Whereas the athletic opportunities for male students at the collegiate and high school levels remain significantly greater than those for female students; and

Whereas the number of funded research projects focusing on the specific needs of women athletes is limited and the information provided by these projects is imperative to the health and performance of future women athletes: Now, therefore, be it

Resolved, That—

(1) February 2, 1995, and February 1, 1996, are each designated as ''National Women and Girls in Sports Day''; and

(2) the President is authorized and requested to issue a proclamation calling on local and State jurisdictions, appropriate Federal agencies, and the people of the United States to observe those days with appropriate ceremonies and activities.

MEASURES REFERRED

The following concurrent resolution, previously received from the House of Representatives for concurrence, was read and referred as indicated:

H. Con. Res. 17. Concurrent resolution relating to the treatment of Social Security under any constitutional amendment requiring a balanced budget; to the Committee on the Budget and the Committee on Governmental Affairs, jointly, pursuant to the order of August 4, 1977, with instructions that if one Committee reports, the other Committee have thirty days to report or be discharged.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. GRAHAM (for himself and Mr. HATFIELD):

S. 308. A bill to increase access to, control the costs associated with, and improve the quality of health care in States through health insurance reform, State innovation, public health, medical research, and reduction of fraud and abuse, and for other purposes; to the Committee on Finance.

By Mr. BENNETT (for himself, Mr. BUMPERS, and Mr. JOHNSTON):

S. 309. A bill to reform the concession policies of the National Park Service, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. WARNER (for himself and Mr. ROBB):

S. 310. A bill to transfer title to certain lands in Shenandoah National Park in the State of Virginia, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. MCCAIN (for himself, Mr. CAMPBELL, and Mr. THOMAS):

S. 311. A bill to elevate the position of Director of Indian Health Service to Assistant Secretary of Health and Human Services, to provide for the organizational independence of the Indian Health Service within the Department of Health and Human Services, and for other purposes; to the Committee on Indian Affairs.

By Mr. MCCAIN (for himself and Mr. INOUYE):

S. 312. A bill to provide for an Assistant Administrator for Indian Lands in the Environmental Protection Agency, and for other purposes; to the Committee on Indian Affairs.

By Mr. EXON:

S. 313. A bill for the relief of Luis A. Gonzalez and Virginia Aguilla Gonzalez; to the Committee on the Judiciary.

By Mr. EXON (for himself and Mr. GORTON):

S. 314. A bill to protect the public from the misuse of the telecommunications network and telecommunications devices and facilities; to the Committee on Commerce, Science, and Transportation.

By Mr. HELMS:

S. 315. A bill to protect the First Amendment rights of employees of the Federal Government; to the Committee on Governmental Affairs.

S. 316. A bill to make it a violation of a right secured by the Constitution and laws of the United States to perform an abortion with knowledge that such abortion is being performed solely because of the gender of the fetus, and for other purposes; to the Committee on the Judiciary.

S. 317. A bill to stop the waste of taxpayer funds on activities by Government agencies to encourage its employees or officials to accept homosexuality as a legitimate or normal lifestyle; to the Committee on Governmental Affairs.

S. 318. A bill to amend the Civil Rights Act of 1964 to make preferential treatment an unlawful employment practice, and for other purposes; to the Committee on Labor and Human Resources.

S. 319. A bill to prohibit the provision of Federal funds to any State or local educational agency that denies or prevents participation in constitutionally-protected prayer in schools; to the Committee on Labor and Human Resources.

S. 320. A bill to protect the lives of unborn human beings, and for other purposes; to the Committee on Governmental Affairs.

S. 321. A bill to amend title X of the Public Health Service Act to permit family planning projects to offer adoption services, and for other purposes; to the Committee on Labor and Human Resources.

By Mrs. KASSEBAUM (for herself and Mr. DOLE):

S. 322. A bill to amend the International Air Transportation Competition Act of 1979; to the Committee on Commerce, Science, and Transportation.

By Mrs. KASSEBAUM:

S. 323. A bill to amend the Goals 2000: Educate America Act to eliminate the National Education Standards and Improvement Council, and for other purposes; to the Committee on Labor and Human Resources.

By Mr. WARNER (for himself, Mr. COCHRAN, Mr. THOMAS, and Mr. SIMPSON):

S. 324. A bill to amend the Fair Labor Standards Act of 1938 to exclude from the definition of employee firefighters and rescue squad workers who perform volunteer services and to prevent employers from requiring employees who are firefighters or rescue squad workers to perform volunteer services, and to allow an employer not to pay overtime compensation to a firefighter or rescue squad worker who performs volunteer services for the employer, and for other purposes; to the Committee on Labor and Human Resources.

By Mr. THOMAS:

S. 325. A bill to make certain technical corrections in laws relating to Native Americans, and for other purposes; to the Committee on Indian Affairs.

By Mr. HATFIELD (for himself, Mr. DORGAN, Mr. FEINGOLD, Mr. BUMPERS, and Mr. HARKIN):

S. 326. A bill to prohibit United States military assistance and arms transfers to foreign governments that are undemocratic, do not adequately protect human rights, are engaged in acts of armed aggression, or are not fully participating in the United Nations Registrar of Conventional Arms; to the Committee on Foreign Relations.

