section 167, except that, for purposes of para-  
17 graph (1), allowances under section 167 shall be  
18 considered as expenditures.

19 “(e) DIRECT ADMINISTRATIVE EXPENDITURES.—  
20 For purposes of this section, the term ‘direct administra-  
21 tive expenditures’ means the administrative expenditures  
22 under the plan to the extent such expenditures are not  
23 subject to tax under section 4501. In determining the  
24 amount of such expenditures, rules similar to the rules of  
25 subsection (d)(3) shall apply.

1 **“SEC. 4503. DEFINITIONS AND SPECIAL RULES.**

2 “(a) DEFINITIONS.—For purposes of this sub-  
3 chapter—

4 “(1) ACCIDENT OR HEALTH COVERAGE.—The  
5 term ‘accident or health coverage’ means any cov-  
6 erage which, if provided by an insurance policy,  
7 would cause such policy to be a taxable health insur-  
8 ance policy (as defined in section 4501(c)).

9 “(2) INSURANCE POLICY.—The term ‘insurance  
10 policy’ means any policy or other instrument where-  
11 by a contract of insurance is issued, renewed, or ex-  
12 tended.

13 “(3) PREMIUM.—The term ‘premium’ means  
14 the gross amount of premiums and other consider-  
15 ation (including advance premiums, deposits, fees,  
16 and assessments) arising from policies issued by a  
17 person acting as the primary insurer, adjusted for  
18 any return or additional premiums paid as a result  
19 of endorsements, cancellations, audits, or retrospec-  
20 tive rating. Amounts returned where the amount is  
21 not fixed in the contract but depends on the experi-  
22 ence of the insurer or the discretion of management  
23 shall not be included in return premiums.

24 “(4) UNITED STATES.—The term ‘United  
25 States’ includes any possession of the United States.

26 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1           “(1) IN GENERAL.—For purposes of this sub-  
2 chapter—

3           “(A) the term ‘person’ includes any gov-  
4 ernmental entity, and

5           “(B) notwithstanding any other law or rule  
6 of law, governmental entities shall not be ex-  
7 empt from the taxes imposed by this subchapter  
8 except as provided in paragraph (2).

9           “(2) EXEMPT GOVERNMENTAL PROGRAMS.—In  
10 the case of an exempt governmental program—

11           “(A) no tax shall be imposed under section  
12 4501 on any premium received pursuant to  
13 such program or on any amount received for  
14 health-related administrative services pursuant  
15 to such program, and

16           “(B) no tax shall be imposed under section  
17 4502 on any expenditures pursuant to such  
18 program.

19           “(3) EXEMPT GOVERNMENTAL PROGRAM.—For  
20 purposes of this subchapter, the term ‘exempt gov-  
21 ernmental program’ means—

22           “(A) the insurance programs established  
23 by parts A and B of title XVIII of the Social  
24 Security Act,

1           “(B) the medical assistance program es-  
2           tablished by title XIX of the Social Security  
3           Act,

4           “(C) any program established by Federal  
5           law for providing medical care (other than  
6           through insurance policies) to individuals (or  
7           the spouses and dependents thereof) by reason  
8           of such individuals being—

9                   “(i) members of the Armed Forces of  
10                   the United States, or

11                   “(ii) veterans, and

12           “(D) any program established by Federal  
13           law for providing medical care (other than  
14           through insurance policies) to members of In-  
15           dian tribes (as defined in section 4(d) of the In-  
16           dian Health Care Improvement Act).

17           “(c) NO COVER OVER TO POSSESSIONS.—Notwith-  
18           standing any other provision of law, no amount collected  
19           under this subchapter shall be covered over to any posses-  
20           sion of the United States.”

21           (b) CLERICAL AMENDMENT.—The table of chapters  
22           for subtitle D is amended by inserting after the item relat-  
23           ing to chapter 36 the following new item:

                  “CHAPTER 37. Health related assessments.”

24           (c) EFFECTIVE DATE.—The amendments made by  
25           this section shall apply with respect to premiums received,

1 and expenses incurred, with respect to coverage for peri-  
2 ods after December 31, 1995.

3 **SEC. 706. TAX ON HIGH COST HEALTH PLANS.**

4 (a) IN GENERAL.—Subchapter A of chapter 37 (re-  
5 lating to assessments on insured and self-insured health  
6 benefits), as added by section 705, is amended by adding  
7 at the end the following new part:

8 **“PART II—HIGH COST HEALTH PLANS**

“Sec. 4511. Tax on high cost health plans.

“Sec. 4512. Definitions and special rules.

9 **“SEC. 4511. TAX ON HIGH COST HEALTH PLANS.**

10 “(a) IMPOSITION OF TAX.—If an applicable health  
11 plan is a high cost plan for any taxable period, there is  
12 hereby imposed a tax equal to 25 percent of the taxable  
13 amount with respect to the high cost plan for the period.

14 “(b) LIABILITY FOR TAX.—

15 “(1) IN GENERAL.—Except as provided in para-  
16 graph (2), the tax imposed by subsection (a) shall be  
17 paid by the issuer of the high cost plan.

18 “(2) SELF-INSURED PLANS.—In the case of a  
19 high cost plan which is a self-insured plan, the tax  
20 shall be paid by the plan sponsor.

21 “(c) HIGH COST PLAN.—For purposes of this sec-  
22 tion—

23 “(1) IN GENERAL.—An applicable health plan  
24 is a high cost plan for any taxable period if—

1           “(A) the premiums received under the plan  
2 during the taxable period, exceed

3           “(B) the sum of the target amounts deter-  
4 mined with respect to each class of enrollment  
5 under the plan.

6           “(2) TARGET AMOUNT.—

7           “(A) IN GENERAL.—The target amount for  
8 any class of enrollment under a plan for any  
9 taxable period is an amount equal to the prod-  
10 uct of—

11                   “(i) the target premium for such  
12 class, and

13                   “(ii) the number of primary insureds  
14 in such class during the period.

15           “(B) PROPORTIONATE REDUCTION OF  
16 TARGET PREMIUM.—The target premium under  
17 subparagraph (A)(i) applicable to an individual  
18 who was a primary insured for only a portion  
19 of the taxable period shall be proportionately  
20 reduced to reflect the period the individual was  
21 not a primary insured.

22           “(3) CERTAIN SUPPLEMENTAL PREMIUMS IN-  
23 CLUDED.—The amount determined under paragraph  
24 (1)(A) shall include applicable supplemental pre-  
25 miums.

1           “(4) CERTAIN ACTUARIAL ADJUSTMENTS DIS-  
2           REGARDED.—The amount determined under para-  
3           graph (1)(A) (after application of paragraph (3))  
4           shall be adjusted, in accordance with regulations, as  
5           follows:

6                   “(A) AGE ADJUSTMENTS UNDER COMMU-  
7                   NITY-RATED PLANS.—In the case of a commu-  
8                   nity-rated plan, to reflect the premiums which  
9                   would have been received if any age adjustment  
10                  factor were disregarded.

11                  “(B) RISK ADJUSTMENTS UNDER OTHER  
12                  PLANS.—In the case of any plan which is not  
13                  a community-rated plan, by adjusting such  
14                  amount so that it does not reflect the relative  
15                  risks among the participants in the plan.

16           “(5) CERTAIN PLANS NOT TREATED AS HIGH  
17           COST PLANS.—

18                   “(A) IN GENERAL.—An applicable health  
19                   plan shall not be treated as a high cost plan for  
20                   any taxable period beginning in a calendar year  
21                   if its adjusted average premium is determined,  
22                   in such manner as the Secretary may prescribe,  
23                   to be in the bottom quartile of the adjusted av-  
24                   erage premiums of all certified standard health

1 plans in the United States for the calendar  
2 year.

3 “(B) ADJUSTED AVERAGE PREMIUM.—For  
4 purposes of subparagraph (A), the adjusted av-  
5 erage premium for any plan shall be determined  
6 in such manner as the Secretary shall prescribe  
7 and shall be equal to the weighted average pre-  
8 mium for all classes of enrollment under the  
9 plan—

10 “(i) adjusted to reflect—

11 “(I) differences in cost-of-living  
12 among community-rated areas,

13 “(II) other differences among  
14 community-rated areas which affect  
15 premium costs,

16 “(III) in the case of a commu-  
17 nity-rated plan, age adjustment fac-  
18 tors, and

19 “(IV) in the case of plans which  
20 are not community-rated plans, rel-  
21 ative risks described in paragraph  
22 (4)(B), and

23 “(ii) determined by taking into ac-  
24 count applicable supplemental premiums  
25 under the plan.

1       “(d) TAXABLE AMOUNT.—For purposes of this sec-  
2 tion, the term ‘taxable amount’ means the excess (if any)  
3 which is determined under subsection (c)(1), except that  
4 in applying subsection (c) for purposes of this subsection,  
5 the reference premium shall be substituted for the target  
6 premium.

7       “(e) TARGET AND REFERENCE PREMIUMS.—For  
8 purposes of this section—

9           “(1) IN GENERAL.—As soon as practicable  
10 after the annual open enrollment period established  
11 under section 21024 of the Social Security Act for  
12 a community rating area, the Secretary shall estab-  
13 lish—

14           “(A) separate target and reference pre-  
15 miums for each class of enrollment under com-  
16 munity-rated plans in such area, and

17           “(B) separate target and reference pre-  
18 miums for each class of enrollment under plans  
19 which are not community-rated plans in such  
20 area.

21       “(2) BASIS FOR ESTABLISHING PREMIUMS.—

22           “(A) TARGET PREMIUMS.—The Secretary  
23 shall establish target premiums under para-  
24 graph (1) for each community rating area at  
25 the levels which the Secretary estimates will re-

1           sult in the following plans being treated as high  
2           cost plans (determined without regard to sub-  
3           section (c)(5)):

4                   “(i) Community-rated certified stand-  
5                   ard health plans in the area which cover  
6                   40 percent of the total primary insureds  
7                   covered by all such plans in the area.

8                   “(ii) Certified standard health plans  
9                   in the area which are not community-rated  
10                  which cover 40 percent of the total pri-  
11                  mary insureds covered by all such plans in  
12                  the area.

13                  “(B) REFERENCE PREMIUMS.—The Sec-  
14                  retary shall establish reference premiums under  
15                  paragraph (1) for each community rating area  
16                  which shall be equal to the average premium  
17                  per primary insured for all certified standard  
18                  health plans offered in the area for the class of  
19                  enrollment for which the premium is being es-  
20                  tablished.

21   **“SEC. 4512. DEFINITIONS AND SPECIAL RULES.**

22                  “(a) APPLICABLE PLANS.—For purposes of this  
23                  part—

1           “(1) APPLICABLE HEALTH PLAN.—The term  
2           ‘applicable health plan’ means a certified standard  
3           health plan or a certified nonstandard health plan.

4           “(2) APPLICABLE SUPPLEMENTAL PREMIUM.—  
5           The term ‘applicable supplemental premium’ means,  
6           with respect to any issuer or plan sponsor of a cer-  
7           tified standard health plan, any premium received by  
8           the issuer or plan sponsor under a certified supple-  
9           mental health plan covering an individual who is  
10          covered under the certified standard health plan.

11          “(b) CERTIFIED HEALTH PLANS.—For purposes of  
12          this part—

13           “(1) CERTIFIED STANDARD HEALTH PLAN.—  
14           The term ‘certified standard health plan’ has the  
15           meaning given such term by section 21011(a)(2) of  
16           the Social Security Act, except that such term does  
17           not include a plan offering the alternative standard  
18           benefit package described in subtitle C of such Act.

19           “(2) CERTIFIED NONSTANDARD HEALTH  
20           PLAN.—The term ‘certified nonstandard health plan’  
21           has the meaning given such term by section  
22           21011(a)(3) of such Act.

23           “(3) CERTIFIED SUPPLEMENTAL HEALTH  
24           PLAN.—The term ‘certified supplemental health

1 plan' has the meaning given such term by section  
2 21011(a)(4) of such Act.

3 “(c) COMMUNITY RATING AREAS AND PLANS.—For  
4 purposes of this part—

5 “(1) COMMUNITY RATING AREA.—The term  
6 ‘community rating area’ means an area established  
7 under section 21021 of the Social Security Act.

8 “(2) COMMUNITY-RATED PLAN.—The term  
9 ‘community-rated plan’ means a plan which is com-  
10 munity-rated under section 21113 of such Act.

11 “(d) PREMIUMS.—For purposes of this part—

12 “(1) IN GENERAL.—The term ‘premium’ has  
13 the meaning given such term by section 4503(a)(3).

14 “(2) ADMINISTRATIVE COSTS.—Amounts re-  
15 ceived for health-related administrative services (as  
16 defined in section 4501(d)) provided in connection  
17 with any applicable health plan or any certified sup-  
18 plemental health plan taken into account under sec-  
19 tion 4511(c)(3) shall be treated as premiums.

20 “(3) SELF-INSURED PLANS.—In the case of a  
21 self-insured plan, premiums shall include—

22 “(A) a reasonable estimate (actuarially de-  
23 termined in such manner as the Secretary may  
24 prescribe) of the expenditures described in sub-

1 sections (d) and (e) of section 4502 with re-  
2 spect to coverage under the plan, and

3 “(B) in the case of any coverage provided  
4 through an insurance policy, premiums paid for  
5 such coverage.

6 “(e) INSURANCE POLICY, SELF-INSURED PLANS,  
7 AND PLAN SPONSOR.—For purposes of this part—

8 “(1) INSURANCE POLICY.—The term ‘insurance  
9 policy’ has the meaning given such term by section  
10 4503(a)(2).

11 “(2) SELF-INSURED PLAN.—The term ‘self-in-  
12 sured plan’ means any certified standard health plan  
13 any portion of the coverage of which is provided  
14 other than through an insurance policy (including an  
15 arrangement described in section 4501(c)(4)(B)).

16 “(3) PLAN SPONSOR.—The term ‘plan sponsor’  
17 has the meaning given such term by section  
18 4502(b)(2), except that in the case of a plan not de-  
19 scribed in such section, such term means the person  
20 or persons who establish or maintain the plan.

21 “(f) TAXABLE PERIOD.—For purposes of this part—

22 “(1) IN GENERAL.—The term ‘taxable period’  
23 means, with respect to any applicable health plan in  
24 a community rating area for any year, the 12-month  
25 period following the close of the annual open enroll-

1       ment period for such area under section 21024 of  
2       the Social Security Act for which an individual en-  
3       rolling during such enrollment period receives cov-  
4       erage under the plan.

5           “(2) SPECIAL RULE FOR MULTISTATE SELF-IN-  
6       SURED PLANS.—If an applicable health plan in a  
7       community rating area has a different annual open  
8       enrollment period than the one described in para-  
9       graph (1), its taxable period for any year shall be  
10      determined under paragraph (1) by reference to its  
11      first coverage period beginning on or after the first  
12      day of the coverage period for the enrollment period  
13      described in paragraph (1).

14      “(g) SPECIAL RULES.—For purposes of this part—

15           “(1) DEPOSITS.—The Secretary may require  
16      deposits of any taxes imposed by section 4511 at  
17      such times as the Secretary determines appropriate.

18           “(2) GOVERNMENTAL ENTITIES SUBJECT TO  
19      TAX.—The rules of section 4503(b) shall apply for  
20      purposes of this part.

21           “(3) PLANS COVERING MORE THAN 1 AREA.—  
22      If an applicable health plan covers individuals resid-  
23      ing in more than 1 community rating area, the indi-  
24      viduals in each such area shall be treated as covered  
25      by a separate plan.

1           “(4) NO COVER OVER TO POSSESSIONS.—Not-  
2           withstanding any other provision of law, no amount  
3           collected under this part shall be covered over to any  
4           possession of the United States.

5           “(h) FUNDING OF SUBSIDIES FOR CHILDREN AND  
6           PREGNANT WOMEN.—In the case of taxable periods be-  
7           ginning after December 31, 1996, and before January 1,  
8           2002, the rate of tax under section 4511(a) shall be in-  
9           creased by 4 percent.

10          “(i) REGULATIONS.—The Secretary shall issue such  
11          regulations as are necessary to carry out the provisions  
12          of this part, including regulations—

13                 “(1) requiring the maintenance of such records,  
14                 and the reporting of such information as the Sec-  
15                 retary determines necessary, and

16                 “(2) which provide that 2 or more plans of a  
17                 person or any related persons must be aggregated,  
18                 or a plan must be treated as 2 or more separate  
19                 plans.”

20          “(b) TAX NOT DEDUCTIBLE.—Section 275(a) (relat-  
21          ing to disallowance of deductions for certain taxes) is  
22          amended by adding at the end the following new para-  
23          graph:

24                 “(7) Taxes imposed by section 4511 (relating to  
25                 taxes on high cost health plans).”

1 (c) CONFORMING AMENDMENTS.—

2 (1) Subchapter A of chapter 37, as added by  
3 section 705, is amended by inserting after the sub-  
4 chapter heading the following:

“Part I. Premium and related assessments.

“Part II. High cost health plans.

5 **“PART I—PREMIUM AND RELATED**  
6 **ASSESSMENTS”.**

7 (2) Section 4503, as so added, is amended by  
8 striking “subchapter” each place it appears and in-  
9 serting “part”.

10 (d) EFFECTIVE DATE.—The amendments made by  
11 this section shall take effect on January 1, 1996.

12 **PART III—RECAPTURE OF CERTAIN HEALTH**  
13 **CARE SUBSIDIES**

14 **SEC. 711. RECAPTURE OF CERTAIN HEALTH CARE SUB-**  
15 **SIDIES RECEIVED BY HIGH-INCOME INDIVID-**  
16 **UALS.**

17 (a) IN GENERAL.—Subchapter A of chapter 1 is  
18 amended by adding at the end the following new part:

19 **“PART VIII—CERTAIN HEALTH CARE SUBSIDIES**  
20 **RECEIVED BY HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Recapture of certain health care subsidies.

1 **“SEC. 59B. RECAPTURE OF CERTAIN HEALTH CARE SUB-**  
2 **SIDIES.**

3       “(a) IMPOSITION OF RECAPTURE AMOUNT.—In the  
4 case of an individual, if the modified adjusted gross in-  
5 come of the taxpayer for the taxable year exceeds the  
6 threshold amount, such taxpayer shall pay (in addition to  
7 any other amount imposed by this subtitle) a recapture  
8 amount for such taxable year equal to the aggregate of  
9 the Medicare part B recapture amounts (if any) for  
10 months during such year that a premium is paid under  
11 part B of title XVIII of the Social Security Act for the  
12 coverage of the individual under such part.

13       “(b) MEDICARE PART B PREMIUM RECAPTURE  
14 AMOUNT FOR MONTH.—For purposes of this section, the  
15 Medicare part B premium recapture amount for any  
16 month is the amount equal to the excess of—

17               “(1) 150 percent of the monthly actuarial rate  
18 for enrollees age 65 and over determined for that  
19 calendar year under section 1839(b) of the Social  
20 Security Act, over

21               “(2) the total monthly premium under section  
22 1839 of the Social Security Act (determined without  
23 regard to subsections (b) and (f) of section 1839 of  
24 such Act).

25       “(c) PHASE-IN OF RECAPTURE AMOUNT.—

1           “(1) IN GENERAL.—If the modified adjusted  
2 gross income of the taxpayer for any taxable year  
3 exceeds the threshold amount by less than \$15,000,  
4 the recapture amount imposed by this section for  
5 such taxable year shall be an amount which bears  
6 the same ratio to the recapture amount which would  
7 (but for this subsection) be imposed by this section  
8 for such taxable year as such excess bears to  
9 \$15,000.

10           “(2) JOINT RETURNS.—If a recapture amount  
11 is determined separately for each spouse filing a  
12 joint return, paragraph (1) shall be applied by sub-  
13 stituting ‘\$30,000’ for ‘\$15,000’ each place it ap-  
14 pears.

15           “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
16 For purposes of this section—

17           “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
18 old amount’ means—

19                   “(A) except as otherwise provided in this  
20 paragraph, \$90,000,

21                   “(B) \$115,000 in the case of a joint re-  
22 turn, and

23                   “(C) zero in the case of a taxpayer who—

1           “(i) is married (as determined under  
2           section 7703) but does not file a joint re-  
3           turn for such year, and

4           “(ii) does not live apart from his  
5           spouse at all times during the taxable year.

6           “(2) MODIFIED ADJUSTED GROSS INCOME.—  
7           The term ‘modified adjusted gross income’ means  
8           adjusted gross income—

9           “(A) determined without regard to sections  
10          135, 911, 931, and 933, and

11          “(B) increased by the amount of interest  
12          received or accrued by the taxpayer during the  
13          taxable year which is exempt from tax.

14          “(3) JOINT RETURNS.—In the case of a joint  
15          return—

16          “(A) the recapture amount under sub-  
17          section (a) shall be the sum of the recapture  
18          amounts determined separately for each spouse,  
19          and

20          “(B) subsections (a) and (c) shall be ap-  
21          plied by taking into account the combined modi-  
22          fied adjusted gross income of the spouses.

23          “(4) COORDINATION WITH OTHER PROVI-  
24          SIONS.—

1           “(A) TREATED AS TAX FOR SUBTITLE F.—  
2           For purposes of subtitle F, the recapture  
3           amount imposed by this section shall be treated  
4           as if it were a tax imposed by section 1.

5           “(B) NOT TREATED AS TAX FOR CERTAIN  
6           PURPOSES.—The recapture amount imposed by  
7           this section shall not be treated as a tax im-  
8           posed by this chapter for purposes of determin-  
9           ing—

10                   “(i) the amount of any credit allow-  
11                   able under this chapter, or

12                   “(ii) the amount of the minimum tax  
13                   under section 55.

14           “(C) TREATED AS PAYMENT FOR MEDICAL  
15           INSURANCE.—The recapture amount imposed  
16           by this section shall be treated as an amount  
17           paid for insurance covering medical care, within  
18           the meaning of section 213(d).

19           “(5) TAXES IMPOSED BY POSSESSIONS.—The  
20           tax imposed by this section shall not apply to a bona  
21           fide resident of a possession with respect to which  
22           the requirements of section 21026 of the Social Se-  
23           curity Act are met.”

24           (b) TRANSFERS TO FEDERAL SUPPLEMENTARY  
25           MEDICAL INSURANCE TRUST FUND.—

1           (1) IN GENERAL.—There are hereby appro-  
2           priated to the Federal Supplementary Medical Insur-  
3           ance Trust Fund amounts equivalent to the aggre-  
4           gate increase in liabilities under chapter 1 of the In-  
5           ternal Revenue Code of 1986 which is attributable  
6           to the application of section 59B(a) of such Code, as  
7           added by this section.

8           (2) TRANSFERS.—The amounts appropriated  
9           by paragraph (1) to the Federal Supplementary  
10          Medical Insurance Trust Fund shall be transferred  
11          from time to time (but not less frequently than  
12          quarterly) from the general fund of the Treasury on  
13          the basis of estimates made by the Secretary of the  
14          Treasury of the amounts referred to in paragraph  
15          (1). Any quarterly payment shall be made on the  
16          first day of such quarter and shall take into account  
17          the recapture amounts referred to in such section  
18          59B(a) for such quarter. Proper adjustments shall  
19          be made in the amounts subsequently transferred to  
20          the extent prior estimates were in excess of or less  
21          than the amounts required to be transferred.

22          (c) REPORTING REQUIREMENTS.—

23                 (1) Paragraph (1) of section 6050F(a) (relating  
24                 to returns relating to social security benefits) is  
25                 amended by striking “and” at the end of subpara-

1 graph (B) and by inserting after subparagraph (C)  
2 the following new subparagraph:

3 “(D) the number of months during the cal-  
4 endar year for which a premium was paid under  
5 part B of title XVIII of the Social Security Act  
6 for the coverage of such individual under such  
7 part, and”.

8 (2) Paragraph (2) of section 6050F(b) is  
9 amended to read as follows:

10 “(2) the information required to be shown on  
11 such return with respect to such individual.”

12 (3) Subparagraph (A) of section 6050F(c)(1) is  
13 amended by inserting before the comma “and in the  
14 case of the information specified in subsection  
15 (a)(1)(D)”.

16 (4) The heading for section 6050F is amended  
17 by inserting “**AND MEDICARE PART B COV-**  
18 **ERAGE**” before the period.

19 (5) The item relating to section 6050F in the  
20 table of sections for subpart B of part III of sub-  
21 chapter A of chapter 61 is amended by inserting  
22 “and Medicare part B coverage” before the period.

23 (d) WAIVER OF CERTAIN ESTIMATED TAX PEN-  
24 ALTIES.—No addition to tax shall be imposed under sec-  
25 tion 6654 of the Internal Revenue Code of 1986 (relating

1 to failure to pay estimated income tax) for any period be-  
 2 fore April 16, 1997, with respect to any underpayment  
 3 to the extent that such underpayment resulted from sec-  
 4 tion 59B(a) of the Internal Revenue Code of 1986, as  
 5 added by this section.

6 (e) CLERICAL AMENDMENT.—The table of parts for  
 7 subchapter A of chapter 1 is amended by adding at the  
 8 end thereof the following new item:

“Part VIII. Certain health care subsidies received by high-income  
 individuals.”

9 (f) EFFECTIVE DATE.—The amendments made by  
 10 this section shall apply to taxable years beginning after  
 11 December 31, 1995.

#### 12 **PART IV—OTHER PROVISIONS**

#### 13 **SEC. 715. INCREASE IN TAX ON CERTAIN HOLLOW POINT** 14 **AND LARGE CALIBER HANDGUN AMMUNI-** 15 **TION.**

16 (a) INCREASE IN MANUFACTURERS TAX.—

17 (1) IN GENERAL.—Section 4181 (relating to  
 18 imposition of tax on firearms) is amended—

19 (A) by striking “Shells, and cartridges”  
 20 and inserting “Shells and cartridges not taxable  
 21 at 10,000 percent”, and

22 (B) by adding at the end the following:

23 “ARTICLES TAXABLE AT 10,000 PERCENT.—

1           “Any jacketed, hollow point projectile  
2           which may be used in a handgun and the jacket  
3           of which is designed to produce, upon impact,  
4           sharp-tipped, barb-like projections that extend  
5           beyond the diameter of the unfired projectile.

6           “Any cartridge with a projectile measuring  
7           .500 inch or greater in diameter which may be  
8           used in a handgun.”

9           (2) ADDITIONAL TAXES ADDED TO THE GEN-  
10          ERAL FUND.—Section 3(a) of the Act of September  
11          2, 1937 (16 U.S.C. 669b(a)), commonly referred to  
12          as the “Pittman-Robertson Wildlife Restoration  
13          Act”, is amended by adding at the end the following  
14          new sentence: “There shall not be covered into the  
15          fund the portion of the tax imposed by such section  
16          4181 that is attributable to any increase in amounts  
17          received in the Treasury under such section by rea-  
18          son of the amendments made by section 715(a)(1) of  
19          the Health Security Act, as estimated by the Sec-  
20          retary.”

21          (b) EFFECTIVE DATES.—

22                (1) IN GENERAL.—The amendments made by  
23                this section shall apply to sales after December 31,  
24                1994.

25                (2) FLOOR STOCKS TAX.—

1 (A) IN GENERAL.—In the case of any arti-  
2 cle held on January 1, 1995, which is taxable  
3 under section 4181 of the Internal Revenue  
4 Code of 1986 on and after such date at a tax  
5 rate of 10,000 percent, there is hereby imposed  
6 a tax equal to the excess of—

7 (i) the tax which would be imposed  
8 under section 4181 of such Code if the ar-  
9 ticle were sold on such date, over

10 (ii) the prior tax (if any) imposed  
11 under such section on such article.

12 (B) CREDIT.—Each person shall be al-  
13 lowed as a credit against the taxes imposed by  
14 subparagraph (A) an amount equal to the taxes  
15 imposed on articles which such person destroys  
16 (in such manner as the Secretary may pre-  
17 scribe) after December 31, 1994, and before  
18 April 1, 1995.

19 (C) PAYMENT.—The taxes imposed by sub-  
20 paragraph (A) on any article shall be paid by  
21 the person holding the article on January 1,  
22 1995. Such taxes shall be paid before April 1,  
23 1995, in such manner as the Secretary of the  
24 Treasury may prescribe.

1 (D) ARTICLES IN FOREIGN TRADE  
2 ZONES.—Notwithstanding the Act of June 18,  
3 1934 (48 Stat. 998, 19 U.S.C. 81a) and any  
4 other provision of law, any article which is lo-  
5 cated in a foreign trade zone on January 1,  
6 1995, shall be subject to the tax imposed by  
7 subparagraph (A) if—

8 (i) internal revenue taxes have been  
9 determined, or customs duties liquidated,  
10 with respect to such article before such  
11 date pursuant to a request made under the  
12 1st proviso of section 3(a) of such Act, or

13 (ii) such article is held on such date  
14 under the supervision of a customs officer  
15 pursuant to the 2d proviso of such section  
16 3(a).

17 (E) CONTROLLED GROUPS.—Rules similar  
18 to the rules of section 5061(e)(3) of such Code  
19 shall apply for purposes of this paragraph.

20 (F) OTHER LAWS APPLICABLE.—All provi-  
21 sions of law, including penalties, applicable with  
22 respect to the taxes imposed by section 4181 of  
23 such Code shall, insofar as applicable and not  
24 inconsistent with the provisions of this sub-  
25 section, apply to the floor stocks taxes imposed

1 by subparagraph (A), to the same extent as if  
2 such taxes were imposed by such section 4181.  
3 The Secretary may treat any person who bore  
4 the ultimate burden of the tax imposed by sub-  
5 paragraph (A) as the person to whom a credit  
6 or refund under such provisions may be allowed  
7 or made.

8 **SEC. 716. MODIFICATION TO SELF-EMPLOYMENT TAX**  
9 **TREATMENT OF CERTAIN S CORPORATION**  
10 **SHAREHOLDERS AND PARTNERS.**

11 (a) TREATMENT OF CERTAIN S CORPORATION  
12 SHAREHOLDERS.—

13 (1) AMENDMENT TO INTERNAL REVENUE  
14 CODE.—Section 1402 (relating to definitions) is  
15 amended by adding at the end the following new  
16 subsection:

17 “(k) TREATMENT OF CERTAIN S CORPORATION  
18 SHAREHOLDERS.—

19 “(1) IN GENERAL.—In the case of any individ-  
20 ual—

21 “(A) who is a 2-percent shareholder (as  
22 defined in section 1372(b)) of an S corporation  
23 for any taxable year of such corporation, and

1           “(B) who provides significant services to or  
2           on behalf of such S corporation during such  
3           taxable year,  
4           such shareholder’s net earnings from self-employ-  
5           ment shall include 80 percent of such shareholder’s  
6           pro rata share (as determined under section  
7           1366(a)) of the taxable income or loss of such cor-  
8           poration for such taxable year from service-related  
9           businesses carried on by such corporation, and to  
10          the extent provided in regulations, for any other tax-  
11          able year to the extent attributable to such services.

12           “(2) CERTAIN EXCEPTIONS TO APPLY.—In de-  
13          termining the amount to be taken into account  
14          under paragraph (1), the exceptions provided in sub-  
15          section (a) shall apply, except that, in the case of  
16          the exceptions provided in subsection (a)(5), rules  
17          similar to the rules of subparagraph (B) thereof  
18          shall apply to shareholders in S corporations.

19           “(3) SERVICE-RELATED BUSINESS.—For pur-  
20          poses of this subsection, the term ‘service-related  
21          business’ means—

22           “(A) any trade or business involving the  
23           performance of services in the fields of health  
24           (other than with respect to inpatient personal  
25           care facilities), law, engineering, architecture,

1 accounting, actuarial services, performing arts,  
2 consulting, athletics, or financial services (other  
3 than lending or brokerage services), or

4 “(B) any other trade or business with re-  
5 spect to which the Secretary determines that  
6 capital is an insignificant income-producing fac-  
7 tor.

8 “(4) APPLICATION OF DEFERRED COMPENSA-  
9 TION RULES.—For purposes of subchapter D of  
10 chapter 1 (and any other provision of this title relat-  
11 ing thereto), in the case of an individual who is  
12 treated as having net earnings from self-employment  
13 by reason of paragraph (1)—

14 “(A) such individual shall not be treated as  
15 a self-employed individual (within the meaning  
16 of section 401(c)(1)) with respect to services  
17 performed for the S corporation, and

18 “(B) such net earnings shall be treated as  
19 compensation received by the individual as an  
20 employee of the S corporation.”

21 (2) AMENDMENT TO SOCIAL SECURITY ACT.—  
22 Section 211 of the Social Security Act is amended  
23 by adding at the end the following new subsection:

24 “Treatment of Certain S Corporation Shareholders

25 “(k)(1) In the case of any individual—

1           “(A) who is a 2-percent shareholder (as defined  
2           in section 1372(b) of the Internal Revenue Code of  
3           1986) of an S corporation for any taxable year of  
4           such corporation, and

5           “(B) who provides significant services to or on  
6           behalf of such S corporation during such taxable  
7           year,

8           such shareholder’s net earnings from self-employment  
9           shall include 80 percent of such shareholder’s pro rata  
10          share (as determined under section 1366(a) of such Code)  
11          of the taxable income or loss of such corporation for such  
12          taxable year from service-related businesses (as defined in  
13          section 1402(k)(3) of such Code) carried on by such cor-  
14          poration, and to the extent provided in regulations, for any  
15          other taxable year to the extent attributable to such serv-  
16          ices.

17          “(2) In determining the amount to be taken into ac-  
18          count under paragraph (1), the exceptions provided in  
19          subsection (a) shall apply, except that, in the case of the  
20          exceptions provided in subsection (a)(5), rules similar to  
21          the rules of subparagraph (B) thereof shall apply to share-  
22          holders in S corporations.”

23          (b) TREATMENT OF CERTAIN LIMITED PARTNERS.—

1           (1) AMENDMENT OF THE INTERNAL REVENUE  
2 CODE.—Paragraph (13) of section 1402(a) is  
3 amended to read as follows:

4           “(13) there shall be excluded the distributive  
5 share of any item of income or loss of a limited part-  
6 ner, as such, other than—

7           “(A) guaranteed payments described in  
8 section 707(c) to that partner for services actu-  
9 ally rendered to or on behalf of the partnership  
10 to the extent that those payments are estab-  
11 lished to be in the nature of remuneration for  
12 those services, or

13           “(B) in the case of a limited partner who  
14 provides significant services to or on behalf of  
15 the partnership for any taxable year of the  
16 partnership, 80 percent of the limited partner’s  
17 distributive share (determined without regard to  
18 payments described in subparagraph (A)) of the  
19 taxable income or loss of such partnership—

20           “(i) for such taxable year from serv-  
21 ice-related businesses (as defined in sub-  
22 section (k)(3)) of such partnership, and

23           “(ii) to the extent provided in regula-  
24 tions, for any other taxable year to the ex-  
25 tent attributable to such services;”.

1           (2) AMENDMENT OF THE SOCIAL SECURITY  
2 ACT.—Paragraph (12) of section 211(a) of the So-  
3 cial Security Act is amended to read as follows:

4           “(12) there shall be excluded the distributive  
5 share of any item of income or loss of a limited part-  
6 ner, as such, other than—

7           “(A) guaranteed payments described in  
8 section 707(c) of the Internal Revenue Code of  
9 1986 to that partner for services actually ren-  
10 dered to or on behalf of the partnership to the  
11 extent that those payments are established to  
12 be in the nature of remuneration for those serv-  
13 ices, or

14           “(B) in the case of a limited partner who  
15 provides significant services to or on behalf of  
16 the partnership for any taxable year of the  
17 partnership, 80 percent of the limited partner’s  
18 distributive share (determined without regard to  
19 payments described in subparagraph (A)) of the  
20 taxable income or loss of such partnership—

21           “(i) for such taxable year from serv-  
22 ice-related businesses (as defined in section  
23 1402(k)(3) of such Code) of such partner-  
24 ship, and

1           “(ii) to the extent provided in regula-  
2           tions prescribed by the Secretary of the  
3           Treasury, for any other taxable year to the  
4           extent attributable to such services;”.

5           (c) INVENTORY INCOME.—Section 1402 (relating to  
6 definitions), as amended by subsection (a), is amended by  
7 adding at the end the following new subsection:

8           “(l) INVENTORY INCOME.—

9           “(1) IN GENERAL.—The net earnings from self-  
10 employment of any taxpayer for any taxable year  
11 under subsection (a) (determined without regard to  
12 this subsection) shall be reduced by 40 percent of  
13 the lesser of—

14           “(A) the taxpayer’s allocable share of net  
15 inventory income, or

16           “(B) the amount of such net earnings in  
17 excess of the applicable amount for the taxable  
18 year.

19           “(2) NET INVENTORY INCOME.—

20           “(A) IN GENERAL.—For purposes of para-  
21 graph (1), the term ‘net inventory income’  
22 means net income from the sale of property de-  
23 scribed in section 1221(1).

24           “(B) DEALERS IN SECURITIES.—For pur-  
25 poses of subparagraph (A)—

1           “(i) any security described in section  
2           475(c)(2) (without regard to the last sen-  
3           tence thereof) which is held by a person as  
4           a dealer in securities (as defined in section  
5           475(c)(1)) shall be treated as property de-  
6           scribed in section 1221(1), and

7           “(ii) net income from any such secu-  
8           rity shall be taken into account to the ex-  
9           tent otherwise taken into account in com-  
10          puting net earnings from self-employment.

11          “(3) APPLICABLE AMOUNT.—For purposes of  
12          paragraph (1), the term ‘applicable amount’ means  
13          the excess of—

14               “(A) \$135,000, adjusted, in the case of  
15               any taxable year beginning in any calendar year  
16               after 1996, in the same manner as is used in  
17               adjusting the contribution and benefit base for  
18               the calendar year under section 230(b) of the  
19               Social Security Act, over

20               “(B) the amount of wages paid to the indi-  
21               vidual during the taxable year.”

22          “(d) EFFECTIVE DATE.—The amendments made by  
23          this section shall apply to taxable years of individuals be-  
24          ginning after December 31, 1995, and to taxable years

1 of S corporations and partnerships ending with or within  
2 such taxable years of individuals.

3 **SEC. 717. EXTENDING MEDICARE COVERAGE OF, AND AP-**  
4 **PLICATION OF HOSPITAL INSURANCE TAX**  
5 **TO, ALL STATE AND LOCAL GOVERNMENT**  
6 **EMPLOYEES.**

7 (a) IN GENERAL.—

8 (1) APPLICATION OF HOSPITAL INSURANCE  
9 TAX.—Section 3121(u)(2) is amended by striking  
10 subparagraphs (C) and (D).

11 (2) COVERAGE UNDER MEDICARE.—Section  
12 210(p) of the Social Security Act (42 U.S.C. 410(p))  
13 is amended by striking paragraphs (3) and (4).

14 (3) EFFECTIVE DATE.—The amendments made  
15 by this subsection shall apply to services performed  
16 after September 30, 1995.

17 (b) TRANSITION IN BENEFITS FOR STATE AND  
18 LOCAL GOVERNMENT EMPLOYEES AND FORMER EM-  
19 PLOYEES.—

20 (1) IN GENERAL.—

21 (A) EMPLOYEES NEWLY SUBJECT TO  
22 TAX.—For purposes of sections 226, 226A, and  
23 1811 of the Social Security Act, in the case of  
24 any individual who performs services during the  
25 calendar quarter beginning October 1, 1995,

1 the wages for which are subject to the tax im-  
2 posed by section 3101(b) of the Internal Reve-  
3 nue Code of 1986 only because of the amend-  
4 ment made by subsection (a), the individual's  
5 medicare qualified State or local government  
6 employment (as defined in subparagraph (B))  
7 performed before October 1, 1995, shall be con-  
8 sidered to be "employment" (as defined for pur-  
9 poses of title II of such Act), but only for pur-  
10 poses of providing the individual (or another  
11 person) with entitlement to hospital insurance  
12 benefits under part A of title XVIII of such Act  
13 for months beginning with October 1995.

14 (B) MEDICARE QUALIFIED STATE OR  
15 LOCAL GOVERNMENT EMPLOYMENT DE-  
16 FINED.—In this paragraph, the term "medicare  
17 qualified State or local government employ-  
18 ment" means medicare qualified government  
19 employment described in section 210(p)(1)(B)  
20 of the Social Security Act (determined without  
21 regard to section 210(p)(3) of such Act, as in  
22 effect before its repeal under subsection (a)(2)).

23 (2) AUTHORIZATION OF APPROPRIATIONS.—  
24 There are authorized to be appropriated to the Fed-  
25 eral Hospital Insurance Trust Fund from time to

1 time such sums as the Secretary of Health and  
2 Human Services deems necessary for any fiscal year  
3 on account of—

4 (A) payments made or to be made during  
5 such fiscal year from such Trust Fund with re-  
6 spect to individuals who are entitled to benefits  
7 under title XVIII of the Social Security Act  
8 solely by reason of paragraph (1),

9 (B) the additional administrative expenses  
10 resulting or expected to result therefrom, and

11 (C) any loss in interest to such Trust  
12 Fund resulting from the payment of those  
13 amounts, in order to place such Trust Fund in  
14 the same position at the end of such fiscal year  
15 as it would have been in if this subsection had  
16 not been enacted.

17 (3) INFORMATION TO INDIVIDUALS WHO ARE  
18 PROSPECTIVE MEDICARE BENEFICIARIES BASED ON  
19 STATE AND LOCAL GOVERNMENT EMPLOYMENT.—  
20 Section 226(g) of the Social Security Act (42 U.S.C.  
21 426(g)) is amended—

22 (A) by redesignating paragraphs (1)  
23 through (3) as subparagraphs (A) through (C),  
24 respectively,

25 (B) by inserting “(1)” after “(g)”, and

1 (C) by adding at the end the following new  
2 paragraph:

3 “(2) The Secretary, in consultation with State  
4 and local governments, shall provide procedures de-  
5 signed to assure that individuals who perform medi-  
6 care qualified government employment by virtue of  
7 service described in section 210(a)(7) are fully in-  
8 formed with respect to (A) their eligibility or poten-  
9 tial eligibility for hospital insurance benefits (based  
10 on such employment) under part A of title XVIII,  
11 (B) the requirements for, and conditions of, such eli-  
12 gibility, and (C) the necessity of timely application  
13 as a condition of becoming entitled under subsection  
14 (b)(2)(C), giving particular attention to individuals  
15 who apply for an annuity or retirement benefit and  
16 whose eligibility for such annuity or retirement bene-  
17 fit is based on a disability.”

18 (c) TECHNICAL AMENDMENTS.—

19 (1) Subparagraph (A) of section 3121(u)(2) is  
20 amended by striking “subparagraphs (B) and (C),”  
21 and inserting “subparagraph (B),”.

22 (2) Subparagraph (B) of section 210(p)(1) of  
23 the Social Security Act (42 U.S.C. 410(p)(1)) is  
24 amended by striking “paragraphs (2) and (3).” and  
25 inserting “paragraph (2).”

1 (3) Section 218 of the Social Security Act (42  
2 U.S.C. 418) is amended by striking subsection (n).

3 (4) The amendments made by this subsection  
4 shall apply after September 30, 1995.

5 **Subtitle B—Tax Treatment of**  
6 **Employer-Provided Health Care**

7 **SEC. 721. TAX TREATMENT OF VOLUNTARY EMPLOYER**  
8 **HEALTH CARE CONTRIBUTIONS.**

9 (a) IN GENERAL.—Chapter 37 (relating to health-re-  
10 lated taxes), as added by section 705, is amended by add-  
11 ing at the end the following new subchapter:

12 **“Subchapter B—Voluntary Employer-**  
13 **Provided Health Benefits**

“Sec. 4521. Taxable employer-provided health benefits.

“Sec. 4522. Discriminatory employer practices.

“Sec. 4523. Exceptions.

“Sec. 4524. Definitions and special rules.

14 **“SEC. 4521. TAXABLE EMPLOYER-PROVIDED HEALTH BENE-**  
15 **FITS.**

16 “(a) IMPOSITION OF TAX.—There is hereby imposed  
17 a tax equal to the product of—

18 “(1) the sum of—

19 “(A) the taxable employer contributions for  
20 any taxable year, plus

21 “(B) the aggregate employer contributions  
22 for permitted coverage described in subpara-  
23 graph (A) or (B) of subsection (b)(2) during

1 any portion of the taxable year during which  
2 there is discriminatory permitted coverage, and

3 “(2) the highest rate of tax imposed under sec-  
4 tion 11(b) for the taxable year.

5 “(b) TAXABLE EMPLOYER CONTRIBUTION.—For  
6 purposes of this section—

7 “(1) IN GENERAL.—The term ‘taxable employer  
8 contribution’ means any employer contribution under  
9 an accident or health plan for coverage of an em-  
10 ployee other than permitted coverage.

11 “(2) PERMITTED COVERAGE.—For purposes of  
12 this subsection, the term ‘permitted coverage’  
13 means—

14 “(A) coverage under a certified standard  
15 health plan (as defined in section 21011(a)(2)  
16 of the Social Security Act),

17 “(B) coverage under a certified supple-  
18 mental health benefit plan (as defined in section  
19 21011(a)(4) of the Social Security Act), except  
20 that this subparagraph shall not apply to cov-  
21 erage of any employee who is covered under  
22 such a certified standard health plan which pro-  
23 vides the alternative standard benefits package  
24 described in subtitle C of such Act,

1           “(C) coverage under a qualified long-term  
2 care insurance policy (as defined in section  
3 7702B(b)),

4           “(D) coverage providing wages or pay-  
5 ments in lieu of wages for any period during  
6 which the employee is absent from work on ac-  
7 count of sickness or injury,

8           “(E) coverage only for accidental death or  
9 dismemberment,

10           “(F) coverage under a medicare supple-  
11 mental policy (as defined in section 1882(g)(1)  
12 of the Social Security Act),

13           “(G) worker’s compensation or similar in-  
14 surance, and

15           “(H) coverage under an equivalent health  
16 care program (as defined in section 21100(6) of  
17 the Social Security Act).

18           “(c) DISCRIMINATORY PERMITTED COVERAGE.—For  
19 purposes of this section, the term ‘discriminatory per-  
20 mitted coverage’ means, with respect to any period, cov-  
21 erage—

22           “(1) which is permitted coverage described in  
23 subparagraph (A) or (B) of subsection (b)(2), and

1           “(2) with respect to which the requirements of  
2           subsection (a) or (b) of section 4522 are not met  
3           during such period.

4   **“SEC. 4522. DISCRIMINATORY EMPLOYER PRACTICES.**

5           “(a) HEALTH STATUS REQUIREMENTS.—For pur-  
6           poses of section 4521(c), an employer meets the require-  
7           ments of this subsection if, with respect to coverage de-  
8           scribed in such section—

9           “(1) there is no waiting period or denial of cov-  
10          erage with respect to an employee, and

11          “(2) the amount of the employer contribution  
12          on behalf of an employee is not conditioned, and  
13          does not vary,

14          by reason of the employee’s health status, claims experi-  
15          ence, medical history, receipt of health care, or lack of evi-  
16          dence of insurability.

17          “(b) UNIFORM CONTRIBUTION REQUIREMENTS.—

18          “(1) IN GENERAL.—For purposes of section  
19          4521(c), an employer meets the requirements of this  
20          subsection if the employer contribution on behalf of  
21          an employee for coverage described in such section  
22          is equivalent to each employer contribution on behalf  
23          of all other employees who elect such coverage under  
24          plans offered by the employer.

1           “(2) EQUIVALENT CONTRIBUTION.—For pur-  
2           poses of paragraph (1), a contribution is equivalent  
3           to any other contribution if—

4                   “(A) it is the same dollar amount as the  
5                   other contribution,

6                   “(B) it represents the same percentage of  
7                   cost under the plan to which it is made as does  
8                   the other contribution, or

9                   “(C) it represents the same percentage of  
10                  the weighted average premium for the class of  
11                  enrollment (as defined in section 1952 of the  
12                  Social Security Act) for the community rating  
13                  area in which the employee works as does the  
14                  other contribution.

15           For purposes of applying subparagraph (B) or (C),  
16           any dollar limitation applicable to all employer con-  
17           tributions (whether expressed as a dollar amount or  
18           a percentage described in subparagraph (C)) shall be  
19           disregarded.

20           “(3) EXCLUDED EMPLOYEES.—

21                   “(A) IN GENERAL.—The following employ-  
22                   ees of an employer shall be excluded from con-  
23                   sideration under this subsection:

1           “(i) Any employee before the employee  
2 has completed 6 months of service with the  
3 employer.

4           “(ii) Any employee who normally  
5 works less than 24 hours per week.

6           “(iii) Any employee who normally  
7 works during not more than 6 months of  
8 any year.

9           “(iv) Any employee who has not at-  
10 tained age 18.

11           “(v) Any employee who is included in  
12 a unit of employees covered by an agree-  
13 ment which the Secretary finds to be a col-  
14 lective bargaining agreement between em-  
15 ployee representatives and 1 or more em-  
16 ployers if there is evidence that employer-  
17 provided benefits for standard health bene-  
18 fits coverage was the subject of good faith  
19 bargaining between the employee rep-  
20 resentatives and employer or employers.

21           “(vi) Any employee who is a non-  
22 resident alien and who receives no earned  
23 income (within the meaning of section  
24 911(d)(2)) from the employer which con-  
25 stitutes income from sources within the

1 United States (within the meaning of sec-  
2 tion 861(a)(3)).

3 “(vii) Any former employee.

4 “(B) COVERAGE OF PART-TIME EMPLOY-  
5 EES.—

6 “(i) IN GENERAL.—If an employer  
7 makes an employer contribution for any  
8 period for coverage described in section  
9 4521(c) for any employee who normally  
10 works at least 10 hours but less than 24  
11 hours per week, subparagraph (A)(ii) shall  
12 be applied by substituting ‘10 hours’ for  
13 ‘24 hours’.

14 “(ii) REQUIREMENTS MAY BE MET  
15 SEPARATELY.—If an employer elects the  
16 application of this clause—

17 “(I) the requirements of this sub-  
18 section shall be applied separately to  
19 employees to whom this subsection ap-  
20 plies by reason of clause (i), and

21 “(II) such employees shall be ex-  
22 cluded in determining whether such  
23 requirements are met with respect to  
24 any other employees.

1           “(iii) PRO RATA CONTRIBUTIONS PER-  
2           MISSIBLE.—For purposes of this sub-  
3           section, contributions on behalf of any em-  
4           ployee to which this subsection applies by  
5           reason of clause (i) shall not fail to be  
6           treated as equivalent solely because they  
7           are proportionate to the number of hours  
8           the employee works.

9           “(4) AGGREGATION RULES.—For purposes of  
10          this subsection—

11           “(A) IN GENERAL.—All employers treated  
12           as a single employer under subsection (b) or (c)  
13           of section 414 shall be treated as a single em-  
14           ployer.

15           “(B) AFFILIATED SERVICE GROUPS.—All  
16           employees of members of an affiliated service  
17           group (as defined in section 414(m)) shall be  
18           treated as employed by a single employer.

19           “(5) SEPARATE LINES OF BUSINESS.—If, under  
20          section 414(r), an employer is treated as operating  
21          separate lines of business for a year, the employer  
22          may apply this subsection separately to employees in  
23          each separate line of business.

1 **“SEC. 4523. EXCEPTIONS.**

2 “(a) EXCEPTION FOR REASONABLE DILIGENCE.—No  
3 tax shall be imposed by this subchapter during any period  
4 for which it is established to the satisfaction of the Sec-  
5 retary that the employer did not know, or exercising rea-  
6 sonable diligence would not have known, that the employer  
7 had taken any action subject to tax under this subchapter.

8 “(b) CORRECTIONS WITHIN 30 DAYS.—No tax shall  
9 be imposed by this subchapter with respect to any action  
10 subject to tax under this subchapter if—

11 “(1) such action was due to reasonable cause  
12 and not to willful neglect, and

13 “(2) such action is corrected during the 30-day  
14 period beginning on the 1st date the employer knew,  
15 or exercising reasonable diligence would have known,  
16 that such action was subject to such tax.

17 “(c) WAIVER BY SECRETARY.—In the case of any ac-  
18 tion subject to tax under this subchapter which is due to  
19 reasonable cause and not to willful neglect, the Secretary  
20 may waive part or all of any tax imposed by this sub-  
21 chapter to the extent that the payment of such tax would  
22 be excessive relative to the failure involved.

23 **“SEC. 4524. DEFINITIONS AND SPECIAL RULES.**

24 “(a) DEFINITIONS.—For purposes of this sub-  
25 chapter—

26 “(1) EMPLOYER.—

1           “(A) IN GENERAL.—The term ‘employer’  
2 means any person or governmental entity for  
3 whom an individual performs services, of what-  
4 ever nature, as an employee (as defined in sec-  
5 tion 3401(c)).

6           “(B) SPECIAL RULES.—

7           “(i) A partnership shall be treated as  
8 the employer of each partner who is an  
9 employee within the meaning of section  
10 401(c)(1).

11           “(ii) An S corporation shall be treated  
12 as the employer of each shareholder who is  
13 an employee within the meaning of section  
14 401(c)(1).

15           “(2) EMPLOYER CONTRIBUTIONS.—

16           “(A) IN GENERAL.—The term ‘employer  
17 contribution’ means, with respect to coverage  
18 under a health plan, a reasonable estimate of  
19 the portion of the cost of the coverage which is  
20 to be provided by the employer.

21           “(B) SPECIAL RULE FOR CAFETERIA  
22 PLANS.—The cost of any coverage provided  
23 through a cafeteria plan shall be determined on  
24 the basis of the coverage available through the  
25 plan.

1       “(b) LIABILITY FOR TAX.—Any tax imposed by this  
2 subchapter shall be paid by the employer.

3       “(c) TAXES TO APPLY TO GOVERNMENTAL AND  
4 OTHER TAX-EXEMPT ENTITIES.—Notwithstanding any  
5 other provision of law or rule of law, none of the following  
6 shall be exempt from the taxes imposed by this sub-  
7 chapter:

8           “(1) The United States, any State or political  
9 subdivision thereof, the District of Columbia, and  
10 any agency or instrumentality of any of the fore-  
11 going.

12           “(2) Any other entity otherwise exempt from  
13 tax under chapter 1.

14       “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
15 standing any other provision of law, no amount collected  
16 under this subchapter shall be covered over to any posses-  
17 sion of the United States.

18       “(e) REGULATIONS.—The Secretary shall prescribe  
19 such regulations as are necessary to carry out the provi-  
20 sions of this subchapter, including regulations providing  
21 for the determination of the amount of any employer con-  
22 tribution, the aggregation of governmental and tax-exempt  
23 entities, and the prevention of the avoidance of any tax  
24 imposed by this subchapter through the use of any ar-  
25 rangement described in section 414(o).”

1 (b) EMPLOYEE LEASING.—Paragraph (3) of section  
 2 414(n) is amended by striking “and” at the end of sub-  
 3 paragraph (B), by striking the period at the end of sub-  
 4 paragraph (C) and inserting “, and”, and by adding at  
 5 the end the following new subparagraph:

6 “(D) subchapter B of chapter 37.”

7 (c) TAX NOT DEDUCTIBLE.—Paragraph (7) of sec-  
 8 tion 275(a), as added by section 706(b), is amended by  
 9 inserting “or 4521 (relating to taxable employer-provided  
 10 health benefits” after “plans)”.

11 (d) CONFORMING AMENDMENT.—The table of sub-  
 12 chapters for chapter 37 is amended by adding at the end  
 13 the following new item:

“SUBCHAPTER B. Voluntary employer-provided health benefits.”

14 (e) EFFECTIVE DATE.—The amendments made by  
 15 this section shall take effect on January 1, 1996.

16 **SEC. 722. ELIMINATION OF EXCLUSION OF HEALTH BENE-**  
 17 **FITS PROVIDED THROUGH A FLEXIBLE**  
 18 **SPENDING ARRANGEMENT.**

19 (a) IN GENERAL.—The text of section 106 (relating  
 20 to contributions by employer to accident and health plans)  
 21 is amended to read as follows:

22 “(a) GENERAL RULE.—Except as otherwise provided  
 23 in this section, gross income of an employee does not in-  
 24 clude employer-provided coverage under an accident or  
 25 health plan.

1       “(b) EXCEPTION FOR COVERAGE THROUGH FLEXI-  
2 BLE SPENDING ARRANGEMENTS.—

3           “(1) IN GENERAL.—Subsection (a) shall not  
4 apply to coverage provided through a flexible spend-  
5 ing or similar arrangement.

6           “(2) FLEXIBLE SPENDING ARRANGEMENT.—  
7 For purposes of this subsection, a flexible spending  
8 arrangement is a benefit program which provides  
9 employees with coverage under which—

10           “(A) specified incurred expenses may be  
11 reimbursed (subject to reimbursement maxi-  
12 mums and other reasonable conditions), and

13           “(B) the maximum amount of reimburse-  
14 ment which is reasonably available to a partici-  
15 pant for such coverage is less than 500 percent  
16 of the cost of such coverage.

17 In the case of an insured plan, the maximum  
18 amount reasonably available shall be determined on  
19 the basis of the underlying coverage.”

20 (b) EMPLOYMENT TAX TREATMENT.—

21       (1) SOCIAL SECURITY TAX.—

22           (A) Subsection (a) of section 3121 is  
23 amended by inserting after paragraph (21) the  
24 following new sentence:

1 “Nothing in paragraph (2) shall exclude from the term  
2 ‘wages’ any amount which is required to be included in  
3 gross income under section 106(b).”

4 (B) Subsection (a) of section 209 of the  
5 Social Security Act is amended by inserting  
6 after paragraph (21) the following new sen-  
7 tence:

8 “Nothing in paragraph (2) shall exclude from the term  
9 ‘wages’ any amount which is required to be included in  
10 gross income under section 106(b) of the Internal Revenue  
11 Code of 1986.”

12 (2) RAILROAD RETIREMENT TAX.—Paragraph  
13 (1) of section 3231(e) is amended by adding at the  
14 end thereof the following new sentence: “Nothing in  
15 clause (i) of the second sentence of this paragraph  
16 shall exclude from the term ‘compensation’ any  
17 amount which is required to be included in gross in-  
18 come under section 106(b).”

19 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
20 section 3306 is amended by inserting after para-  
21 graph (16) the following new sentence:

22 “Nothing in paragraph (2) shall exclude from the term  
23 ‘wages’ any amount which is required to be included in  
24 gross income under section 106(b).”

1           (4) WAGE WITHHOLDING.—Subsection (a) of  
2           section 3401 is amended by adding at the end there-  
3           of the following new sentence:

4           “Nothing in the preceding provisions of this subsection  
5           shall exclude from the term ‘wages’ any amount which is  
6           required to be included in gross income under section  
7           106(b).”

8           (c) EFFECTIVE DATE.—

9           (1) IN GENERAL.—The amendments made by  
10          this section shall take effect on January 1, 1996.

11          (2) BENEFITS PROVIDED PURSUANT TO COL-  
12          LECTIVE BARGAINING AGREEMENTS.—In the case of  
13          a flexible spending arrangement maintained pursu-  
14          ant to 1 or more collective bargaining agreements  
15          between employee representatives and 1 or more em-  
16          ployers which was ratified before June 30, 1994, the  
17          amendments referred to in paragraph (1) shall not  
18          apply to benefits pursuant to any such agreement  
19          before the later of—

20                 (A) January 1, 1996, or

21                 (B) the earlier of—

22                         (i) the date on which the last of such  
23                         agreements terminate (determined without  
24                         regard to any extension thereof on or after  
25                         June 30, 1994), or

1 (ii) January 1, 1998.

2 **SEC. 723. 2-YEAR EXTENSION OF DEDUCTION FOR HEALTH**  
3 **INSURANCE COSTS OF SELF-EMPLOYED INDI-**  
4 **VIDUALS.**

5 (a) IN GENERAL.—Paragraph (6) of section 162(l)  
6 (relating to special rules for health insurance costs of self-  
7 employed individuals) is amended by striking “1993” and  
8 inserting “1995”.

9 (b) EFFECTIVE DATE.—The amendment made by  
10 paragraph (1) shall apply to taxable years beginning after  
11 December 31, 1993.

12 **SEC. 724. LIMITATION ON PREPAYMENT OF MEDICAL IN-**  
13 **SURANCE PREMIUMS.**

14 (a) GENERAL RULE.—Subsection (d) of section 213  
15 is amended by adding at the end the following new para-  
16 graph:

17 “(10) LIMITATION ON PREPAYMENTS.—If the  
18 taxpayer pays a premium or other amount which  
19 constitutes medical care under paragraph (1), to the  
20 extent such premium or other amount is properly al-  
21 locable to insurance coverage or care to be provided  
22 during periods more than 12 months after the  
23 month in which such payment is made, such pre-  
24 mium shall be treated as paid ratably over the pe-  
25 riod during which such insurance coverage or care is

1 to be provided. The preceding sentence shall not  
2 apply to any premium to which paragraph (7) ap-  
3 plies.”

4 (b) EFFECTIVE DATE.—The amendment made by  
5 subsection (a) shall apply to amounts paid after December  
6 31, 1994.

7 **Subtitle C—Deduction for Individ-**  
8 **uals Purchasing Own Health In-**  
9 **surance**

10 **SEC. 731. DEDUCTION FOR HEALTH INSURANCE COSTS OF**  
11 **INDIVIDUALS.**

12 (a) IN GENERAL.—Section 213 (relating to deduction  
13 for medical, dental, etc. expenses) is amended by adding  
14 at the end the following new subsection:

15 “(f) STANDARD HEALTH INSURANCE COSTS OF IN-  
16 DIVIDUALS.—

17 “(1) IN GENERAL.—The adjusted gross income  
18 limitation under subsection (a) shall not apply to  
19 100 percent of the amounts paid by an eligible indi-  
20 vidual during the taxable year for qualified health  
21 care costs (and such amounts shall not be taken into  
22 account in determining whether such limitation ap-  
23 plies to other amounts).

24 “(2) QUALIFIED HEALTH CARE COSTS.—For  
25 purposes of this subsection—

1           “(A) IN GENERAL.—The term ‘qualified  
2 health care costs’ means expenses for coverage  
3 of the taxpayer, the taxpayer’s spouse, or any  
4 dependent under a certified standard health  
5 plan.

6           “(B) LIMITATIONS.—For purposes of sub-  
7 paragraph (A)—

8           “(i) NO DEDUCTION FOR EMPLOYER-  
9 SUBSIDIZED HEALTH COSTS.—Qualified  
10 health care costs shall not include any  
11 amount paid for coverage of an individual  
12 under a certified standard health plan for  
13 any month if the individual is eligible to  
14 participate for such month in an employer-  
15 subsidized certified standard health plan  
16 maintained by any employer of the tax-  
17 payer, the taxpayer’s spouse, or any de-  
18 pendent.

19           “(ii) CERTAIN PREPAYMENTS.—If any  
20 amount paid during a taxable year is allo-  
21 cable to coverage to be provided more than  
22 12 months after the month of payment,  
23 such amount shall be treated as paid rat-  
24 ably over the period of the coverage.

1           “(3) OTHER DEFINITIONS AND SPECIAL  
2 RULES.—For purposes of this subsection—

3           “(A) CERTIFIED STANDARD HEALTH  
4 PLAN.—The term ‘certified standard health  
5 plan’ has the meaning given such term by sec-  
6 tion 21011(a)(2) of the Social Security Act.

7           “(B) EMPLOYER.—The term ‘employer’  
8 has the meaning given such term by section  
9 4524(a)(1).

10           “(C) DEDUCTION NOT ALLOWED FOR  
11 SELF-EMPLOYMENT TAX PURPOSES.—The de-  
12 duction allowable by reason of this subsection  
13 shall not be taken into account in determining  
14 an individual’s net earnings from self-employ-  
15 ment (within the meaning of section 1402(a))  
16 for purposes of chapter 2.

17           “(4) REDUCTION IN PERCENTAGE.—For re-  
18 quirement that the President reduce the percentage  
19 under paragraph (1) to offset deficits in Federal  
20 health care spending, see section 801 of the Health  
21 Security Act.”

22           (b) DEDUCTION ALLOWED AGAINST GROSS IN-  
23 COME.—Section 62(a) (defining adjusted gross income) is  
24 amended by inserting after paragraph (15) the following  
25 new paragraph:

1           “(16) DEDUCTION FOR QUALIFIED HEALTH  
2           CARE COSTS.—The deduction allowed under section  
3           213(a) for amounts described in section 213(f).”

4           (c) EFFECTIVE DATE.—The amendments made by  
5           this section shall apply to taxable years beginning after  
6           December 31, 1995.

## 7           **Subtitle D—Exempt Organizations**

### 8           **PART I—HEALTH CARE ORGANIZATIONS**

#### 9           **SEC. 741. QUALIFICATION AND DISCLOSURE REQUIRE-** 10           **MENTS FOR NONPROFIT HEALTH CARE OR-** 11           **GANIZATIONS.**

12           (a) TREATMENT OF HOSPITALS AND OTHER ENTI-  
13           TIES PROVIDING HEALTH CARE SERVICES.—Section 501  
14           (relating to exemption from tax on corporations, certain  
15           trusts, etc.) is amended by redesignating subsection (n)  
16           as subsection (o) and by inserting after subsection (m) the  
17           following new subsection:

18           “(n) QUALIFICATION OF HEALTH CARE ORGANIZA-  
19           TIONS AS EXEMPT ORGANIZATIONS.—

20           “(1) IN GENERAL.—An organization which is  
21           described in paragraph (3) or (4) of subsection (c)  
22           and the predominant activity of which is the provi-  
23           sion of health care services shall be exempt from tax  
24           under subsection (a) only if—

1           “(A) such organization, with the participa-  
2           tion of community representatives, annually—

3                   “(i) assesses its community’s needs  
4                   for health care services and qualified out-  
5                   reach services, and

6                   “(ii) prepares a written plan to meet  
7                   those needs,

8           “(B) pursuant to such plan, such organiza-  
9           tion provides (directly or indirectly) significant  
10          qualified outreach services,

11          “(C) such organization does not discrimi-  
12          nate against individuals in the provision of  
13          health care services on the basis of participation  
14          in a government-sponsored health plan, and

15          “(D) such organization does not discrimi-  
16          nate against individuals in the provision of  
17          emergency health care services on the basis of  
18          ability to pay.

19          “(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance or-  
20          ganization shall not be treated as described in sub-  
21          section (c)(3) unless substantially all of its primary  
22          care health services are provided as described in sub-  
23          section (m)(6)(A).  
24

1           “(3) DEFINITIONS AND SPECIAL RULE.—For  
2 purposes of this subsection—

3           “(A) QUALIFIED OUTREACH SERVICES.—

4           The term ‘qualified outreach services’ means  
5 health care services (or preventive care, edu-  
6 cational, or social services programs related  
7 thereto) which are provided—

8           “(i) in 1 or more medically under-  
9 served areas,

10           “(ii) at below cost to individuals who  
11 are otherwise unable to afford such serv-  
12 ices, or

13           “(iii) at emergency care facilities  
14 which provide specialty services and which  
15 normally operate at a loss.

16           Such term shall not include insurance described  
17 in subparagraph (B)(iii) unless such insurance  
18 is provided on a subsidized basis.

19           “(B) HEALTH CARE SERVICES.—The term  
20 ‘health care services’ means—

21           “(i) any activity which consists of pro-  
22 viding medical care (as defined in section  
23 213(d)(1)(A)) to individuals,

24           “(ii) in the case of an organization de-  
25 scribed in subsection (c)(3), any activity

1           which is treated as accomplishing an ex-  
2           empt purpose of the organization solely be-  
3           cause it is carried on as part of an activity  
4           described in clause (i), and

5           “(iii) insurance (other than commer-  
6           cial-type insurance, as defined in sub-  
7           section (m)) for the activities described in  
8           clauses (i) and (ii).

9           “(C) MEDICALLY UNDERSERVED AREA.—

10          The term ‘medically underserved area’ means,  
11          with respect to a health care service, any area  
12          reasonably determined by the organization (in a  
13          manner not inconsistent with regulations pre-  
14          scribed by the Secretary) to have—

15               “(i) a shortage (relative to the num-  
16               ber of individuals needing such service) of  
17               health professionals performing such serv-  
18               ice, or

19               “(ii) a population group experiencing  
20               such a shortage.

21          Such term includes a health professional short-  
22          age area (as defined in section 332 of the Pub-  
23          lic Health Service Act).

24          “(4) EXCEPTIONS.—This subsection shall not  
25          apply to any organization which—

1           “(A) demonstrates, in a manner not incon-  
2           sistent with regulations prescribed by the Sec-  
3           retary, that one of its principal purposes is aca-  
4           demic training or medical research, or

5           “(B) provides health care services exclu-  
6           sively on an uncompensated basis, regardless of  
7           ability to pay.

8           “(5) DISALLOWANCE OF CHARITABLE DEDUC-  
9           TIONS.—No gift or bequest to an organization which  
10          is not exempt from tax by reason of this subsection  
11          shall be allowed as a deduction under section 170,  
12          545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or  
13          2522.

14          “(6) REQUIREMENTS SUPPLEMENT OTHER RE-  
15          QUIREMENTS.—The requirements of this subsection  
16          are in addition to, and not in lieu of, the require-  
17          ments otherwise applicable to an organization de-  
18          scribed in paragraph (3) or (4) of subsection (c).”

19          (b) REPORTING AND DISCLOSURE OF NEEDS AS-  
20          SESSMENT AND PLAN.—

21                 (1) REPORTING.—

22                         (A) ORGANIZATIONS DESCRIBED IN SEC-  
23                         TION 501(C)(3).—Subsection (b) of section 6033  
24                         (relating to certain organizations described in  
25                         section 501(c)(3)) is amended by striking

1 “and” at the end of paragraph (9), by redesignating paragraph (10) as paragraph (12), and  
2 by inserting after paragraph (9) the following  
3 new paragraphs:  
4

5 “(10) in the case of an organization which pre-  
6 pares a plan described in section 501(n)(1)(A) (re-  
7 lating to community needs)—

8 “(A) a copy of such plan for the year, and

9 “(B) information on the implementation of  
10 such plan for the year (including unrecovered  
11 costs and revenues foregone in furtherance of  
12 such plan),

13 “(11) such information as the Secretary may  
14 require with respect to any taxable inurement (as  
15 defined in section 4958(d)), and”.

16 (B) ORGANIZATIONS DESCRIBED IN SEC-  
17 TION 501(C)(4).—Section 6033 is amended by re-  
18 designating subsection (f) as subsection (g) and  
19 by inserting after subsection (e) the following  
20 new subsection:

21 “(f) CERTAIN ORGANIZATIONS DESCRIBED IN SEC-  
22 TION 501(c)(4).—Every organization described in section  
23 501(c)(4) which is subject to the requirements of sub-  
24 section (a) and which prepares a plan described in section

1 501(n)(1)(A) (relating to community needs) for the  
2 year—

3 “(1) shall include a copy of such plan with the  
4 return required under subsection (a) for the year,  
5 and

6 “(2) shall include on such return the informa-  
7 tion referred to in paragraphs (10)(B) and (11) of  
8 subsection (b) with respect to such organization.”

9 (2) DISCLOSURE.—

10 (A) IN GENERAL.—Subsection (e) of sec-  
11 tion 6104 (relating to public inspection of cer-  
12 tain annual returns and applications for exemp-  
13 tion) is amended by adding at the end the fol-  
14 lowing new paragraph:

15 “(3) COMMUNITY HEALTH CARE NEEDS AS-  
16 SESSMENT AND PLAN.—

17 “(A) IN GENERAL.—Every organization  
18 which is required to prepare a plan described in  
19 section 501(n)(1)(A) (relating to community  
20 needs)—

21 “(i) shall make a copy of such plan  
22 (and the assessment on which such plan is  
23 based) available for inspection during regu-  
24 lar business hours by any individual at the  
25 principal office of such organization and, if

1 such organization regularly maintains 1 or  
2 more regional or district offices having 3  
3 or more employees, at each such regional  
4 or district office, and

5 “(ii) upon request of an individual  
6 made at such principal office or such a re-  
7 gional or district office, shall provide—

8 “(I) a copy of such plan (and as-  
9 sessment), and

10 “(II) a copy of the annual return  
11 filed under section 6033,  
12 to such individual without charge other  
13 than a reasonable fee for any reproduction  
14 and mailing costs.

15 If the request under clause (ii) is made in per-  
16 son, such copies shall be provided immediately  
17 and, if made other than in person, shall be pro-  
18 vided within 30 days.

19 “(B) PERIOD OF AVAILABILITY.—Subpara-  
20 graph (A) shall apply—

21 “(i) with respect to any plan (and as-  
22 sessment) during the 3-year period after  
23 the close of the year for which such plan  
24 is prepared, and

1           “(ii) with respect to any return, dur-  
2           ing the 3-year period beginning on the fil-  
3           ing date (as defined in paragraph (1)(D)).

4           “(C) LIMITATION.—Subparagraph (A)(ii)  
5           shall not apply to any request if the Secretary  
6           determines, upon application by an organiza-  
7           tion, that such request is part of a harassment  
8           campaign and that compliance with such re-  
9           quest is not in the public interest.”

10           (B) TECHNICAL AMENDMENT.—The head-  
11           ing for subsection (e) of section 6104 is amend-  
12           ed by striking “AND APPLICATIONS FOR EX-  
13           EMPTION” and inserting “, APPLICATIONS FOR  
14           EXEMPTION, AND COMMUNITY NEEDS ASSESS-  
15           MENT AND PLAN FOR HEALTH AND OUTREACH  
16           SERVICES”.

17           (c) EFFECTIVE DATES.—

18           (1) IN GENERAL.—Except as provided in para-  
19           graph (2), the amendments made by this section  
20           shall take effect on January 1, 1995.

21           (2) HMO SERVICE REQUIREMENT.—So much of  
22           the amendments made by this section as relates to  
23           section 501(n)(2) of the Internal Revenue Code of  
24           1986, as added by this section, shall take effect on  
25           the date of the enactment of this Act.

1 **SEC. 742. EXCISE TAXES FOR PRIVATE INUREMENT BY TAX-**  
 2 **EXEMPT HEALTH CARE ORGANIZATIONS.**

3 (a) IN GENERAL.—Chapter 42 (relating to private  
 4 foundations and certain other tax-exempt organizations)  
 5 is amended by redesignating subchapter D as subchapter  
 6 E and by inserting after subchapter C the following new  
 7 subchapter:

8 **“Subchapter D—Private Inurement by Tax-**  
 9 **Exempt Health Care Organizations**

“Sec. 4958. Taxes on private inurement.

“Sec. 4959. Other definitions.

10 **“SEC. 4958. TAXES ON PRIVATE INUREMENT.**

11 “(a) INITIAL TAXES.—

12 “(1) ON THE BENEFICIARY.—There is hereby  
 13 imposed on any taxable inurement a tax equal to 25  
 14 percent of the amount thereof. The tax imposed by  
 15 this paragraph shall be paid by any beneficiary of  
 16 such inurement.

17 “(2) ON THE MANAGEMENT.—In any case in  
 18 which there is a tax imposed by paragraph (1), there  
 19 is hereby imposed on the participation of any organi-  
 20 zation manager of an organization in any taxable  
 21 inurement which occurs with respect to such organi-  
 22 zation, knowing that it is taxable inurement, a tax  
 23 equal to 2½ percent of the amount thereof, unless  
 24 such participation is not willful and is due to reason-

1       able cause. The tax imposed by this paragraph shall  
2       be paid by any organization manager who partici-  
3       pated in the taxable inurement.

4       “(b) ADDITIONAL TAXES.—

5           “(1) ON THE BENEFICIARY.—In any case in  
6       which an initial tax is imposed by subsection (a)(1)  
7       on any taxable inurement and such inurement is not  
8       corrected within the taxable period, there is hereby  
9       imposed a tax equal to 200 percent of the amount  
10      of the taxable inurement. The tax imposed by this  
11      paragraph shall be paid by any beneficiary of such  
12      inurement.

13          “(2) ON THE MANAGEMENT.—In any case in  
14      which an additional tax is imposed by paragraph (1),  
15      if an organization manager refused to agree to part  
16      or all of the correction, there is hereby imposed a  
17      tax equal to 50 percent of the amount of the taxable  
18      inurement. The tax imposed by this paragraph shall  
19      be paid by any organization manager who refused to  
20      agree to part or all of the correction.

21          “(c) SPECIAL RULES RELATING TO LIABILITY FOR  
22      TAX.—For purposes of this section—

23           “(1) JOINT AND SEVERAL LIABILITY.—If more  
24      than one person is liable under any paragraph of  
25      subsection (a) or (b) with respect to any one taxable

1 inurement, all such persons shall be jointly and sev-  
2 erally liable under such paragraph with respect to  
3 such inurement.

4 “(2) LIMIT FOR MANAGEMENT.—With respect  
5 to any 1 taxable inurement, the maximum amount  
6 of the tax imposed by subsection (a)(2) shall not ex-  
7 ceed \$10,000, and the maximum amount of the tax  
8 imposed by subsection (b)(2) shall not exceed  
9 \$10,000.

10 “(d) TAXABLE INUREMENT.—For purposes of this  
11 section, the term ‘taxable inurement’ means any  
12 inurement not permitted under paragraph (3) or (4) of  
13 section 501(c), as the case may be, in a transaction involv-  
14 ing an applicable tax-exempt health care organization in  
15 which—

16 “(1) the value of any economic benefit provided  
17 to or for the use of a disqualified person exceeds the  
18 value of the consideration (including the perform-  
19 ance of services) received by the organization for  
20 providing such benefit, or

21 “(2) the amount of any economic benefit pro-  
22 vided to or for the use of a disqualified person is de-  
23 termined in whole or in part by the gross or net rev-  
24 enues of 1 or more activities of the organization.

1 The amount of any taxable inurement with respect to any  
2 such transaction shall be the excess described in para-  
3 graph (1) or the amount described in paragraph (2). For  
4 purposes of paragraph (1), an economic benefit shall not  
5 be treated as provided as consideration for the perform-  
6 ance of services unless the organization clearly indicated  
7 its intent to so treat such benefit.

8 “(e) OTHER DEFINITIONS.—For purposes of this  
9 section—

10 “(1) DISQUALIFIED PERSON.—The term ‘dis-  
11 qualified person’ means, with respect to any trans-  
12 action—

13 “(A) any person who was, at any time dur-  
14 ing the 5-year period ending on the date of  
15 such transaction—

16 “(i) an organization manager, or

17 “(ii) an individual (other than an or-  
18 ganization manager)—

19 “(I) in a position to exercise sub-  
20 stantial influence over the affairs of  
21 the organization, or

22 “(II) performing substantial  
23 medical services as a physician pursu-  
24 ant to an employment or other con-

1                   tractual relationship with the organi-  
2                   zation or a related organization,

3                   “(B) a member of the family of an individ-  
4                   ual described in subparagraph (A), and

5                   “(C) a 35-percent controlled entity.

6                   “(2) ORGANIZATION MANAGER.—The term ‘or-  
7                   ganization manager’ means, with respect to any ap-  
8                   plicable tax-exempt health care organization, any of-  
9                   ficer, director, or trustee of such organization (or  
10                  any individual having powers or responsibilities simi-  
11                  lar to those of officers, directors, or trustees of the  
12                  organization).

13                  “(3) 35-PERCENT CONTROLLED ENTITY.—

14                  “(A) IN GENERAL.—The term ‘35-percent  
15                  controlled entity’ means—

16                         “(i) a corporation in which persons  
17                         described in subparagraph (A) or (B) of  
18                         paragraph (1) own more than 35 percent  
19                         of the total combined voting power,

20                         “(ii) a partnership in which such per-  
21                         sons own more than 35 percent of the  
22                         profits interest, and

23                         “(iii) a trust or estate in which such  
24                         persons own more than 35 percent of the  
25                         beneficial interest.

1           “(B) CONSTRUCTIVE OWNERSHIP  
2 RULES.—Rules similar to the rules of para-  
3 graphs (3) and (4) of section 4946(a) shall  
4 apply for purposes of this subsection.

5           “(4) FAMILY MEMBERS.—The members of an  
6 individual’s family shall be determined under section  
7 4946(d); except that such members also shall in-  
8 clude the brothers and sisters (whether by the whole  
9 or halfblood) of the individual and their spouses.

10          “(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANI-  
11 ZATIONS.—

12           “(1) IN GENERAL.—For purposes of this sec-  
13 tion, the status of any organization as an applicable  
14 tax-exempt health care organization shall be termi-  
15 nated only if—

16           “(A)(i) such organization notifies the Sec-  
17 retary (at such time and in such manner as the  
18 Secretary may by regulations prescribe) of its  
19 intent to accomplish such termination, or

20           “(ii) there is a final determination by the  
21 Secretary that such status has terminated, and

22           “(B)(i) such organization pays the tax im-  
23 posed by paragraph (2) (or any portion not  
24 abated pursuant to paragraph (3)), or

1           “(ii) the entire amount of such tax is  
2           abated pursuant to paragraph (3).

3           “(2) IMPOSITION OF TAX.—There is hereby im-  
4           posed on each organization referred to in paragraph  
5           (1) a tax equal to the lesser of—

6                   “(A) the amount which the organization  
7                   substantiates by adequate records or other cor-  
8                   roborating evidence as the aggregate tax benefit  
9                   resulting from its exemption from tax under  
10                  section 501(a), or

11                   “(B) the value of the net assets of such or-  
12                  ganization.

13           “(3) ABATEMENT OF TAX.—The Secretary may  
14           abate the unpaid portion of the assessment of any  
15           tax imposed by paragraph (2), or any liability in re-  
16           spect thereof, if the applicable tax-exempt health  
17           care organization distributes all of its net assets to  
18           1 or more organizations each of which has been in  
19           existence, and described in section 501(c)(3), for a  
20           continuous period of at least 60 calendar months. If  
21           the distributing organization is described in section  
22           501(c)(4), the preceding sentence shall be applied by  
23           treating the reference to section 501(c)(3) as includ-  
24           ing a reference to section 501(c)(4).

1           “(4) CERTAIN RULES MADE APPLICABLE.—  
2           Rules similar to the rules of subsections (d), (e), and  
3           (f) of section 507 shall apply for purposes of this  
4           subsection.

5   **“SEC. 4959. OTHER DEFINITIONS.**

6           “(a) APPLICABLE TAX-EXEMPT HEALTH CARE OR-  
7           GANIZATION.—For purposes of this subchapter, the term  
8           ‘applicable tax-exempt health care organization’ means  
9           any organization—

10           “(1) the predominant activity of which is the  
11           provision of health care services (as defined in sec-  
12           tion 501(n)(3)), and

13           “(2) which (without regard to any taxable  
14           inurement) would be described in paragraph (3) or  
15           (4) of section 501(c) and exempt from tax under  
16           section 501(a).

17           Such term does not include a private foundation (as de-  
18           fined in section 509(a)).

19           “(b) TAXABLE PERIOD; CORRECTION.—For purposes  
20           of this subchapter—

21           “(1) TAXABLE PERIOD.—The term ‘taxable pe-  
22           riod’ means, with respect to any taxable inurement,  
23           the period beginning with the date on which the  
24           inurement occurs and ending on the earliest of—

1           “(A) the date of mailing a notice of defi-  
2           ciency under section 6212 with respect to the  
3           tax imposed by subsection (a)(1) of section  
4           4958, or

5           “(B) the date on which the tax imposed by  
6           such subsection (a)(1) is assessed.

7           “(2) CORRECTION.—The terms ‘correction’ and  
8           ‘correct’ mean, with respect to any taxable  
9           inurement, undoing the inurement to the extent pos-  
10          sible, establishing safeguards to prevent future such  
11          inurement, and where fully undoing the inurement is  
12          not possible, such additional corrective action as is  
13          prescribed by the Secretary by regulations.”

14          (b) APPLICATION OF PRIVATE INUREMENT RULE TO  
15          TAX-EXEMPT HEALTH CARE ORGANIZATIONS DE-  
16          SCRIBED IN SECTION 501(c)(4).—Paragraph (4) of sec-  
17          tion 501(c) is amended by inserting “(A)” after “(4)” and  
18          by adding at the end the following:

19                 “(B) Subparagraph (A) shall not apply to an  
20                 entity the predominant activity of which is the provi-  
21                 sion of health care services (as defined in subsection  
22                 (n)(3)) unless no part of the net earnings of such  
23                 entity inures to the benefit of any private share-  
24                 holder or individual.”

25          (c) TECHNICAL AND CONFORMING AMENDMENTS.—

1           (1) Subsection (e) of section 4955 is amend-  
2 ed—

3                   (A) by striking “SECTION 4945” in the  
4 heading and inserting “SECTIONS 4945 and  
5 4958”, and

6                   (B) by inserting before the period “or a  
7 taxable inurement for purposes of section  
8 4958”.

9           (2) Subsections (a), (b), and (c) of section 4963  
10 are each amended by inserting “4958,” after  
11 “4955,”.

12           (3) Subsection (e) of section 6213 is amended  
13 by inserting “4958 (relating to private inurement),”  
14 before “4971”.

15           (4) Paragraphs (2) and (3) of section 7422(g)  
16 are each amended by inserting “4958,” after  
17 “4955,”.

18           (5) Subsection (b) of section 7454 is amended  
19 by inserting “or whether an organization manager  
20 (as defined in section 4958(f)) has ‘knowingly’ par-  
21 ticipated in taxable inurement (as defined in section  
22 4958(d)),” after “section 4912(b),”.

23           (6) The table of subchapters for chapter 42 is  
24 amended by striking the last item and inserting the  
25 following:

“SUBCHAPTER D. Private inurement by tax-exempt health care organizations.

“SUBCHAPTER E. Abatement of first and second tier taxes in certain cases.”

1 (d) EFFECTIVE DATES.—

2 (1) IN GENERAL.—Except as provided in para-  
3 graph (2), the amendments made by this section  
4 shall apply to inurement occurring on or after June  
5 30, 1994.

6 (2) APPLICATION OF BINDING CONTRACT RULE  
7 TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DE-  
8 SCRIBED IN SECTION 501(C)(4).—The amendments  
9 made by this section shall not apply to any  
10 inurement involving an organization described in  
11 section 501(c)(4) of the Internal Revenue Code of  
12 1986 occurring before July 1, 1996, pursuant to a  
13 written contract which was binding on June 29,  
14 1994, and at all times thereafter before such  
15 inurement occurred.

16 **SEC. 743. TREATMENT OF HEALTH MAINTENANCE ORGANI-**  
17 **ZATIONS, PARENT ORGANIZATIONS, AND**  
18 **HEALTH INSURANCE PURCHASING COOPERA-**  
19 **TIVES.**

20 (a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—

22 (1) IN GENERAL.—Section 501(m) (relating to  
23 certain organizations providing commercial-type in-

1 surance not exempt from tax) is amended by adding  
2 at the end the following new paragraph:

3 “(6) CERTAIN ACTIVITIES PROVIDED BY  
4 HEALTH MAINTENANCE ORGANIZATIONS NOT TREAT-  
5 ED AS COMMERCIAL-TYPE INSURANCE.—For pur-  
6 poses of this subsection, the provision of (or the ar-  
7 ranging for the provision of) medical care on a pre-  
8 paid basis by a health maintenance organization  
9 shall not be treated as providing commercial-type in-  
10 surance if (and only if) such care is—

11 “(A) care provided by such organization to  
12 its members at its own facilities through health  
13 care professionals who do not provide substan-  
14 tial health care services other than on behalf of  
15 such organization,

16 “(B) care provided by a health care profes-  
17 sional to a member of such organization on a  
18 basis under which substantially all of the risks  
19 of the rates of utilization is assumed by the  
20 provider of such care,

21 “(C) care (other than primary care) pro-  
22 vided to a member of such organization pursu-  
23 ant to a referral by such organization, or

1           “(D) emergency care provided to a member  
2 of such organization at a location outside such  
3 member’s area of residence.”

4           (2) TECHNICAL AMENDMENTS.—

5           (A) Paragraph (3) of section 501(m) is  
6 amended by striking subparagraph (B) and by  
7 redesignating subparagraphs (C), (D), and (E)  
8 as subparagraphs (B), (C), and (D), respec-  
9 tively.

10           (B) Paragraph (5) of section 501(m) is  
11 amended by striking “paragraph (3)(E)” and  
12 inserting “paragraph (3)(D)”.

13           (b) TREATMENT OF PARENT ORGANIZATIONS OF  
14 HEALTH CARE PROVIDERS.—Section 509(a) (defining  
15 private foundation) is amended by striking “and” at the  
16 end of paragraph (3), by redesignating paragraph (4) as  
17 paragraph (5), and by inserting after paragraph (3) the  
18 following new paragraph:

19           “(4) an organization which is organized and op-  
20 erated for the benefit of, and which directly or indi-  
21 rectly controls, an organization described in section  
22 170(b)(1)(A)(iii), and”.

23           (c) PURCHASING COOPERATIVES EXEMPT FROM  
24 TAX.—

1           (1) IN GENERAL.—Subsection (c) of section  
2           501 (relating to exemption from tax on corporations,  
3           certain trusts, etc.) is amended by adding at the end  
4           the following new paragraph:

5           “(26)(A) Any health insurance purchasing co-  
6           operative described in part III of subtitle D of title  
7           XXI of the Social Security Act.

8           “(B) Such a cooperative shall not be exempt  
9           from tax pursuant to any provision other than this  
10          paragraph.

11          “(C) Such a cooperative shall not be exempt  
12          from tax unless—

13                 “(i) no part of the net earnings of such co-  
14                 operative inures to the benefit of any private  
15                 shareholder or individual,

16                 “(ii) no substantial part of the activities of  
17                 such cooperative is carrying on propaganda, or  
18                 otherwise attempting, to influence legislation  
19                 (except as otherwise provided in subsection (h)),  
20                 and

21                 “(iii) such cooperative does not participate  
22                 in, or intervene in (including the publishing or  
23                 distributing of statements), any political cam-  
24                 paign on behalf of (or in opposition to) any can-  
25                 didate for public office.”

1           (2) CERTAIN PROVISIONS APPLICABLE TO OR-  
2           GANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE  
3           APPLICABLE TO PURCHASING COOPERATIVES.—Sec-  
4           tion 501 is amended by redesignating subsection (o)  
5           as subsection (p) and by inserting after subsection  
6           (n) the following new subsection:

7           “(o) CERTAIN PROVISIONS MADE APPLICABLE TO  
8           HEALTH INSURANCE PURCHASING COOPERATIVES.—A  
9           health insurance purchasing cooperative described in sub-  
10          section (c)(26) shall be treated—

11           “(1) as described in subsection (c)(3) for pur-  
12          poses of applying subsection (h) (relating to expendi-  
13          tures by public charities to influence legislation),  
14          section 4955 (relating to taxes on political expendi-  
15          tures of section 501(c)(3) organizations), and sec-  
16          tion 4958 (relating to private inurement), and

17           “(2) as described in subsection (h)(4).”

18          (d) EFFECTIVE DATE.—The amendments made by  
19          this section shall take effect on the date of the enactment  
20          of this Act.

1 **SEC. 744. TAX TREATMENT OF TAXABLE ORGANIZATIONS**  
2 **PROVIDING HEALTH INSURANCE AND OTHER**  
3 **PREPAID HEALTH CARE SERVICES.**

4 (a) GENERAL RULE.—Section 831 is amended by re-  
5 designating subsection (c) as subsection (d) and by insert-  
6 ing after subsection (b) the following new subsection:

7 “(c) TREATMENT OF ORGANIZATIONS PROVIDING  
8 HEALTH INSURANCE AND OTHER PREPAID HEALTH  
9 CARE SERVICES.—

10 “(1) GENERAL RULE.—Any organization to  
11 which this subsection applies shall be taxable under  
12 this part in the same manner as if it were an insur-  
13 ance company other than a life insurance company.

14 “(2) ORGANIZATIONS TO WHICH SUBSECTION  
15 APPLIES.—This subsection shall apply to any organi-  
16 zation—

17 “(A) which is not exempt from taxation  
18 under this subtitle,

19 “(B) which is not taxable as a life insur-  
20 ance company under part I of this subchapter,

21 “(C) which is not an organization to which  
22 section 833 applies, and

23 “(D) the primary and predominant busi-  
24 ness activity of which during the taxable year  
25 consists of 1 or more of the following:

1           “(i) Issuing accident and health insur-  
2           ance contracts or the reinsuring of risks  
3           undertaken by other insurance companies  
4           under such contracts.

5           “(ii) Operating as a health mainte-  
6           nance organization.

7           “(iii) Entering into arrangements  
8           under which—

9                   “(I) fixed payments or premiums  
10                  are received as consideration for the  
11                  organization’s agreement to provide or  
12                  arrange for the provision of health  
13                  care services, regardless of how the  
14                  health care services are provided or  
15                  arranged to be provided, and

16                   “(II) substantially all of the risks  
17                  of the rates of utilization of such serv-  
18                  ices is assumed by such organization  
19                  or the provider of such services.

20           In the case of an organization which has as a mate-  
21           rial business activity the issuing of accident and  
22           health insurance contracts or the reinsuring of risks  
23           undertaken by other insurance companies under  
24           such contracts, the administering of accident and  
25           health insurance contracts by such organization shall

1 be treated as part of such business activity for pur-  
2 poses of subparagraph (D)(i).”

3 (b) EFFECTIVE DATE.—

4 (1) IN GENERAL.—The amendment made by  
5 this section shall apply to taxable years beginning  
6 after December 31, 1994.

7 (2) TRANSITIONAL RULES.—

8 (A) ORGANIZATIONS TO WHICH PARA-  
9 GRAPH APPLIES.—This paragraph shall apply  
10 to any organization to which section 831(c) of  
11 the Internal Revenue Code of 1986 (as added  
12 by subsection (a)) applies for such organiza-  
13 tion’s first taxable year beginning after Decem-  
14 ber 31, 1994; except that this paragraph shall  
15 not apply if such organization treated itself as  
16 an insurance company taxable under part II of  
17 subchapter L of chapter 1 of such Code on its  
18 original Federal income tax return for its tax-  
19 able year beginning in 1992 and for all of its  
20 taxable years thereafter beginning before Janu-  
21 ary 1, 1995.

22 (B) TREATMENT OF CURRENTLY TAXABLE  
23 COMPANIES.—Except as provided in regulations  
24 prescribed by the Secretary of the Treasury or

1 his delegate, in the case of any organization to  
2 which this paragraph applies—

3 (i) the amendments made by this sec-  
4 tion shall be treated as a change in the  
5 method of accounting, and

6 (ii) all adjustments required to be  
7 taken into account under section 481 of  
8 the Internal Revenue Code of 1986 shall  
9 be taken into account for such company's  
10 first taxable year beginning after Decem-  
11 ber 31, 1994.

12 (C) TREATMENT OF CURRENTLY TAX-EX-  
13 EMPT COMPANIES.—Except as provided in regu-  
14 lations prescribed by the Secretary of the  
15 Treasury or his delegates, in the case of any or-  
16 ganization to which this paragraph applies and  
17 which was exempt from tax under chapter 1 of  
18 the Internal Revenue Code of 1986 for such or-  
19 ganization's last taxable year beginning before  
20 January 1, 1995—

21 (i) no adjustment shall be made under  
22 section 481 (or any other provision) of  
23 such Code on account of a change in its  
24 method of accounting required by this sec-

1           tion for its first taxable year beginning  
2           after December 31, 1994, and

3           (ii) for purposes of determining gain  
4           or loss, the adjusted basis of any asset  
5           held by such organization on the first day  
6           of such taxable year shall be treated as  
7           equal to its fair market value as of such  
8           day.

9   **SEC. 745. ORGANIZATIONS SUBJECT TO SECTION 833.**

10       (a) IN GENERAL.—Section 833(c) (relating to orga-  
11       nization to which section applies) is amended by adding  
12       at the end the following new paragraph:

13           “(4) TREATMENT AS EXISTING BLUE CROSS OR  
14       BLUE SHIELD ORGANIZATION.—

15           “(A) IN GENERAL.—Paragraph (2) shall  
16       be applied to an organization described in sub-  
17       paragraph (B) as if it were a Blue Cross or  
18       Blue Shield organization.

19           “(B) APPLICABLE ORGANIZATION.—An or-  
20       ganization is described in this subparagraph if  
21       it—

22           “(i) is organized under, and governed  
23       by, State laws which are specifically and  
24       exclusively applicable to not-for-profit

1 health insurance or health service type or-  
2 ganizations, and

3 “(ii) is not a Blue Cross or Blue  
4 Shield organization or health maintenance  
5 organization.”

6 (b) EFFECTIVE DATE.—The amendment made by  
7 this section shall apply to taxable years beginning after  
8 December 31, 1986.

9 **SEC. 746. TAX EXEMPTION FOR HIGH-RISK INSURANCE**  
10 **POOLS.**

11 Subsection (c) of section 501 (relating to list of ex-  
12 empt organizations) is amended by adding at the end the  
13 following new paragraph:

14 “(27)(A) In the case of taxable years beginning after  
15 December 31, 1989, and before January 1, 1997, a quali-  
16 fied high risk health insurance pool.

17 “(B) For purposes of subparagraph (A), the term  
18 ‘qualified high risk health insurance pool’ means an en-  
19 tity—

20 “(i) which was established by a State or politi-  
21 cal subdivision thereof to provide health insurance  
22 on a nonprofit basis to persons unable to obtain  
23 health insurance because of health conditions,

24 “(ii) with respect to which the State or political  
25 subdivision—



1           nesses as determined by applying section  
2           513(a).

3           “(B) GOVERNMENTAL UNIT NOT TO IN-  
4           CLUDE FEDERAL GOVERNMENT.—The term  
5           ‘governmental unit’ does not include the United  
6           States or any agency or instrumentality thereof.

7           “(C) 501(c)(3) ORGANIZATION.—The term  
8           ‘501(c)(3) organization’ means any organization  
9           described in section 501(c)(3) and exempt from  
10          tax under section 501(a).”

11          (b) REPEAL OF QUALIFIED 501(c)(3) BOND DES-  
12          IGNATION.—Section 145 (relating to qualified 501(c)(3)  
13          bonds) is repealed.

14          (c) CONFORMING AMENDMENTS.—

15           (1) Paragraph (3) of section 141(b) is amend-  
16          ed—

17           (A) by striking “government use” in sub-  
18           paragraph (A)(ii)(I) and subparagraph (B)(ii)  
19           and inserting “exempt person use”,

20           (B) by striking “a government use” in sub-  
21           paragraph (B) and inserting “an exempt person  
22           use”,

23           (C) by striking “related business use” in  
24           subparagraph (A)(ii)(II) and subparagraph (B)  
25           and inserting “related private business use”,

1 (D) by striking “RELATED BUSINESS USE”  
2 in the heading of subparagraph (B) and insert-  
3 ing “RELATED PRIVATE BUSINESS USE”, and

4 (E) by striking “GOVERNMENT USE” in the  
5 heading thereof and inserting “EXEMPT PERSON  
6 USE”.

7 (2) Subparagraph (A) of section 141(b)(6) is  
8 amended by striking “a governmental unit” and in-  
9 serting “an exempt person”.

10 (3) Paragraph (7) of section 141(b) is amend-  
11 ed—

12 (A) by striking “government use” and in-  
13 serting “exempt person use”, and

14 (B) by striking “GOVERNMENT USE” in  
15 the heading thereof and inserting “EXEMPT  
16 PERSON USE”.

17 (4) Section 141(b) is amended by striking para-  
18 graph (9).

19 (5) Paragraph (1) of section 141(c) is amended  
20 by striking “governmental units” and inserting “ex-  
21 empt persons”.

22 (6) Section 141 is amended by redesignating  
23 subsection (e) as subsection (f) and by inserting  
24 after subsection (d) the following new subsection:

1       “(e) CERTAIN ISSUES USED TO PROVIDE RESIDEN-  
2 TIAL RENTAL HOUSING FOR FAMILY UNITS.—

3           “(1) IN GENERAL.—Except as provided in para-  
4 graph (2), for purposes of this title, the term ‘pri-  
5 vate activity bond’ includes any bond issued as part  
6 of an issue if any portion of the net proceeds of the  
7 issue are to be used (directly or indirectly) by an ex-  
8 empt person described in section 150(a)(2)(A)(ii) to  
9 provide residential rental property for family units.  
10 This paragraph shall not apply if the bond would  
11 not be a private activity bond if the section  
12 501(c)(3) organization were not an exempt person.

13           “(2) EXCEPTION FOR BONDS USED TO PROVIDE  
14 QUALIFIED RESIDENTIAL RENTAL PROJECTS.—  
15 Paragraph (1) shall not apply to any bond issued as  
16 part of an issue if the portion of such issue which  
17 is to be used as described in paragraph (1) is to be  
18 used to provide—

19           “(A) a residential rental property for fam-  
20 ily units if the first use of such property is pur-  
21 suant to such issue,

22           “(B) qualified residential rental projects  
23 (as defined in section 142(d)), or

24           “(C) property which is to be substantially  
25 rehabilitated in a rehabilitation beginning with-

1 in the 2-year period ending 1 year after the  
2 date of the acquisition of such property.

3 “(3) SUBSTANTIAL REHABILITATION.—

4 “(A) IN GENERAL.—Except as provided in  
5 subparagraph (B), rules similar to the rules of  
6 section 47(c)(1)(C) shall apply in determining  
7 for purposes of paragraph (2)(C) whether prop-  
8 erty is substantially rehabilitated.

9 “(B) EXCEPTION.—For purposes of sub-  
10 subparagraph (A), clause (ii) of section 47(c)(1)(C)  
11 shall not apply, but the Secretary may extend  
12 the 24-month period in section 47(c)(1)(C)(i)  
13 where appropriate due to circumstances not  
14 within the control of the owner.

15 “(4) CERTAIN PROPERTY TREATED AS NEW  
16 PROPERTY.—Solely for purposes of determining  
17 under paragraph (2)(A) whether the 1st use of prop-  
18 erty is pursuant to tax-exempt financing—

19 “(A) IN GENERAL.—If—

20 “(i) the 1st use of property is pursu-  
21 ant to taxable financing,

22 “(ii) there was a reasonable expecta-  
23 tion (at the time such taxable financing  
24 was provided) that such financing would be  
25 replaced by tax-exempt financing, and

1           “(iii) the taxable financing is in fact  
2           so replaced within a reasonable period  
3           after the taxable financing was provided,  
4           then the 1st use of such property shall be treat-  
5           ed as being pursuant to the tax-exempt financ-  
6           ing.

7           “(B) SPECIAL RULE WHERE NO OPERAT-  
8           ING STATE OR LOCAL PROGRAM FOR TAX-EX-  
9           EMPT FINANCING.—If, at the time of the 1st  
10          use of property, there was no operating State or  
11          local program for tax-exempt financing of the  
12          property, the 1st use of the property shall be  
13          treated as pursuant to the 1st tax-exempt fi-  
14          nancing of the property.

15          “(C) DEFINITIONS.—For purposes of this  
16          paragraph—

17                 “(i) TAX-EXEMPT FINANCING.—The  
18                 term ‘tax-exempt financing’ means financ-  
19                 ing provided by tax-exempt bonds.

20                 “(ii) TAXABLE FINANCING.—The  
21                 term ‘taxable financing’ means financing  
22                 which is not tax-exempt financing.”

23           (7) Section 141(f), as redesignated by para-  
24           graph (6), is amended—

1 (A) by adding “or” at the end of subpara-  
2 graph (E),

3 (B) by striking “, or” at the end of sub-  
4 paragraph (F), and inserting in lieu thereof a  
5 period, and

6 (C) by striking subparagraph (G).

7 (8) The last sentence of section 144(b)(1) is  
8 amended by striking “(determined” and all that fol-  
9 lows to the period.

10 (9) Clause (ii) of section 144(c)(2)(C) is  
11 amended by striking “a governmental unit” and in-  
12 serting “an exempt person”.

13 (10) Section 146(g) is amended—

14 (A) by striking paragraph (2), and

15 (B) by redesignating the remaining para-  
16 graphs after paragraph (1) as paragraphs (2)  
17 and (3), respectively.

18 (11) The heading of section 146(k)(3) is  
19 amended by striking “GOVERNMENTAL” and insert-  
20 ing “EXEMPT PERSON”.

21 (12) The heading of section 146(m) is amended  
22 by striking “GOVERNMENT” and inserting “EXEMPT  
23 PERSON”.

24 (13) Subsection (h) of section 147 is amended  
25 to read as follows:

1       “(h) CERTAIN RULES NOT TO APPLY TO MORTGAGE  
2 REVENUE BONDS AND QUALIFIED STUDENT LOAN  
3 BONDS.—Subsections (a), (b), (c), and (d) shall not apply  
4 to any qualified mortgage bond, qualified veterans’ mort-  
5 gage bond, or qualified student loan bond.”

6           (14) Section 147 is amended by striking para-  
7 graph (4) of subsection (b) and redesignating para-  
8 graph (5) of such subsection as paragraph (4).

9           (15) Subparagraph (F) of section 148(d)(3) is  
10 amended—

11           (A) by striking “or which is a qualified  
12 501(c)(3) bond”, and

13           (B) by striking “GOVERNMENTAL USE  
14 BONDS AND QUALIFIED 501(C)(3)” in the heading  
15 thereof and inserting “EXEMPT PERSON”.

16           (16) Subclause (II) of section 148(f)(4)(B)(ii)  
17 is amended by striking “(other than a qualified  
18 501(c)(3) bond)”.

19           (17) Clause (iv) of section 148(f)(4)(C) is  
20 amended—

21           (A) by striking “a governmental unit or a  
22 501(c)(3) organization” each place it appears  
23 and inserting “an exempt person”,

24           (B) by striking “qualified 501(c)(3)  
25 bonds,” and

1 (C) by striking the comma after “private  
2 activity bonds” the first place it appears.

3 (18) Subparagraph (A) of section 148(f)(7) is  
4 amended by striking “(other than a qualified  
5 501(c)(3) bond)”.

6 (19) Paragraph (2) of section 149(d) is amend-  
7 ed—

8 (A) by striking “(other than a qualified  
9 501(c)(3) bond)”, and

10 (B) by striking “CERTAIN PRIVATE” in the  
11 heading thereof and inserting “PRIVATE”.

12 (20) Section 149(e)(2) is amended—

13 (A) by striking “which is not a private ac-  
14 tivity bond” in the second sentence and insert-  
15 ing “which is a bond issued for an exempt per-  
16 son described in section 150(a)(2)(A)(i)”, and

17 (B) by adding at the end the following new  
18 sentence: “Subparagraph (D) shall not apply to  
19 any bond which is not a private activity bond  
20 but which would be such a bond if the  
21 501(c)(3) organization using the proceeds  
22 thereof were not an exempt person.”

23 (21) The heading of subsection (b) of section  
24 150 is amended by striking “TAX-EXEMPT PRIVATE

1       ACTIVITY BONDS” and inserting “CERTAIN TAX-EX-  
2       EMPT BONDS”.

3           (22) Paragraph (3) of section 150(b) is amend-  
4       ed—

5           (A) by inserting “owned by a 501(c)(3) or-  
6       ganization” after “any facility” in subpara-  
7       graph (A),

8           (B) by striking “any private activity bond  
9       which, when issued, purported to be a tax-ex-  
10      empt qualified 501(c)(3) bond” in subpara-  
11      graph (A) and inserting “any bond which, when  
12      issued, purported to be a tax-exempt bond, and  
13      which would be a private activity bond if the  
14      501(c)(3) organization using the proceeds  
15      thereof were not an exempt person”, and

16          (C) by striking the heading thereof and in-  
17      serting “BONDS FOR EXEMPT PERSONS OTHER  
18      THAN GOVERNMENTAL UNITS.—”.

19          (23) Paragraph (5) of section 150(b) is amend-  
20      ed—

21          (A) by striking “private activity” in sub-  
22      paragraph (A),

23          (B) by inserting “and which would be a  
24      private activity bond if the 501(c)(3) organiza-  
25      tion using the proceeds thereof were not an ex-

1           empt person” after “tax-exempt bond” in sub-  
2           paragraph (A),

3           (C) by striking subparagraph (B) and in-  
4           serting the following new subparagraph:

5           “(B) such facility is required to be owned  
6           by an exempt person, and”, and

7           (D) by striking “GOVERNMENTAL UNITS  
8           OR 501(C)(3) ORGANIZATIONS” in the heading  
9           thereof and inserting “EXEMPT PERSONS”.

10          (24) Section 150 is amended by adding at the  
11          end the following new subsection:

12          “(f) CERTAIN RULES TO APPLY TO BONDS FOR EX-  
13          EMPT PERSONS OTHER THAN GOVERNMENTAL UNITS.—

14                 “(1) IN GENERAL.—Nothing in section 103(a)  
15                 or any other provision of law shall be construed to  
16                 provide an exemption from Federal income tax for  
17                 interest on any bond which would be a private activ-  
18                 ity bond if the 501(c)(3) organization using the pro-  
19                 ceeds thereof were not an exempt person unless such  
20                 bond satisfies the requirements of subsections (b)  
21                 and (f) of section 147.

22                 “(2) SPECIAL RULE FOR POOLED FINANCING  
23                 OF 501(C)(3) ORGANIZATION.—

24                         “(A) IN GENERAL.—At the election of the  
25                         issuer, a bond described in paragraph (1) shall

1 be treated as meeting the requirements of sec-  
2 tion 147(b) if such bond meets the require-  
3 ments of subparagraph (B).

4 “(B) REQUIREMENTS.—A bond meets the  
5 requirements of this subparagraph if—

6 “(i) 95 percent or more of the net  
7 proceeds of the issue of which such bond is  
8 a part are to be used to make or finance  
9 loans to 2 or more 501(c)(3) organizations  
10 or governmental units for acquisition of  
11 property to be used by such organizations,

12 “(ii) each loan described in clause (i)  
13 satisfies the requirements of section 147(b)  
14 (determined by treating each loan as a sep-  
15 arate issue),

16 “(iii) before such bond is issued, a de-  
17 mand survey was conducted which shows a  
18 demand for financing greater than an  
19 amount equal to 120 percent of the  
20 lendable proceeds of such issue, and

21 “(iv) 95 percent or more of the net  
22 proceeds of such issue are to be loaned to  
23 501(c)(3) organizations or governmental  
24 units within 1 year of issuance and, to the  
25 extent there are any unspent proceeds

1           after such 1-year period, bonds issued as  
2           part of such issue are to be redeemed as  
3           soon as possible thereafter (and in no  
4           event later than 18 months after issuance).

5           A bond shall not meet the requirements of this  
6           subparagraph if the maturity date of any bond  
7           issued as part of such issue is more than 30  
8           years after the date on which the bond was is-  
9           sued (or, in the case of a refunding or series of  
10          refundings, the date on which the original bond  
11          was issued).”

12          (25) Section 1302 of the Tax Reform Act of  
13          1986 is repealed.

14          (26) Subparagraph (C) of section 57(a)(5) is  
15          amended by striking clause (ii) and redesignating  
16          clauses (iii) and (iv) as clauses (ii) and (iii), respec-  
17          tively.

18          (27) Paragraph (3) of section 103(b) is amend-  
19          ed by inserting “and section 150(f)” after “section  
20          149”.

21          (28) Paragraph (3) of section 265(b) is amend-  
22          ed—

23                  (A) by striking clause (ii) of subparagraph  
24                  (B) and inserting the following:

1           “(ii) CERTAIN BONDS NOT TREATED  
2           AS PRIVATE ACTIVITY BONDS.—For pur-  
3           poses of clause (i)(II), there shall not be  
4           treated as a private activity bond any obli-  
5           gation issued to refund (or which is part of  
6           a series of obligations issued to refund) an  
7           obligation issued before August 8, 1986,  
8           which was not an industrial development  
9           bond (as defined in section 103(b)(2) as in  
10          effect on the day before the date of the en-  
11          actment of the Tax Reform Act of 1986)  
12          or a private loan bond (as defined in sec-  
13          tion 103(o)(2)(A), as so in effect, but with-  
14          out regard to any exemption from such  
15          definition other than section  
16          103(o)(2)(A)).”; and

17          (B) by striking “(other than a qualified  
18          501(c)(3) bond, as defined in section 145)” in  
19          subparagraph (C)(ii)(I).

20          (d) EFFECTIVE DATE.—The amendments made by  
21          this section shall apply to bonds (including refunding  
22          bonds) issued after December 31, 1994.

1 **Subtitle E—Tax Treatment of Long-**  
2 **Term Care Insurance and Services**

3 **SEC. 751. QUALIFIED LONG-TERM CARE SERVICES TREAT-**  
4 **ED AS MEDICAL CARE.**

5 (a) GENERAL RULE.—Paragraph (1) of section  
6 213(d) (defining medical care) is amended by striking  
7 “or” at the end of subparagraph (B), by redesignating  
8 subparagraph (C) as subparagraph (D), and by inserting  
9 after subparagraph (B) the following new subparagraph:

10 “(C) for qualified long-term care services  
11 (as defined in subsection (g)), or”.

12 (b) QUALIFIED LONG-TERM CARE SERVICES DE-  
13 FINED.—Section 213 (relating to the deduction for medi-  
14 cal, dental, etc., expenses) is amended by adding at the  
15 end the following new subsection:

16 “(g) QUALIFIED LONG-TERM CARE SERVICES.—For  
17 purposes of this section—

18 “(1) IN GENERAL.—The term ‘qualified long-  
19 term care services’ means necessary diagnostic, cur-  
20 ing, mitigating, treating, preventive, therapeutic, and  
21 rehabilitative services, and maintenance and per-  
22 sonal care services (whether performed in a residen-  
23 tial or nonresidential setting) which—

1           “(A) are required by an individual during  
2 any period the individual is an incapacitated in-  
3 dividual (as defined in paragraph (2)),

4           “(B) have as their primary purpose—

5               “(i) the provision of needed assistance  
6 with 1 or more activities of daily living (as  
7 defined in paragraph (3)), or

8               “(ii) protection from threats to health  
9 and safety due to severe cognitive impair-  
10 ment, and

11           “(C) are provided pursuant to a continuing  
12 plan of care prescribed by a licensed profes-  
13 sional (as defined in paragraph (4)).

14           “(2) INCAPACITATED INDIVIDUAL.—The term  
15 ‘incapacitated individual’ means any individual  
16 who—

17               “(A) is unable to perform, without sub-  
18 stantial assistance from another individual (in-  
19 cluding assistance involving cueing or substan-  
20 tial supervision), at least 2 activities of daily  
21 living as defined in paragraph (3), or

22               “(B) has severe cognitive impairment as  
23 defined by the Secretary in consultation with  
24 the Secretary of Health and Human Services.

1 Such term shall not include any individual otherwise  
2 meeting the requirements of the preceding sentence  
3 unless a licensed professional within the preceding  
4 12-month period has certified that such individual  
5 meets such requirements.

6 “(3) ACTIVITIES OF DAILY LIVING.—Each of  
7 the following is an activity of daily living:

8 “(A) Eating.

9 “(B) Toileting.

10 “(C) Transferring.

11 “(D) Bathing.

12 “(E) Dressing.

13 “(4) LICENSED PROFESSIONAL.—The term ‘li-  
14 censed professional’ means—

15 “(A) a physician or registered professional  
16 nurse, or

17 “(B) any other individual who meets such  
18 requirements as may be prescribed by the Sec-  
19 retary after consultation with the Secretary of  
20 Health and Human Services.

21 “(5) CERTAIN SERVICES NOT INCLUDED.—The  
22 term ‘qualified long-term care services’ shall not in-  
23 clude any services provided to an individual—

24 “(A) by a relative (directly or through a  
25 partnership, corporation, or other entity) unless

1 the relative is a licensed professional with re-  
2 spect to such services, or

3 “(B) by a corporation or partnership which  
4 is related (within the meaning of section 267(b)  
5 or 707(b)) to the individual.

6 For purposes of this paragraph, the term ‘relative’  
7 means an individual bearing a relationship to the in-  
8 dividual which is described in paragraphs (1)  
9 through (8) of section 152(a).”

10 (c) TECHNICAL AMENDMENTS.—

11 (1) Subparagraph (D) of section 213(d)(1) (as  
12 redesignated by subsection (a)) is amended to read  
13 as follows:

14 “(D) for insurance (including amounts  
15 paid as premiums under part B of title XVIII  
16 of the Social Security Act, relating to supple-  
17 mentary medical insurance for the aged) cover-  
18 ing medical care referred to in—

19 “(i) subparagraphs (A) and (B), or

20 “(ii) subparagraph (C), but only if  
21 such insurance is provided under a quali-  
22 fied long-term care insurance policy (as de-  
23 fined in section 7702B(b)) and the amount  
24 paid for such insurance is not disallowed  
25 under section 7702B(d)(4).”

1           (2) Paragraph (6) of section 213(d) is amend-  
2 ed—

3           (A) by striking “subparagraphs (A) and  
4 (B)” and inserting “subparagraph (A), (B),  
5 and (C)”, and

6           (B) by striking “paragraph (1)(C)” in sub-  
7 paragraph (A) and inserting “paragraph  
8 (1)(D)”.

9           (d) EFFECTIVE DATE.—The amendments made by  
10 this section shall apply to taxable years beginning after  
11 December 31, 1995.

12 **SEC. 752. TREATMENT OF LONG-TERM CARE INSURANCE.**

13           (a) GENERAL RULE.—Chapter 79 (relating to defini-  
14 tions) is amended by inserting after section 7702A the fol-  
15 lowing new section:

16 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSUR-**  
17 **ANCE.**

18           “(a) IN GENERAL.—For purposes of this title—

19           “(1) a qualified long-term care insurance policy  
20 (as defined in subsection (b)) shall be treated as an  
21 accident or health insurance contract,

22           “(2) amounts (other than policyholder dividends  
23 (as defined in section 808) or premium refunds) re-  
24 ceived under a qualified long-term care insurance  
25 policy shall be treated as amounts received for per-

1       sonal injuries and sickness and shall be treated as  
2       reimbursement for expenses actually incurred for  
3       medical care (as defined in section 213(d)),

4             “(3) except to the extent provided in section  
5       106(c), any plan of an employer providing coverage  
6       under a qualified long-term care insurance policy  
7       shall be treated as an accident or health plan with  
8       respect to such coverage,

9             “(4) except as provided in subsection (d)(4),  
10       amounts paid for a qualified long-term care insur-  
11       ance policy providing the benefits described in sub-  
12       section (b)(6)(B) shall be treated as payments made  
13       for insurance for purposes of section 213(d)(1)(D),  
14       and

15            “(5) a qualified long-term care insurance policy  
16       shall be treated as a guaranteed renewable contract  
17       subject to the rules of section 816(e).

18       “(b) QUALIFIED LONG-TERM CARE INSURANCE POL-  
19       ICY.—For purposes of this title—

20            “(1) IN GENERAL.—The term ‘qualified long-  
21       term care insurance policy’ means any certified long-  
22       term care policy (as defined in section 21011(b)(2)  
23       of the Social Security Act) that—

24            “(A) limits benefits under such policy to  
25       individuals who are certified by a licensed pro-

1           fessional (as defined in section 213(g)(4)) with-  
2           in the preceding 12-month period—

3                   “(i) as being unable to perform, with-  
4                   out substantial assistance from another in-  
5                   dividual (including assistance involving  
6                   cueing or substantial supervision), 2 or  
7                   more activities of daily living (as defined in  
8                   section 213(g)(3)), or

9                   “(ii) having a severe cognitive impair-  
10                  ment (as defined in section 213(g)(2)(B)),  
11                  and

12                  “(B) satisfies the requirements of para-  
13                  graphs (2), (3), (4), (5), and (6).

14                  “(2) PREMIUM REQUIREMENTS.—The require-  
15                  ments of this paragraph are met with respect to a  
16                  policy if such policy provides that premium pay-  
17                  ments may not be made earlier than the date such  
18                  payments would have been made if the contract pro-  
19                  vided for level annual payments over the life expect-  
20                  ancy of the insured or 20 years, whichever is short-  
21                  er. A policy shall not be treated as failing to meet  
22                  the requirements of the preceding sentence solely by  
23                  reason of a provision in the policy providing for a  
24                  waiver of premiums if the insured becomes an indi-  
25                  vidual certified in accordance with paragraph (1)(A).

1           “(3) PROHIBITION OF CASH VALUE.—The re-  
2           quirements of this paragraph are met if the policy  
3           does not provide for a cash value or other money  
4           that can be paid, assigned, pledged as collateral for  
5           a loan, or borrowed, other than as provided in para-  
6           graph (4).

7           “(4) REFUNDS OF PREMIUMS AND DIVI-  
8           DENDS.—The requirements of this paragraph are  
9           met with respect to a policy if such policy provides  
10          that—

11                 “(A) policyholder dividends are required to  
12                 be applied as a reduction in future premiums  
13                 or, to the extent permitted under paragraph  
14                 (6), to increase benefits described in subsection  
15                 (a)(2),

16                 “(B) refunds of premiums upon a partial  
17                 surrender or a partial cancellation are required  
18                 to be applied as a reduction in future pre-  
19                 miums, and

20                 “(C) any refund on the death of the in-  
21                 sured, or on a complete surrender or cancella-  
22                 tion of the policy, cannot exceed the aggregate  
23                 premiums paid under the contract.

24           Any refund on a complete surrender or cancellation  
25           of the policy shall be includible in gross income to

1 the extent that any deduction or exclusion was allow-  
2 able with respect to the premiums.

3 “(5) COORDINATION WITH OTHER ENTITLED-  
4 MENTS.—The requirements of this paragraph are  
5 met with respect to a policy if such policy does not  
6 pay, or provide reimbursement for, expenses in-  
7 curred to the extent that such expenses are also paid  
8 or reimbursed under title XVIII of the Social Secu-  
9 rity Act or are paid or reimbursed under a certified  
10 standard health plan (as defined in section  
11 21011(a)(2) of the Social Security Act).

12 “(6) MAXIMUM BENEFIT.—

13 “(A) IN GENERAL.—The requirements of  
14 this paragraph are met if the benefits payable  
15 under the policy for any period (whether on a  
16 periodic basis or otherwise) may not exceed the  
17 dollar amount in effect for such period.

18 “(B) NONREIMBURSEMENT PAYMENTS  
19 PERMITTED.—Benefits shall include all pay-  
20 ments described in subsection (a)(2) to or on  
21 behalf of an insured individual without regard  
22 to the expenses incurred during the period to  
23 which the payments relate. For purposes of sec-  
24 tion 213(a), such payments shall be treated as

1 compensation for expenses paid for medical  
2 care.

3 “(C) DOLLAR AMOUNT.—The dollar  
4 amount in effect under this paragraph shall be  
5 \$150 per day (or the equivalent amount within  
6 the calendar year in the case of payments on  
7 other than a per diem basis).

8 “(D) ADJUSTMENTS FOR INCREASED  
9 COSTS.—

10 “(i) IN GENERAL.—In the case of any  
11 calendar year after 1996, the dollar  
12 amount in effect under subparagraph (C)  
13 for any period or portion thereof occurring  
14 during such calendar year shall be equal to  
15 the sum of—

16 “(I) the amount in effect under  
17 subparagraph (C) for the preceding  
18 calendar year (after application of this  
19 subparagraph), plus

20 “(II) the product of the amount  
21 referred to in subclause (I) multiplied  
22 by the cost-of-living adjustment for  
23 the calendar year.

24 “(ii) COST-OF-LIVING ADJUSTMENT.—  
25 For purposes of clause (i), the cost-of-liv-

1 ing adjustment for any calendar year is the  
2 percentage (if any) by which the cost index  
3 under clause (iii) for the preceding cal-  
4 endar year exceeds such index for the sec-  
5 ond preceding calendar year.

6 “(iii) COST INDEX.—The Secretary, in  
7 consultation with the Secretary of Health  
8 and Human Services, shall before January  
9 1, 1997, establish a cost index to measure  
10 increases in costs of nursing home and  
11 similar facilities. The Secretary may from  
12 time to time revise such index to the extent  
13 necessary to accurately measure increases  
14 or decreases in such costs.

15 “(iv) SPECIAL RULE FOR CALENDAR  
16 YEAR 1997.—Notwithstanding clause (ii),  
17 for purposes of clause (i), the cost-of-living  
18 adjustment for calendar year 1997 is the  
19 sum of 1.5 percent plus the percentage by  
20 which the CPI for calendar year 1996 (as  
21 defined in section 1(f)(4)) exceeds the CPI  
22 for calendar year 1995 (as so defined).

23 “(E) PERIOD.—For purposes of this para-  
24 graph, a period begins on the date that an indi-  
25 vidual has a condition which would qualify for

1 certification under subsection (b)(1)(A) and  
2 ends on the earlier of the date upon which—

3 “(i) such individual has not been so  
4 certified within the preceding 12-months,  
5 or

6 “(ii) the individual’s condition ceases  
7 to be such as to qualify for certification  
8 under subsection (b)(1)(A).

9 “(F) AGGREGATION RULE.—For purposes  
10 of this paragraph, all policies issued with re-  
11 spect to the same insured shall be treated as  
12 one policy.

13 “(c) TREATMENT OF LONG-TERM CARE INSURANCE  
14 POLICIES.—For purposes of this title, any amount re-  
15 ceived or coverage provided under a long-term care insur-  
16 ance policy that is not a qualified long-term care insurance  
17 policy shall not be treated as an amount received for per-  
18 sonal injuries or sickness or provided under an accident  
19 or health plan and shall not be treated as excludible from  
20 gross income under any provision of this title.

21 “(d) TREATMENT OF COVERAGE PROVIDED AS PART  
22 OF A LIFE INSURANCE CONTRACT.—Except as otherwise  
23 provided in regulations prescribed by the Secretary, in the  
24 case of any long-term care insurance coverage (whether

1 or not qualified) provided by rider on a life insurance con-  
2 tract—

3 “(1) IN GENERAL.—This section shall apply as  
4 if the portion of the contract providing such cov-  
5 erage is a separate contract or policy.

6 “(2) PREMIUMS AND CHARGES FOR LONG-TERM  
7 CARE COVERAGE.—Premium payments for coverage  
8 under a long-term care insurance policy and charges  
9 against the life insurance contract’s cash surrender  
10 value (within the meaning of section 7702(f)(2)(A))  
11 for such coverage shall be treated as premiums for  
12 purposes of subsection (b)(2).

13 “(3) APPLICATION OF SECTION 7702.—Section  
14 7702(c)(2) (relating to the guideline premium limi-  
15 tation) shall be applied by increasing the guideline  
16 premium limitation with respect to a life insurance  
17 contract, as of any date—

18 “(A) by the sum of any charges (but not  
19 premium payments) described in paragraph (2)  
20 made to that date under the contract, less

21 “(B) any such charges the imposition of  
22 which reduces the premiums paid for the con-  
23 tract (within the meaning of section  
24 7702(f)(1)).

1           “(4) APPLICATION OF SECTION 213.—No deduc-  
2           tion shall be allowed under section 213(a) for  
3           charges against the life insurance contract’s cash  
4           surrender value described in paragraph (2), unless  
5           such charges are includible in income as a result of  
6           the application of section 72(e)(10) and the coverage  
7           provided by the rider is a qualified long-term care  
8           insurance policy under subsection (b).

9           “(5) AMOUNT OF DISTRIBUTION UNDER  
10          RIDER.—This subsection shall not apply to any rider  
11          on a life insurance contract unless the percentage re-  
12          duction in the cash surrender value of the contract  
13          by reason of any payment under the rider does not  
14          exceed the percentage reduction in the death benefit  
15          payable under the contract by reason of the pay-  
16          ment.

17 For purposes of this subsection, the term ‘portion’ means  
18 only the terms and benefits under a life insurance contract  
19 that are in addition to the terms and benefits under the  
20 contract without regard to the coverage under a long-term  
21 care insurance policy, except that the coverage under a  
22 rider described in this subsection shall not fail to be treat-  
23 ed as such an addition by reason of a reduction in the  
24 contract’s death benefit or cash surrender value resulting  
25 from any payment under the rider.

1       “(e) REGULATIONS.—The Secretary shall prescribe  
2 such regulations as may be necessary to carry out the re-  
3 quirements of this section, including regulations to prevent  
4 the avoidance of this section by providing long-term care  
5 insurance coverage under a life insurance contract and to  
6 provide for the proper allocation of amounts between the  
7 long-term care and life insurance portions of a contract.”

8       (b) EMPLOYER CONTRIBUTIONS TO LONG-TERM  
9 CARE COVERAGE NOT EXCLUDED.—

10           (1) IN GENERAL.—Section 106 (relating to con-  
11 tributions by employer to accident and health plans),  
12 as amended by section 7202, is amended by adding  
13 at the end the following new subsection:

14       “(c) EXCEPTION FOR LONG-TERM CARE INSUR-  
15 ANCE.—Subsection (a) shall not apply to employer-pro-  
16 vided coverage under any qualified long-term care insur-  
17 ance policy.”

18           (2) EMPLOYMENT TAX TREATMENT.—Each of  
19 the following provisions, as amended by section  
20 7202(b), is amended by striking “section 106(b)”  
21 and inserting “subsection (b) or (c) of section 106”:

22                   (A) The last sentence of section 3121(a).

23                   (B) The last sentence of section 209(a) of  
24 the Social Security Act.

1 (C) The last sentence of section  
2 3231(e)(1).

3 (D) The last sentence of section 3306(b).

4 (E) The last sentence of section 3401(a).

5 (c) CLERICAL AMENDMENT.—The table of sections  
6 for chapter 79 is amended by inserting after the item re-  
7 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance.”

8 (d) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendments made by  
10 this section shall apply to policies issued after De-  
11 cember 31, 1995, except that a policy issued before  
12 January 1, 1996, which, on January 1, 1996, satis-  
13 fies the requirements of a qualified long-term care  
14 insurance policy as set forth in section 7702B(b) of  
15 the Internal Revenue Code of 1986 shall be treated  
16 as having been issued on January 1, 1996.

17 (2) TRANSITION RULE.—If, after the date of  
18 enactment of this Act and before January 1, 1996,  
19 a policy providing for long-term care insurance cov-  
20 erage is exchanged solely for a qualified long-term  
21 care insurance policy (as defined in section  
22 7702B(b) of such code), no gain or loss shall be rec-  
23 ognized on the exchange, except that gain (if any)  
24 shall be recognized to the extent of the sum of the  
25 money and the fair market value of the other prop-

1       erty received. For purposes of this paragraph, the  
2       cancellation of a policy providing for long-term care  
3       insurance coverage and reinvestment of the cancella-  
4       tion proceeds in a qualified long-term care insurance  
5       policy within 60 days thereafter shall be treated as  
6       an exchange.

7               (3) ISSUANCE OF RIDER NOT TREATED AS MA-  
8       TERIAL CHANGE.—For purposes of applying section  
9       101(f), 7702, or 7702A of such Code to any con-  
10      tract, the issuance of a rider on a life insurance con-  
11      tract providing long-term care insurance coverage  
12      shall not be treated as a modification or material  
13      change of such contract.

14   **SEC. 753. TAX TREATMENT OF ACCELERATED DEATH BENE-**  
15                   **FITS UNDER LIFE INSURANCE CONTRACTS.**

16       (a) GENERAL RULE.—Section 101 (relating to cer-  
17      tain death benefits) is amended by adding at the end the  
18      following new subsection:

19               “(g) TREATMENT OF CERTAIN ACCELERATED  
20      DEATH BENEFITS.—

21               “(1) IN GENERAL.—For purposes of this sec-  
22      tion, any amount received under a life insurance  
23      contract on the life of an insured who is a terminally  
24      ill individual shall be treated as an amount paid by  
25      reason of the death of such insured.

1           “(2) NECESSARY CONDITIONS.—

2           “(A) IN GENERAL.—Paragraph (1) shall  
3 not apply to any amount received unless—

4           “(i) the total amount received is not  
5 less than the present value (determined  
6 under subparagraph (B)) of the reduction  
7 in the death benefit otherwise payable in  
8 the event of the death of the insured, and

9           “(ii) the percentage reduction in the  
10 cash surrender value of the contract by  
11 reason of the distribution does not exceed  
12 the percentage reduction in the death ben-  
13 efit payable under the contract by reason  
14 of such distribution.

15           “(B) PRESENT VALUE.—The present value  
16 of the reduction in the death benefit shall be  
17 determined by—

18           “(i) using a discount rate which is  
19 based on an interest rate which does not  
20 exceed the highest interest rate set forth in  
21 subparagraph (C), and

22           “(ii) assuming that the death benefit  
23 (or the portion thereof) would have been  
24 paid on the date which is 12 months after

1 the date of the certification referred to in  
2 paragraph (3).

3 “(C) RATES.—The interest rates set forth  
4 in this subparagraph are the following:

5 “(i) the 90-day Treasury bill yield,

6 “(ii) the rate described as Moody’s  
7 Corporate Bond Yield Average-Monthly  
8 Average Corporates as published by  
9 Moody’s Investors Service, Inc., or any  
10 successor thereto, for the calendar month  
11 ending 2 months before the date on which  
12 the rate is determined, and

13 “(iii) the rate used to compute the  
14 cash surrender values under the contract  
15 during the applicable period plus 1 percent  
16 per annum.

17 “(D) SPECIAL RULES RELATING TO  
18 LIENS.—If a lien is imposed against a life in-  
19 surance contract with respect to any amount re-  
20 ferred to in paragraph (1)—

21 “(i) for purposes of subparagraph (A),  
22 the amount of such lien shall be treated as  
23 a reduction (at the time of receipt) in the  
24 death benefit or cash surrender value to  
25 the extent that such benefit or value, as

1           the case may be, is (or may become) sub-  
2           ject to the lien, and

3           “(ii) paragraph (1) shall not apply to  
4           the amount received unless any rate of in-  
5           terest with respect to any amount in con-  
6           nection with which such lien is imposed  
7           does not exceed the highest rate set forth  
8           in subparagraph (C).

9           “(3) TERMINALLY ILL INDIVIDUAL.—For pur-  
10          poses of this subsection, the term ‘terminally ill indi-  
11          vidual’ means an individual who the insurer has de-  
12          termined, after receipt of an acceptable certification  
13          by a licensed physician, has an illness or physical  
14          condition which can reasonably be expected to result  
15          in death within 12 months after the date of certifi-  
16          cation.

17          “(4) EXCEPTION FOR BUSINESS-RELATED POLI-  
18          CIES.—This subsection shall not apply in the case of  
19          any amount paid to any taxpayer other than the in-  
20          sured if such taxpayer has an insurable interest with  
21          respect to the life of the insured by reason of the in-  
22          sured being a director, officer, or employee of the  
23          taxpayer or by reason of the insured having a finan-  
24          cial interest in any trade or business carried on by  
25          the taxpayer.”

1 (b) EFFECTIVE DATES.—

2 (1) IN GENERAL.—Except as provided in para-  
3 graph (2), the amendment made by this section shall  
4 apply to amounts received after the date of the en-  
5 actment of this Act.

6 (2) DELAY IN APPLICATION OF DISCOUNT  
7 RULES.—Clause (i) of section 101(g)(2)(A) of the  
8 Internal Revenue Code of 1986 shall not apply to  
9 any amount received before January 1, 1995.

10 (3) ISSUANCE OF RIDER NOT TREATED AS MA-  
11 TERIAL CHANGE.—For purposes of applying section  
12 101(f), 7702, or 7702A of the Internal Revenue  
13 Code of 1986 to any contract, the issuance of a  
14 qualified accelerated death benefit rider (as defined  
15 in section 818(g) of such Code (as added by this  
16 Act)) shall not be treated as a modification or mate-  
17 rial change of such contract.

18 **SEC. 754. TAX TREATMENT OF COMPANIES ISSUING QUALI-**  
19 **FIED ACCELERATED DEATH BENEFIT RID-**  
20 **ERS.**

21 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-  
22 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-  
23 ing to other definitions and special rules) is amended by  
24 adding at the end the following new subsection:

1       “(g) QUALIFIED ACCELERATED DEATH BENEFIT  
2 RIDERS TREATED AS LIFE INSURANCE.—For purposes of  
3 this part—

4           “(1) IN GENERAL.—Any reference to a life in-  
5 surance contract shall be treated as including a ref-  
6 erence to a qualified accelerated death benefit rider  
7 on such contract.

8           “(2) QUALIFIED ACCELERATED DEATH BENE-  
9 FIT RIDERS.—For purposes of this subsection, the  
10 term ‘qualified accelerated death benefit rider’  
11 means any rider on a life insurance contract which  
12 provides for a distribution to an individual upon the  
13 insured becoming a terminally ill individual (as de-  
14 fined in section 101(g)(3)).”

15       (b) EFFECTIVE DATE.—The amendments made by  
16 this section shall take effect on January 1, 1995.

17       **Subtitle F—Health Care Trust**  
18                                   **Funds**

19       **SEC. 761. ESTABLISHMENT OF HEALTH CARE TRUST**  
20                                   **FUNDS.**

21       (a) IN GENERAL.—Subchapter A of chapter 98 (re-  
22 lating to establishment of trust funds) is amended by add-  
23 ing at the end the following new part:

24           **“PART II—HEALTH CARE TRUST FUNDS**

“Sec. 9551. Health Security Trust Fund.

“Sec. 9552. Graduate Medical Education and Academic Health Centers Trust Fund.

“Sec. 9553. Biomedical and Behavioral Research Trust Fund.

1 **“SEC. 9551. HEALTH SECURITY TRUST FUND.**

2 “(a) CREATION OF TRUST FUND.—

3 “(1) IN GENERAL.—There is established in the  
4 Treasury of the United States a trust fund to be  
5 known as the ‘Health Security Trust Fund’, consist-  
6 ing of such amounts as may be appropriated or cred-  
7 ited to it under this section or section 9602(b).

8 “(2) ACCOUNTS IN THE TRUST FUND.—The  
9 Health Security Trust Fund shall consist of—

10 “(A) the Health Insurance Account,

11 “(B) the Infrastructure Development Ac-  
12 count,

13 “(C) the State Health Quality and  
14 Consumer Protection Account,

15 “(D) the Long-Term Care Account, and

16 “(E) the Federal Outlay Program Fraud  
17 and Abuse Control Account.

18 Each such account shall consist of such amounts as  
19 may be allocated to it under this section.

20 “(b) TRANSFERS TO THE TRUST FUND.—

21 “(1) IN GENERAL.—There are hereby appro-  
22 priated to the Health Security Trust Fund—

23 “(A) amounts equivalent to the taxes re-  
24 ceived in the Treasury under section 5701 (re-

1           lating to taxes imposed on tobacco products) to  
2           the extent such amounts are attributable to the  
3           rates of tax in excess of such rates of tax in ef-  
4           fect on the day before the date of the enact-  
5           ment of the Health Security Act,

6           “(B) amounts equivalent to the taxes re-  
7           ceived in the Treasury under section 4511 (re-  
8           lating to taxes on high cost health plans),

9           “(C) the amount determined by the Sec-  
10          retary, after consultation with the Secretary of  
11          Health and Human Services, to be equal to the  
12          sum of—

13                 “(i) the decrease in Federal expendi-  
14                 tures under title XIX of the Social Secu-  
15                 rity Act by reason of the provisions of, and  
16                 the amendments made by, the Health Se-  
17                 curity Act, and

18                 “(ii) any reduction in payments to  
19                 States under such title by reason of the  
20                 State maintenance-of-effort requirement  
21                 under section 1931(d) of the Social Secu-  
22                 rity Act,

23          “(D) amounts determined by the Sec-  
24          retary, after consultation with the Secretary of  
25          Health and Human Services, to be equal to the

1 decrease in Federal expenditures (other than  
2 any decrease described in paragraph (2)) attrib-  
3 utable to the provisions of subtitle G of title  
4 XXI of the Social Security Act (relating to  
5 automobile insurance coordination), and

6 “(E) amounts equivalent to the following  
7 amounts received in the Treasury:

8 “(i) Criminal fines imposed and col-  
9 lected, and amounts resulting from the for-  
10 feiture of property, in cases involving a  
11 Federal health care offense (as defined in  
12 section 1128D of the Social Security Act).

13 “(ii) Penalties and damages imposed  
14 and collected under the False Claims Act  
15 (31 U.S.C. 3729 et seq.), in cases involving  
16 claims related to the provision of health  
17 care items and services (other than funds  
18 awarded to a relator or for restitution).

19 “(iii) Administrative penalties and as-  
20 sessments imposed and collected under sec-  
21 tion 1128A of the Social Security Act (ex-  
22 cept as otherwise provided by law).

23 “(2) TRANSFERS FROM OTHER TRUST  
24 FUNDS.—The Secretary of Health and Human Serv-  
25 ices shall transfer each fiscal year to the Health Se-

1 security Trust Fund from the Federal Hospital Insur-  
2 ance Trust Fund and the Federal Supplementary  
3 Medical Insurance Trust Fund the amount which  
4 the Secretary estimates is equal to the decrease in  
5 expenditures in each such trust fund attributable to  
6 the provisions of subtitle G of title XXI of the Social  
7 Security Act (relating to automobile insurance co-  
8 ordination).

9 “(3) TRANSFERS FROM CERTAIN RECOVERED  
10 AMOUNTS AND GIFTS.—The Secretary of Health and  
11 Human Services shall transfer each fiscal year to  
12 the Health Security Trust Fund—

13 “(A) the portion of amounts recovered  
14 under section 1128A(a) of the Social Security  
15 Act with respect to a certified health plan or  
16 certified long-term care policy which is not re-  
17 paid to the plan or policy, or

18 “(B) any money gifts or bequests made to  
19 or on behalf of the United States for allocation  
20 to the account described in subsection  
21 (a)(2)(E).

22 “(c) HEALTH INSURANCE ACCOUNT.—

23 “(1) TRANSFERS TO THE ACCOUNT.—There  
24 shall be allocated to the Health Insurance Account  
25 all amounts received in the Health Security Trust

1 Fund which are not allocated to any other account  
2 under this section.

3 “(2) EXPENDITURES FROM ACCOUNT.—  
4 Amounts in the Health Insurance Account are ap-  
5 propriated to the Secretary of Health and Human  
6 Services to carry out the health insurance premium  
7 assistance program and the cost-sharing grant pro-  
8 gram established under part B of title XIX of the  
9 Social Security Act, and to the extent any such  
10 amount is not expended during any fiscal year, such  
11 amount shall be available for such purpose for sub-  
12 sequent fiscal years.

13 “(d) INFRASTRUCTURE DEVELOPMENT ACCOUNT.—

14 “(1) TRANSFERS TO THE ACCOUNT.—

15 “(A) IN GENERAL.—There shall be allo-  
16 cated to the Infrastructure Development Ac-  
17 count from amounts received in the Health Se-  
18 curity Trust Fund each fiscal year,  
19 \$1,300,000,000.

20 “(B) ADJUSTMENT.—In the case of any  
21 fiscal year beginning after fiscal year 1999, the  
22 dollar amount under subparagraph (A) in effect  
23 for the preceding fiscal year (after application  
24 of this subparagraph) shall be increased by an  
25 amount equal to the product of—

1 “(i) such dollar amount, and

2 “(ii) the estimated percent change in  
3 the Consumer Price Index for all urban  
4 consumers (United States city average)  
5 during the 12-month period ending at the  
6 midpoint of the fiscal year, with appro-  
7 priate adjustments to reflect previous  
8 underestimations or overestimations under  
9 this subparagraph in the projected percent-  
10 age change in such index.

11 “(2) EXPENDITURES FROM ACCOUNT.—  
12 Amounts in the Infrastructure Development Account  
13 are appropriated to carry out the programs estab-  
14 lished under parts I and II of subtitle F of title XXI  
15 of the Social Security Act, and to the extent any  
16 such amount is not expended during any fiscal year,  
17 such amount shall be available for such purpose for  
18 subsequent fiscal years.

19 “(e) STATE HEALTH QUALITY AND CONSUMER PRO-  
20 TECTION ACCOUNT.—

21 “(1) TRANSFERS TO ACCOUNT.—There is allo-  
22 cated to the State Health Quality and Consumer  
23 Protection Account from amounts received in the  
24 Health Security Trust Fund each fiscal year the  
25 amounts determined as follows:

1           “(A) For fiscal year 1995, \$200,000,000.

2           “(B) For fiscal years 1996, 1997, and  
3           1998, \$500,000,000.

4           “(C) For fiscal years 1999 through 2004,  
5           \$450,000,000.

6           “(2) EXPENDITURES FROM ACCOUNT.—  
7           Amounts in the State Health Quality and Consumer  
8           Protection Account are appropriated to carry out the  
9           programs established by sections 21003(c)(3),  
10          21503, and 21816 of the Social Security Act, and to  
11          the extent any such amount is not expended during  
12          any fiscal year, such amount shall be available for  
13          such purpose for subsequent fiscal years.

14          “(f) LONG-TERM CARE ACCOUNT.—

15               “(1) TRANSFERS TO ACCOUNT.—There is allo-  
16               cated to the Long-Term Care Account each fiscal  
17               year amounts described in subsections (b)(1)(D) and  
18               (2).

19               “(2) EXPENDITURES FROM ACCOUNT.—  
20               Amounts in the Long-Term Care Account are appro-  
21               priated to carry out the program established under  
22               part C of title XIX of the Social Security Act, and  
23               to the extent any such amount is not expended dur-  
24               ing any fiscal year, such amount shall be available  
25               for such purpose for subsequent fiscal years.

1       “(g) FEDERAL OUTLAY PROGRAM FRAUD AND  
2 ABUSE ACCOUNT.—

3           “(1) TRANSFERS TO ACCOUNT.—There is allo-  
4 cated to the Federal Outlay Program Fraud and  
5 Abuse Account each fiscal year an amount equal to  
6 the sum of \$75,000,000, plus 50 percent of the  
7 amounts transferred to the Trust Fund under sub-  
8 section (b)(1)(E), plus the amounts transferred to  
9 the Trust Fund under subsection (b)(3)(B).

10       “(2) EXPENDITURES FROM ACCOUNT.—

11           “(A) IN GENERAL.—Amounts in the Fed-  
12 eral Outlay Program Fraud and Abuse Account  
13 are appropriated to carry out the program de-  
14 scribed in section 1128C of the Social Security  
15 Act.

16           “(B) MAINTENANCE OF EFFORT.—No  
17 amounts in the Federal Outlay Program Fraud  
18 and Abuse Account which are made available to  
19 any Federal agency shall replace or reduce the  
20 amount of appropriations otherwise made avail-  
21 able under appropriation Acts for such agency.

22       “(h) ALLOCATION OF INTEREST.—Amounts credited  
23 to the Health Security Trust Fund under section 9602(b)  
24 for any fiscal year shall be allocated to each account rat-

1 ably on the basis of the amounts allocated to the account  
2 for the fiscal year (without regard to this subsection).

3 **“SEC. 9552. GRADUATE MEDICAL EDUCATION AND ACA-**  
4 **DEMIC HEALTH CENTERS TRUST FUND.**

5 “(a) CREATION OF TRUST FUND.—

6 “(1) IN GENERAL.—There is established in the  
7 Treasury of the United States a trust fund to be  
8 known as the ‘Graduate Medical Education and Aca-  
9 demic Health Centers Trust Fund’, consisting of  
10 such amounts as may be appropriated or credited to  
11 the Academic Health Centers Trust Fund as pro-  
12 vided in this section or section 9602(b).

13 “(2) ACCOUNTS IN THE TRUST FUND.—The  
14 Graduate Medical Education and Academic Health  
15 Centers Trust Fund shall consist of the following 2  
16 accounts:

17 “(A) The Graduate Medical and Nursing  
18 Education Trust Fund.

19 “(B) The Academic Health Centers Trust  
20 Fund.

21 Each such account shall consist of such amounts as  
22 are allocated to it under this section.

23 “(b) TRANSFERS TO THE TRUST FUND.—

24 “(1) TAXES.—There are hereby appropriated to  
25 the Graduate Medical Education and Academic

1 Health Centers Trust Fund amounts received in the  
2 Treasury under sections 4501 and 4502 (relating to  
3 assessments on insured and self-insured health  
4 plans), other than any portion of such amounts  
5 transferred to the Biomedical and Behavioral Re-  
6 search Trust Fund under section 9553(b).

7 “(2) TRANSFERS FROM OTHER TRUST  
8 FUNDS.—The Secretary of Health and Human Serv-  
9 ices shall transfer each fiscal year to the Graduate  
10 Medical Education and Academic Health Centers  
11 Trust Fund from the Federal Hospital Insurance  
12 Trust Fund and the Federal Supplementary Medical  
13 Insurance Trust Fund established under the Social  
14 Security Act the sum of—

15 “(A) the amount that would have been  
16 paid from the Federal Hospital Insurance Trust  
17 Fund in such fiscal year under section  
18 1886(d)(5)(B) of such Act (as in effect before  
19 the date of the enactment of the Health Secu-  
20 rity Act), plus

21 “(B) the amount that would have been  
22 paid from such trust funds in such fiscal year  
23 under section 1886(h) of such Act (as so in ef-  
24 fect).

1       “(c) GRADUATE MEDICAL AND NURSING EDUCATION  
2 TRUST FUND.—

3           “(1) TRANSFERS.—There is allocated to the  
4 Graduate Medical and Nursing Education Trust  
5 Fund each fiscal year an amount equal to the sum  
6 of—

7           “(A) amounts described in subsection  
8 (b)(2)(B), plus

9           “(B) the excess of—

10           “(i) the amounts made available  
11 under subpart I of part D of title XVIII of  
12 the Social Security Act, over

13           “(ii) the amount described in subpara-  
14 graph (A).

15           “(2) EXPENDITURES.—Amounts in the Grad-  
16 uate Medical and Nursing Education Trust Fund  
17 are appropriated to carry out the programs estab-  
18 lished under subpart I of part D of title XVIII of  
19 the Social Security Act, and to the extent any such  
20 amount is not expended during any fiscal year, such  
21 amount shall be available for such purpose for sub-  
22 sequent fiscal years.

23       “(d) ACADEMIC HEALTH CENTERS TRUST FUND.—

1           “(1) TRANSFERS.—There is allocated to the  
2 Academic Health Centers Trust Fund each fiscal  
3 year an amount equal to the sum of—

4           “(A) amounts described in subsection  
5 (b)(2)(A), plus

6           “(B) the excess of—

7           “(i) the amounts made available  
8 under subpart II of part D of title XVIII  
9 of the Social Security Act, over

10           “(ii) the amount described in subpara-  
11 graph (A).

12           “(2) EXPENDITURES.—Amounts in the Aca-  
13 demic Health Centers Trust Fund are appropriated  
14 to carry out the programs established under subpart  
15 II of part D of title XVIII of the Social Security  
16 Act, and to the extent any such amount is not ex-  
17 pended during any fiscal year, such amount shall be  
18 available for such purpose for subsequent fiscal  
19 years.

20           “(e) RULES RELATING TO ACCOUNTS.—

21           “(1) INSUFFICIENT FUNDS.—If, for any fiscal  
22 year, the sum of the amounts required to be allo-  
23 cated under subsections (c) and (d) exceeds the  
24 amounts received in the Graduate Medical Edu-  
25 cation and Academic Health Centers Trust Fund,

1 then each of such amounts required to be so allo-  
2 cated shall be reduced to an amount which bears the  
3 same ratio to such amount as the amounts received  
4 in the trust fund bear to the amounts required to be  
5 so allocated (without regard to this paragraph).

6 “(2) ALLOCATION OF EXCESS FUNDS AND IN-  
7 TEREST.—Amounts received in the Graduate Medi-  
8 cal Education and Academic Health Centers Trust  
9 Fund in excess of the amounts required to be allo-  
10 cated under subsections (c) and (d), and amounts  
11 credited to such trust fund under section 9602(b),  
12 for any fiscal year shall be allocated to each account  
13 ratably on the basis of the amounts allocated to the  
14 account for the fiscal year (without regard to this  
15 paragraph).

16 **“SEC. 9553. BIOMEDICAL AND BEHAVIORAL RESEARCH**  
17 **TRUST FUND.**

18 “(a) CREATION OF TRUST FUND.—There is estab-  
19 lished in the Treasury of the United States a trust fund  
20 to be known as the ‘Biomedical and Behavioral Research  
21 Trust Fund’, consisting of such amounts as may be appro-  
22 priated or credited to the Biomedical and Behavioral Re-  
23 search Trust Fund as provided in this section or section  
24 9602(b).

1       “(b) TRANSFERS TO THE TRUST FUND.—There are  
2 hereby appropriated to the Biomedical and Behavioral Re-  
3 search Trust Fund amounts equivalent to 14.3 percent of  
4 amounts received in the Treasury under sections 4501 and  
5 4502 (relating to assessments on insured and self-insured  
6 health plans).

7       “(c) EXPENDITURES FROM THE TRUST FUND.—

8           “(1) IN GENERAL.—The Secretary shall pay an-  
9 nually, within 30 days after the President signs an  
10 appropriations Act for the Departments of Labor,  
11 Health and Human Services, and Education and re-  
12 lated agencies, or by the end of the first quarter, to  
13 the Secretary of Health and Human Services, an  
14 amount equal to the amount in the Biomedical and  
15 Behavioral Research Trust Fund at the time of such  
16 payment.

17           “(2) DISTRIBUTION OF AMOUNTS.—The Sec-  
18 retary of Health and Human Services shall distrib-  
19 ute—

20           “(A) 3 percent of the amounts received  
21 under paragraph (1) during any fiscal year to  
22 the Office of the Director of the National Insti-  
23 tutes of Health and for construction of intra-  
24 mural and extramural buildings and facilities

1 under section 1502 of the National Institutes of  
2 Health Revitalization Act of 1993,

3 “(B) 20 percent of the amounts received  
4 under paragraph (1) during any fiscal year to  
5 the Agency for Health Care Policy and Re-  
6 search for health care services research under  
7 section 21502 of the Social Security Act, and

8 “(C) the remainder of the amounts re-  
9 ceived under paragraph (1) during any fiscal  
10 year to member institutes of the National Insti-  
11 tutes of Health in the same proportion to the  
12 total amount received under such paragraph, as  
13 the amount of annual appropriations under ap-  
14 propriations Acts for each member institute for  
15 the fiscal year bears to the total amount of ap-  
16 propriations under appropriations Acts for all  
17 member institutes of the National Institutes of  
18 Health for the fiscal year.

19 “(3) MAINTENANCE OF EFFORT.—No amounts  
20 in the Biomedical and Behavioral Research Trust  
21 Fund shall replace or reduce the amount of appro-  
22 priations for the National Institutes of Health under  
23 appropriations Acts.”

1 (b) CONFORMING AMENDMENT.—Subchapter A of  
 2 chapter 98 is amended by inserting after the subchapter  
 3 heading the following new items:

“Part I. General trust funds.  
 “Part II. Health care trust funds.

4 **“PART I—GENERAL TRUST FUNDS”.**  
 5 **Subtitle G—Other Revenue**  
 6 **Provisions**

7 **PART I—EMPLOYMENT STATUS PROVISIONS**

8 **SEC. 771. EMPLOYMENT STATUS PROPOSAL REQUIRED**  
 9 **FROM DEPARTMENT OF THE TREASURY.**

10 Not later than January 1, 1996, the Secretary of the  
 11 Treasury shall submit to the Committee on Ways and  
 12 Means of the House of Representatives and the Committee  
 13 on Finance of the Senate a legislative proposal providing  
 14 statutory standards for the classification of workers as  
 15 employees or independent contractors.

16 **SEC. 772. INCREASE IN SERVICES REPORTING PENALTIES.**

17 (a) INCREASE IN PENALTY.—Section 6721(a) (relat-  
 18 ing to imposition of penalty) is amended by adding at the  
 19 end the following new paragraph:

20 “(3) INCREASED PENALTY FOR RETURNS IN-  
 21 VOLVING PAYMENTS FOR SERVICES.—

22 “(A) IN GENERAL.—Subject to the overall  
 23 limitation of paragraph (1), the amount of the  
 24 penalty under paragraph (1) for any failure

1 with respect to any applicable return shall be  
2 equal to the greater of \$50 or 5 percent of the  
3 amount required to be reported correctly but  
4 not so reported.

5 “(B) EXCEPTION WHERE SUBSTANTIAL  
6 COMPLIANCE.—Subparagraph (A) shall not  
7 apply to failures with respect to applicable re-  
8 turns required to be filed by a person during  
9 any calendar year if the aggregate amount  
10 which is timely and correctly reported on appli-  
11 cable returns filed by the person for the cal-  
12 endar year is at least 97 percent of the aggre-  
13 gate amount which is required to be reported  
14 on applicable returns by the person for the cal-  
15 endar year.

16 “(C) APPLICABLE RETURN.—For purposes  
17 of this paragraph, the term ‘applicable return’  
18 means any information return required to be  
19 filed under—

20 “(i) section 6041(a) but only if such  
21 return relates to payments to any person  
22 for services performed by such person  
23 (other than as an employee), or

24 “(ii) section 6041A(a).”

1 (b) CONFORMING AMENDMENT.—Section 6721(a)(1)  
 2 is amended by striking “In” and inserting “Except as pro-  
 3 vided in paragraph (3), in”.

4 (c) EFFECTIVE DATE.—The amendments made by  
 5 this section shall apply to returns the due date for which  
 6 (without regard to extensions) is more than 30 days after  
 7 the date of the enactment of this Act.

8 **PART II—TAX INCENTIVES FOR HEALTH**  
 9 **SERVICES PROVIDERS**

10 **SEC. 775. NONREFUNDABLE CREDIT FOR CERTAIN PRI-**  
 11 **MARY HEALTH SERVICES PROVIDERS.**

12 (a) IN GENERAL.—Subpart A of part IV of sub-  
 13 chapter A of chapter 1 (relating to nonrefundable personal  
 14 credits) is amended by inserting after section 22 the fol-  
 15 lowing new section:

16 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

17 “(a) ALLOWANCE OF CREDIT.—There shall be al-  
 18 lowed as a credit against the tax imposed by this chapter  
 19 for the taxable year an amount equal to the product of—

20 “(1) the number of months during such taxable  
 21 year—

22 “(A) during which the taxpayer is a quali-  
 23 fied primary health services provider, and

24 “(B) which are within the taxpayer’s eligi-  
 25 ble service period, and

1           “(2) \$1,000 (\$500 in the case of a qualified  
2 practitioner who is not a physician).

3           “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-  
4 VIDER.—For purposes of this section—

5           “(1) IN GENERAL.—The term ‘qualified pri-  
6 mary health services provider’ means, with respect to  
7 any month, any qualified practitioner who—

8           “(A) has in effect a certification by the  
9 Bureau as a provider of primary health services  
10 and such certification is, when issued, for a  
11 health professional shortage area in which the  
12 qualified practitioner is providing primary  
13 health services,

14           “(B) is providing primary health services  
15 full time in the health professional shortage  
16 area identified in such certification, and

17           “(C) has not received a scholarship under  
18 the National Health Service Corps Scholarship  
19 Program or any loan repayments under the  
20 National Health Service Corps Loan Repay-  
21 ment Program.

22           “(2) SPECIAL RULES RELATING TO SHORTAGE  
23 AREAS.—

24           “(A) AREAS CEASING TO BE SHORTAGE  
25 AREAS.—For purposes of paragraph (1)(B) and

1 subsection (e)(2), a provider shall be treated as  
2 providing services in a health professional  
3 shortage area when such area ceases to be such  
4 an area if it was such an area on the first day  
5 of the provider's eligible service period.

6 “(B) AREAS WITHIN METROPOLITAN  
7 AREAS.—A qualified practitioner who is provid-  
8 ing services within a metropolitan statistical  
9 area (as defined in section 143(k)(2)) shall not  
10 be treated as meeting the requirements of para-  
11 graph (1)(B) unless such services are provided  
12 for, or on behalf of, a governmental or non-  
13 profit entity.

14 “(3) QUALIFIED PRACTITIONER.—The term  
15 ‘qualified practitioner’ means a physician, a physi-  
16 cian assistant, a nurse practitioner, or a certified  
17 nurse-midwife.

18 “(c) ELIGIBLE SERVICE PERIOD.—For purposes of  
19 this section, the term ‘eligible service period’ means the  
20 period of 36 consecutive calendar months beginning with  
21 the first month the taxpayer is a qualified primary health  
22 services provider (as specified in the certification under  
23 subsection (b)(1)(A)). A taxpayer shall not have more  
24 than 1 eligible service period.

1 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—

2 For purposes of this section—

3 “(1) BUREAU.—The term ‘Bureau’ means the  
4 Bureau of Primary Health Care, Health Resources  
5 and Services Administration of the United States  
6 Public Health Service.

7 “(2) PHYSICIAN.—The term ‘physician’ has the  
8 meaning given to such term by section 1861(r) of  
9 the Social Security Act.

10 “(3) PHYSICIAN ASSISTANT; NURSE PRACTI-  
11 TIONER.—The terms ‘physician assistant’ and ‘nurse  
12 practitioner’ have the meanings given to such terms  
13 by section 1861(aa)(5) of the Social Security Act.

14 “(4) CERTIFIED NURSE-MIDWIFE.—The term  
15 ‘certified nurse-midwife’ has the meaning given to  
16 such term by section 1861(gg)(2) of the Social Secu-  
17 rity Act.

18 “(5) PRIMARY HEALTH SERVICES.—The term  
19 ‘primary health services’ has the meaning given such  
20 term by section 330(b)(1) of the Public Health Serv-  
21 ice Act.

22 “(6) HEALTH PROFESSIONAL SHORTAGE  
23 AREA.—The term ‘health professional shortage area’  
24 has the meaning given such term by section  
25 332(a)(1)(A) of the Public Health Service Act.

1           “(7) PRACTITIONER CURRENTLY PRACTICING IN  
2 SHORTAGE AREAS.—In the case of a qualified practi-  
3 tioner who, on December 31, 1994, was providing  
4 primary health services in any health professional  
5 shortage area—

6           “(A) the practitioner’s eligible service pe-  
7 riod shall begin on January 1, 1995, and

8           “(B) if such practitioner is a physician,  
9 subsection (a)(2) shall be applied by substitut-  
10 ing ‘\$500’ for ‘\$1,000’.

11       “(e) RECAPTURE OF CREDIT.—

12           “(1) IN GENERAL.—If there is a recapture  
13 event during any taxable year, then—

14           “(A) no credit shall be allowed under sub-  
15 section (a) for such taxable year and any suc-  
16 ceeding taxable year, and

17           “(B) the tax of the taxpayer under this  
18 chapter for such taxable year shall be increased  
19 by an amount equal to the aggregate credits al-  
20 lowed to such taxpayer under this section for all  
21 prior taxable years.

22       “(2) RECAPTURE EVENT DEFINED.—

23           “(A) IN GENERAL.—For purposes of this  
24 subsection, the term ‘recapture event’ means  
25 the failure of the taxpayer to be a qualified pri-

1           mary health services provider during any of the  
2           first 24 months during the taxpayer's eligible  
3           service period.

4           “(B) SECRETARIAL WAIVER.—The Sec-  
5           retary, in consultation with the Secretary of  
6           Health and Human Services, may waive any re-  
7           capture event caused by extraordinary cir-  
8           cumstances.

9           “(3) NO CREDITS AGAINST TAX; MINIMUM  
10          TAX.—Any increase in tax under this subsection  
11          shall not be treated as a tax imposed by this chapter  
12          for purposes of determining the amount of any cred-  
13          it under subpart A, B, or D of this part or for pur-  
14          poses of section 55.”

15          (b) CLERICAL AMENDMENT.—The table of sections  
16          for subpart A of part IV of subchapter A of chapter 1  
17          is amended by inserting after the item relating to section  
18          22 the following new item:

                  “Sec. 23. Primary health services providers.”

19          (c) EFFECTIVE DATE.—The amendments made by  
20          this section shall apply to taxable years beginning after  
21          December 31, 1994.

22          **SEC. 776. EXPENSING OF MEDICAL EQUIPMENT.**

23          (a) IN GENERAL.—Paragraph (1) of section 179(b)  
24          (relating to dollar limitation on expensing of certain depre-  
25          ciable business assets) is amended to read as follows:

1 “(1) DOLLAR LIMITATION.—

2 “(A) GENERAL RULE.—The aggregate cost  
3 which may be taken into account under sub-  
4 section (a) for any taxable year shall not exceed  
5 \$17,500.

6 “(B) HEALTH CARE PROPERTY.—The ag-  
7 gregate cost which may be taken into account  
8 under subsection (a) shall be increased by the  
9 lesser of—

10 “(i) the cost of section 179 property  
11 which is health care property placed in  
12 service during the taxable year, or

13 “(ii) \$15,000.”

14 (b) DEFINITION.—Section 179(d) (relating to defini-  
15 tions) is amended by adding at the end the following new  
16 paragraph:

17 “(11) HEALTH CARE PROPERTY.—

18 “(A) IN GENERAL.—For purposes of this  
19 section, the term ‘health care property’ means  
20 section 179 property—

21 “(i) which is medical equipment used  
22 in the screening, monitoring, observation,  
23 diagnosis, or treatment of patients in a  
24 laboratory, medical, or hospital environ-  
25 ment,

1           “(ii) which is owned (directly or indi-  
2           rectly) and used by 1 or more physicians  
3           (as defined in section 1861(r) of the Social  
4           Security Act) in the active conduct of the  
5           full-time trade or business of all such phy-  
6           sicians of providing primary health services  
7           (as defined in section 330(b)(1) of the  
8           Public Health Service Act) in a health pro-  
9           fessional shortage area (as defined in sec-  
10          tion 332(a)(1)(A) of the Public Health  
11          Service Act), and

12           “(iii) substantially all the use of which  
13          is in such area.

14          “(B) SPECIAL RULE FOR METROPOLITAN  
15          STATISTICAL AREAS.—A physician who is pro-  
16          viding services within a metropolitan statistical  
17          area (as defined in section 143(k)(2)) shall not  
18          be treated as meeting the requirements of sub-  
19          paragraph (A)(ii) unless such services are pro-  
20          vided for, or on behalf of, a governmental or  
21          nonprofit entity.”

22          (c) RECAPTURE.—Paragraph (10) of section 179(d)  
23          is amended by inserting “and with respect to any health  
24          care property which ceases (other than by an area failing

1 to be treated as a health professional shortage area) to  
2 be health care property at any time” before the period.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to property placed in service in  
5 taxable years beginning after December 31, 1994.

6 **PART III—MISCELLANEOUS PROVISIONS**

7 **SEC. 781. POST-RETIREMENT MEDICAL AND LIFE INSUR-**  
8 **ANCE RESERVES.**

9 (a) MINIMUM PERIOD FOR WORKING LIVES.—Sec-  
10 tion 419A(c)(2) (relating to additional reserves for post-  
11 retirement medical and life insurance benefits) is amended  
12 by inserting “(but not less than 10 years)” after “working  
13 lives of the covered employees”.

14 (b) SEPARATE ACCOUNTING.—

15 (1) REQUIREMENT.—Section 419A(c)(2) is  
16 amended by adding at the end the following new  
17 flush sentence:

18 “Such reserve shall be maintained as a separate account.”

19 (2) USE OF RESERVE FOR OTHER PURPOSES.—  
20 Paragraph (1) of section 4976(b) (defining disquali-  
21 fied benefit) is amended by striking “and” at the  
22 end of subparagraph (B), by striking the period at  
23 the end of subparagraph (C) and inserting “, and”,  
24 and by adding after subparagraph (C) the following  
25 new subparagraph:

1           “(D) any payment to which subparagraph  
2           (C) does not apply which is out of an account  
3           described in section 419A(c)(2) and which is  
4           not used to provide a post-retirement medical  
5           benefit or life insurance benefit.”

6           (c) EFFECTIVE DATES.—

7           (1) IN GENERAL.—Except as provided in para-  
8           graph (2), the amendments made by this section  
9           shall apply to contributions paid or accrued after  
10          December 31, 1994, in taxable years ending after  
11          such date.

12          (2) SEPARATE ACCOUNTING.—The amendments  
13          made by subsection (b) shall apply to contributions  
14          paid or accrued after the date of the enactment of  
15          this Act, in taxable years ending after such date.

16 **SEC. 782. COORDINATION WITH HEALTH CARE CONTINU-**  
17 **ATION PROVISIONS.**

18          (a) AMENDMENTS TO INTERNAL REVENUE CODE.—

19               (1) IN GENERAL.—Clause (i) of section  
20               4980B(f)(2)(B) (defining period of coverage) is  
21               amended to read as follows:

22                       “(i) MAXIMUM PERIOD.—The later  
23                       of—

1                   “(I) the date which is 6 months  
2                   after the date of the qualifying event,  
3                   or

4                   “(II) the last day of the calendar  
5                   year in which the qualifying event oc-  
6                   curs.”

7                   (2) CONFORMING AMENDMENTS.—Section  
8                   4980B(f)(2) is amended—

9                   (A) by striking clause (v) of subparagraph  
10                  (B),

11                  (B) by striking the last sentence of sub-  
12                  paragraph (C), and

13                  (C) by striking subparagraph (E).

14                  (b) AMENDMENTS TO ERISA.—

15                  (1) IN GENERAL.—Section 602(2)(A) of the  
16                  Employee Retirement Income Security Act of 1974  
17                  (29 U.S.C. 1162(2)(A)) is amended to read as fol-  
18                  lows:

19                         “(A) MAXIMUM REQUIRED PERIOD.—The  
20                         later of—

21                                 “(i) the date which is 6 months after  
22                                 the date of the qualifying event, or

23                                 “(ii) the last day of the calendar year  
24                                 in which the qualifying event occurs.”

1           (2) CONFORMING AMENDMENTS.—Section 602  
2 of such Act (29 U.S.C. 1162) is amended—

3           (A) by striking subparagraph (E) of para-  
4 graph (2),

5           (B) by striking the last sentence of para-  
6 graph (3), and

7           (C) by striking paragraph (5).

8 (c) AMENDMENTS TO PHSA.—

9           (1) IN GENERAL.—Section 2202(2)(A) of the  
10 Public Health Service Act (42 U.S.C. 300bb-  
11 2(2)(A)) is amended to read as follows:

12           “(A) MAXIMUM REQUIRED PERIOD.—The  
13 later of—

14           “(i) the date which is 6 months after  
15 the date of the qualifying event, or

16           “(ii) the last day of the calendar year  
17 in which the qualifying event occurs.”

18           (2) CONFORMING AMENDMENTS.—Section 2202  
19 of such Act (42 U.S.C. 300bb-2) is amended—

20           (A) by striking subparagraph (E) of para-  
21 graph (2),

22           (B) by striking the last sentence of para-  
23 graph (3), and

24           (C) by striking paragraph (5).

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section apply to qualifying events occurring after De-  
3 cember 31, 1996.

4 **SEC. 783. CREDIT FOR COST OF PERSONAL ASSISTANCE**  
5 **SERVICES REQUIRED BY EMPLOYED INDIVID-**  
6 **UALS.**

7 (a) IN GENERAL.—Subpart A of part IV of sub-  
8 chapter A of chapter 1 (relating to nonrefundable personal  
9 credits), as amended by section 775, is amended by insert-  
10 ing after section 23 the following new section:

11 **“SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES RE-**  
12 **QUIRED BY EMPLOYED INDIVIDUALS.**

13 “(a) ALLOWANCE OF CREDIT.—

14 “(1) IN GENERAL.—In the case of an eligible  
15 individual, there shall be allowed as a credit against  
16 the tax imposed by this chapter for the taxable year  
17 an amount equal to the applicable percentage of the  
18 personal assistance expenses paid or incurred by the  
19 taxpayer during such taxable year.

20 “(2) APPLICABLE PERCENTAGE.—For purposes  
21 of paragraph (1), the term ‘applicable percentage’  
22 means 50 percent reduced (but not below zero) by  
23 10 percentage points for each \$5,000 by which the  
24 modified adjusted gross income (as defined in sec-  
25 tion 59B(d)(2)) of the taxpayer for the taxable year

1 exceeds \$45,000. In the case of a married individual  
2 filing a separate return, the preceding sentence shall  
3 be applied by substituting ‘\$2,500’ for ‘\$5,000’ and  
4 ‘\$22,500’ for ‘\$45,000’.

5 “(b) LIMITATION.—The amount of personal assist-  
6 ance expenses for the benefit of an individual which may  
7 be taken into account under subsection (a) for the taxable  
8 year shall not exceed the lesser of—

9 “(1) \$15,000, or

10 “(2) such individual’s earned income (as de-  
11 fined in section 32(c)(2)) for the taxable year.

12 In the case of a joint return, the amount under the preced-  
13 ing sentence shall be determined separately for each  
14 spouse.

15 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this  
16 section, the term ‘eligible individual’ means any individual  
17 (other than a nonresident alien) who, by reason of any  
18 medically determinable physical impairment which can be  
19 expected to result in death or which has lasted or can be  
20 expected to last for a continuous period of not less than  
21 12 months, is unable to engage in any substantial gainful  
22 activity without personal assistance services appropriate to  
23 carry out activities of daily living. An individual shall not  
24 be treated as an eligible individual unless such individual

1 furnishes such proof thereof (in such form and manner,  
2 and at such times) as the Secretary may require.

3 “(d) OTHER DEFINITIONS.—For purposes of this  
4 section—

5 “(1) PERSONAL ASSISTANCE EXPENSES.—The  
6 term ‘personal assistance expenses’ means expenses  
7 for—

8 “(A) personal assistance services appro-  
9 priate to carry out activities of daily living in or  
10 outside the home,

11 “(B) homemaker/chore services incidental  
12 to the provision of such personal assistance  
13 services,

14 “(C) in the case of an individual with a  
15 cognitive impairment, assistance with life skills,

16 “(D) communication services,

17 “(E) work-related support services,

18 “(F) coordination of services described in  
19 this paragraph,

20 “(G) assistive technology and devices, in-  
21 cluding assessment of the need for particular  
22 technology and devices and training of family  
23 members, and

24 “(H) modifications to the principal place of  
25 abode of the individual to the extent the ex-

1           penses for such modifications would (but for  
2           subsection (e)(2)) be expenses for medical care  
3           (as defined by section 213) of such individual.

4           “(2) ACTIVITIES OF DAILY LIVING.—The term  
5           ‘activities of daily living’ means eating, toileting,  
6           transferring, bathing, and dressing.

7           “(e) SPECIAL RULES.—

8           “(1) PAYMENTS TO RELATED PERSONS.—No  
9           credit shall be allowed under this section for any  
10          amount paid by the taxpayer to any person who is  
11          related (within the meaning of section 267 or  
12          707(b)) to the taxpayer.

13          “(2) COORDINATION WITH MEDICAL EXPENSE  
14          DEDUCTION.—Any amount taken into account in de-  
15          termining the credit under this section shall not be  
16          taken into account in determining the amount of the  
17          deduction under section 213.

18          “(3) BASIS REDUCTION.—For purposes of this  
19          subtitle, if a credit is allowed under this section for  
20          any expense with respect to any property, the in-  
21          crease in the basis of such property which would  
22          (but for this paragraph) result from such expense  
23          shall be reduced by the amount of the credit so al-  
24          lowed.

1       “(f) COST-OF-LIVING ADJUSTMENT.—In the case of  
2 any taxable year beginning after 1996, the \$45,000 and  
3 \$22,500 amounts in subsection (a)(2) and the \$15,000  
4 amount in subsection (b) shall be increased by an amount  
5 equal to—

6           “(1) such dollar amount, multiplied by

7           “(2) the cost-of-living adjustment determined  
8 under section 1(f)(3) for the calendar year in which  
9 the taxable year begins by substituting ‘calendar  
10 year 1995’ for ‘calendar year 1992’ in subparagraph  
11 (B) thereof.

12 If any increase determined under the preceding sentence  
13 is not a multiple of \$1,000, such increase shall be rounded  
14 to the nearest multiple of \$1,000.”

15       (b) TECHNICAL AMENDMENT.—Subsection (a) of  
16 section 1016 is amended by striking “and” at the end of  
17 paragraph (24), by striking the period at the end of para-  
18 graph (25) and inserting “, and”, and by adding at the  
19 end thereof the following new paragraph:

20           “(26) in the case of any property with respect  
21 to which a credit has been allowed under section 24,  
22 to the extent provided in section 24(e)(3).”

23       (c) CLERICAL AMENDMENT.—The table of sections  
24 for subpart A of part IV of subchapter A of chapter 1

1 is amended by inserting after the item relating to section  
2 23 the following new item:

“Sec. 24. Cost of personal assistance services required by em-  
ployed individuals.”

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to taxable years beginning after  
5 December 31, 1995.

6 **SEC. 784. DISCLOSURE OF RETURN INFORMATION FOR AD-**  
7 **MINISTRATION OF CERTAIN PROGRAMS**  
8 **UNDER THE HEALTH SECURITY ACT.**

9 (a) IN GENERAL.—Section 6103(l) (relating to dis-  
10 closure of returns and return information for purposes  
11 other than tax administration) is amended by adding at  
12 the end the following new paragraph:

13 “(15) DISCLOSURE OF RETURN INFORMATION  
14 FOR PURPOSES OF HEALTH SECURITY ACT.—

15 “(A) IN GENERAL.—The Secretary shall,  
16 upon written request, disclose current return in-  
17 formation described in subparagraph (B) to any  
18 Federal, State, or local agency administering an  
19 assistance program under the Health Security  
20 Act.

21 “(B) INFORMATION.—The information de-  
22 scribed in this subparagraph is information  
23 which consists only of adjusted gross income,  
24 the untaxed portion of social security benefits,

1 tax-exempt interest income, marital status, and  
2 dependents.

3 “(C) RESTRICTION ON DISCLOSURE.—The  
4 Secretary shall disclose return information  
5 under subparagraph (A) only for purposes of,  
6 and to the extent necessary in, determining eli-  
7 gibility for, or the correct amount of, assistance  
8 provided under the Health Security Act.

9 “(D) EXCLUSION FROM MATCHING PRO-  
10 GRAM.—Any matches of information under this  
11 paragraph shall not be treated as a matching  
12 program for purposes of section 552a of title 5,  
13 United States Code.”

14 (b) CONFORMING AMENDMENTS.—

15 (1) Section 6103(a)(2) is amended by inserting  
16 “or (15)” after “subsection (l)(7)(D)”.

17 (2) Section 6103(p)(3)(A) is amended by strik-  
18 ing “or (14)” and inserting “(14), or (15)”.

19 (3) Section 6103(p)(4) is amended—

20 (A) by striking “or (12)” in the matter  
21 preceding subparagraph (A) and inserting  
22 “(12), or (15)”, and

23 (B) by striking “or (14)” in subparagraph  
24 (F)(ii) and inserting “(14), or (15)”.

1           (4) Section 7213(a)(2) is amended by striking  
2           “or (12)” and inserting “(12), or (15)”.

3 **SEC. 785. SPECIAL RULE FOR DEFERRED COMPENSATION**  
4 **PLANS OF GROUP MEDICAL PRACTICES.**

5           (a) IN GENERAL.—Section 457(e) is amended by  
6 adding at the end the following new paragraph:

7           “(14) TREATMENT OF EXCESS BENEFIT AR-  
8 RANGEMENTS OF CERTAIN GROUP MEDICAL PRAC-  
9 TICES.—

10           “(A) IN GENERAL.—In the case of an indi-  
11 vidual who—

12           “(i) is a member of a group medical  
13 practice which is exempt from taxation  
14 under section 501(a) and which is de-  
15 scribed in section 501(c)(3), and

16           “(ii) is a participant in an eligible de-  
17 ferred compensation plan maintained by  
18 such practice which is an excess benefit  
19 plan,

20 subsections (b)(2) and (c)(1) shall not apply in de-  
21 termining the maximum amount which may be de-  
22 ferred under such plan for a taxable year.

23           “(B) EXCESS BENEFIT PLAN.—For pur-  
24 poses of subparagraph (A), the term ‘excess  
25 benefit plan’ means a plan (or separable part

1           thereof) which is maintained by an employer  
2           solely for purposes of providing benefits for cer-  
3           tain employees in excess of the limitations on  
4           contributions and benefits imposed by section  
5           415.”

6           (b) EFFECTIVE DATE.—The amendments made by  
7 this section apply to taxable years beginning after Decem-  
8 ber 31, 1994.

9           **Subtitle H—Ensuring Health Care**  
10           **Financing**

11           **SEC. 791. ENSURING HEALTH CARE FINANCING.**

12           (a) PURPOSE.—

13           (1) IN GENERAL.—The purpose of this section  
14 is to ensure that programs established under this  
15 Act, and unanticipated increases in other Federal  
16 health spending, do not increase the Federal deficit.

17           (2) DEFINITION.—For purposes of this sub-  
18 section, the term “other Federal health spending”  
19 includes medicare expenditures, medicaid expendi-  
20 tures, and the revenue losses associated with the em-  
21 ployee exclusion of employer-provided accident and  
22 health coverage and the deductibility of individual  
23 medical expenses in excess of 7.5 percent of adjusted  
24 gross income.

1           (b) LEGAL ENTITLEMENTS CONTINGENT.—Any enti-  
2 tlement provided by this Act to premium and cost-sharing  
3 assistance, or to tax deductions for health insurance pre-  
4 miums provided by section 731 of this Act, shall be subject  
5 to the operation of this section.

6           (c) DETERMINATION OF UNFINANCED HEALTH  
7 SPENDING.—

8           (1) CURRENT HEALTH SPENDING ESTIMATE.—

9           (A) FISCAL YEARS THROUGH 2004.—Not  
10 later than the date that is 60 days after the  
11 date of enactment of this Act, the President  
12 shall issue an executive order setting forth the  
13 current health spending estimate for fiscal year  
14 1995 and for each subsequent fiscal year  
15 through 2004, which shall consist of estimates  
16 (for each year) projecting what Federal outlays  
17 or revenues would have been if this Act had not  
18 been enacted, for the following:

19                   (i) total outlays under the Medicare  
20 and Medicaid programs (including admin-  
21 istrative costs and offsetting receipts); and

22                   (ii) revenue losses associated with—

23                           (I) the employee exclusion of em-  
24 ployer-provided accident and health  
25 coverage; and

1 (II) the deductibility of individual  
2 medical expenses in excess of 7.5 per-  
3 cent of adjusted gross income.

4 (B) FISCAL YEARS AFTER 2004.—For each  
5 fiscal year following fiscal year 2004, the cur-  
6 rent health spending estimate is the estimate  
7 set forth in the executive order for fiscal year  
8 2004, modified by an annual adjustment factor  
9 set forth in such order.

10 (2) PRESIDENT'S BUDGET TO INCLUDE  
11 HEALTH REFORM ESTIMATES.—

12 (A) ESTIMATES FOR UPCOMING FISCAL  
13 YEAR AND CURRENT YEAR.—When the Presi-  
14 dent submits the budget for fiscal year 1996  
15 (as required by section 1105 of title 31), and  
16 for each fiscal year thereafter, the President  
17 shall include a health reform estimate (as speci-  
18 fied in paragraph (3)) with respect to the up-  
19 coming fiscal year and the current fiscal year.

20 (B) DETERMINATIONS FOR PRIOR FISCAL  
21 YEAR.—When the President submits the budget  
22 for fiscal year 1997 (as required by section  
23 1105 of title 31), and for each fiscal year there-  
24 after, the President shall include determinations  
25 for the fiscal year which ended the prior Sep-

1           tember, with respect to the items specified in  
2           the health reform estimate (as specified in  
3           paragraph (3)).

4           (3) HEALTH REFORM ESTIMATE.—

5                 (A) IN GENERAL.—The health reform esti-  
6           mate is a calculation, for the applicable fiscal  
7           year, of—

8                         (i) updated projections for the appli-  
9                         cable fiscal year for each item set forth in  
10                        the current health estimate (as set forth in  
11                        paragraph (1)); plus

12                       (ii) the health reform outlays set forth  
13                        in subparagraph (B); minus

14                       (iii) the net health reform revenues  
15                        set forth in subparagraph (C).

16                 (B) HEALTH REFORM OUTLAYS.—Health  
17           reform outlays equal—

18                         (i) total outlays for premium and cost  
19                         sharing assistance (including administra-  
20                         tive costs) projected for the fiscal year;  
21                         plus

22                         (ii) other changes in outlays resulting  
23                         from this Act, including discretionary ap-  
24                         propriations enacted pursuant to this Act.

1 (C) NET HEALTH REFORM REVENUES.—

2 Net health reform revenues equal—

3 (i) total new revenues projected for  
4 the applicable fiscal year due to the in-  
5 crease in the tobacco excise tax and the tax  
6 on high cost health plans provided in this  
7 Act; minus

8 (ii) total revenue losses projected for  
9 the applicable fiscal year due to the deduc-  
10 tion for purchase by individuals and the  
11 self-employed of health insurance policies  
12 provided by section 731 of this Act; plus or  
13 minus

14 (iii) other changes in revenues result-  
15 ing from this Act (which are not reflected  
16 in the updated current health estimate as  
17 set forth in subparagraph (A)(i)).

18 (4) DETERMINATION OF UNFINANCED HEALTH  
19 SPENDING AND EXCESS HEALTH FINANCING.—Each  
20 health reform estimate required by this subsection  
21 shall be accompanied by a comparison of such esti-  
22 mate with the current health spending estimate for  
23 the applicable fiscal year. If the applicable health re-  
24 form estimate exceeds the applicable current health  
25 spending estimate, the President shall report the

1 amount of the excess as unfinanced health spending  
2 for the applicable fiscal year. If the applicable health  
3 reform estimate is less than the applicable current  
4 health spending estimate, the President shall report  
5 such difference as excess health financing for the ap-  
6 plicable fiscal year.

7 (d) OFFSETTING UNFINANCED HEALTH SPEND-  
8 ING.—

9 (1) REQUIREMENT TO FULLY OFFSET  
10 UNFINANCED HEALTH SPENDING.—If the Presi-  
11 dent's budget includes a determination of unfinanced  
12 health spending pursuant to subsection (c)(4) for  
13 the upcoming fiscal year, the current fiscal year, or  
14 the fiscal year which ended the prior October, such  
15 determination shall be accompanied by an executive  
16 order effective on October 1 of that calendar year  
17 which fully offsets in the fiscal year beginning Octo-  
18 ber 1 the sum of such unfinanced health spending  
19 (for the upcoming fiscal year, the current fiscal year,  
20 and the prior fiscal year) in the manner provided in  
21 this subsection. Such executive order shall be accom-  
22 panied by such regulations as are required under  
23 subsection (d)(4).

1           (2) OFFSETS.—The offsets required by this  
2 subsection shall be accomplished through a combina-  
3 tion of—

4           (A) subject to the provisions of paragraph

5           (3)—

6           (i) in the case of the premium assist-  
7           ance program, reducing the percentages  
8           otherwise in effect for the fiscal year under  
9           clauses (i) and (ii) of section 1952  
10          (a)(2)(A) of the Social Security Act, and

11          (ii) in the case of the cost-sharing as-  
12          sistance program, reducing payments to  
13          the States under section 1957 of such Act;

14          (B) reducing the percentage specified in  
15          section 213(f)(1) of the Internal Revenue Code  
16          of 1986; and

17          (C) increasing out-of-pocket limits in the  
18          standard and alternative benefits packages as  
19          imposed by the National Health Benefits Board  
20          pursuant to this Act, to the extent such actions  
21          will produce measurable Federal outlay savings.

22          (3) ELIGIBILITY PERCENTAGE FOR PREGNANT  
23          WOMEN AND CHILDREN REDUCED LAST.—Any re-  
24          duction under paragraph (2)(A)—

1 (A) shall be made first by reducing the  
2 percentages under sections 1952(a)(2)(A)(i) of  
3 the Social Security Act and by reducing the  
4 payments to States under 1957 of such Act;  
5 and

6 (B) to the extent sufficient offsets may not  
7 be made under subparagraph (A), shall then be  
8 made by reducing the percentage under section  
9 1952(a)(2)(A)(ii) of such Act.

10 (4) PROPORTIONALITY.—The President shall  
11 apply the offset mechanisms provided in paragraph  
12 (2) (A), (B), and (C) proportionally, to the extent  
13 possible, but in no case shall the total amount of off-  
14 sets be less than the amount required by subsection  
15 (d)(1).

16 (5) CONSULTATION.—In making the determina-  
17 tions required by this subsection, the President shall  
18 consult with the Director of the Office of Manage-  
19 ment and Budget, the Secretary of the Treasury,  
20 and the National Health Benefits Board. Any order  
21 modifying the new tax deductions shall be accom-  
22 panied by Treasury regulations implementing such  
23 modification. Any order modifying out-of-pocket lim-  
24 its shall be accompanied by National Health Bene-

1 fits Board regulations implementing such modifica-  
2 tion.

3 (e) CARRYOVER OF EXCESS HEALTH FINANCING.—  
4 If the President’s budget includes a determination of ex-  
5 cess health financing pursuant to subsection (c)(4) for a  
6 fiscal year, such amount shall be included in calculating  
7 the health reform estimate for the subsequent fiscal year,  
8 by including such amount in the calculation of total net  
9 revenues projected for that year under subsection  
10 (c)(3)(C)(iii).

11 (f) RECOMMENDATIONS FOR ALTERNATIVE REDUC-  
12 TIONS.—If the President’s budget for a fiscal year is ac-  
13 companied by an executive order under subsection (d)(1),  
14 the National Health Care Commission shall, within a rea-  
15 sonable time, transmit to the Speaker of the House of  
16 Representatives and the President of the Senate a report  
17 including alternative proposals to offset the projected ex-  
18 cess outlays.

19 (g) GAO AUDIT OF REDUCTIONS.—If the President  
20 has issued an executive order under subsection (d)(1), the  
21 General Accounting Office shall report to Congress, as  
22 soon thereafter as possible following the date of transmit-  
23 tal of the President’s budget, an analysis of whether the  
24 executive order has fully complied with the requirements  
25 of this section.