By Mr. HATCH (for himself, Mr. BAUCUS, Mr. EXON, Mr. LIEBERMAN, Mr. GRASSLEY, Mr. JOHNSTON, and Mr. KERREY):

S. 327. A bill to amend the Internal Revenue Code of 1986 to provide clarification for the deductibility of expenses incurred by a taxpayer in connection with the business use of the home; to the Committee on Finance.

By Mr. SANTORUM:

S. 328. A bill to amend the Clean Air Act to provide for an optional provision for the reduction of work-related vehicle trips and miles travelled in ozone nonattainment areas designated as severe, and for other purposes; to the Committee on Environment and Public Works.

By Mr. FEINGOLD (for himself and Mr. KOHL):

S. 329. A bill to direct the Secretary of the Interior to submit a plan to Congress to achieve full and fair payment for Bureau of Reclamation water used for agricultural purposes, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. FEINGOLD:

S. 330. A bill to amend the Agricultural Act of 1949 to require producers of an agricultural commodity for which an acreage limitation program is in effect to pay certain costs as a condition of agricultural loans, purchases, and payment, and for other purposes.

By Mr. KOHL:

S. 331. A bill to amend the Internal Revenue Code of 1986 to provide for the rollover of gain from the sale of farm assets into an individual retirement account; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MOYNIHAN (for himself, Mr. D'AMATO, and Mr. LEVIN):

S. Res. 75. A resolution to designate October, 1996, as ''Roosevelt History Month,'' and for other purposes; to the Committee on the Judiciary.

By Mr. HELMS:

S. Res. 76. A resolution to amend Senate Resolution 338 (which establishes the Select Committee on Ethics) to change the membership of the select committee from members of the Senate to private citizens; to the Committee on Rules and Administration.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. GRAHAM (for himself and Mr. HATFIELD):

S. 308. A bill to increase access to, control the costs associated with, and improve the quality of health care in States through health insurance reform, State innovation, public health, medical research, and reduction of fraud and abuse, and for other purposes; to the Committee on Finance.

THE HEALTH PARTNERSHIP ACT

Mr. GRAHAM. Mr. President, many people count the death of health care reform as being in 1994, when the Congress failed to adopt the proposals that had been adopted as submitted by the

President, by various factions within the Congress itself, by some groups that were external to the Congress. I personally think that is the wrong date for the death of health care reform in America. I believe the appropriate date for health care reform's demise occurred 20 years earlier, in 1974.

Prior to 1974 we in fact had a very vibrant, innovative, creative set of health care reform initiatives. They all had one principal characteristic, they were emerging from the States. We had a decentralized federalized system of health care innovation.

The State of the Presiding Officer was one of those States involved in those early efforts of health care reform, as was my State and the State of Oregon, the State of our colleague, Senator HATFIELD. Maybe the best known example of those innovations that occurred prior to 1974 was the State of Hawaii.

The State of Hawaii set some objectives in terms of increasing the percentage of its population covered, to reduce the cost of health care, and to focus attention on the prevention of illness rather than crisis intervention. Hawaii, as an example, has achieved almost all the objectives that were established two decades ago.

But in 1974 the Congress began to restrict the capacity of States to serve as the laboratories for health care innovation through restrictions on the ability of States to secure waivers from Federal laws such as Medicaid, the health care program for indigent Americans, and the restrictions on the States' ability to innovate as it related to persons who secured their insurance through a place of employment, the so-called ERISA restraints. States, for 20 years, have largely been restricted from their role of serving as centers of innovation, of field-based experience on what would actually work in terms of improving the health of Americans.

The legislation we are going to introduce today seeks to reverse that 20-year period of sterility. As Supreme Court Justice Louis Brandeis once said,

> It is one of the happy incidents of the Federal system that a single, courageous State may, if its citizens choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country.

We propose to restore that opportunity of States to serve as that novel laboratory to try things to see if they work; if they do, to enlarge them; if they do not, to discard them—but not put the entire Nation at risk as we experiment with new approaches to achieve the objective of better health for all Americans.

There are some principles behind the bill that Senator HATFIELD and I will introduce, and those principles include the concept of incrementalism. Incrementalism is not just a synonym for drift and indecision that you move willy-nilly from one step to the other. Incrementalism infers that you have a clear set of goals, destinations, and then you understand the steps that are required to get from where you are to that destination.

While these goals can be defined with greater specificity—and they shall be—the basic goals that we seek to attain with this legislation are:

First, to increase the access of Americans to health care services;

Second, to contain the level of increase of the cost of health care services;

Three, to reduce the incidence of illness and disease by a greater investment in those things that we know will tend to maintain a state of good health.

A second principle of our proposal is decentralization. One of the common elements of all of the health care legislation considered in 1994, no matter how much they differed in specifics, is that they all shared one thing in common; that is, they assume that the solution to health care was a centralized solution. There was an assumption that health care can be dealt with by one-suit-fits-all approach.

Senator HATFIELD and I believe that is fundamentally flawed—that in a Nation that is as large and diverse as the United States of America the attempt to have a central health care system for all of our almost 260 million citizens is an inherent prescription for failure. The differences just between let us say a State such as Wyoming, which has large land area and relatively few people who have a principal problem, is how to provide not the financing but just the actual access to health care professionals in such a diffused population compared for instance to a highly urbanized State such as New Jersey where the issues are fundamentally different. To attempt to have such a health care approach to such extreme circumstances is in our opinion not a logical beginning point for health care reform.

Finally, we believe in the concept of partnership, that States and local communities and individual citizens will bring a great deal to the table. They are the ones who are most directly affected by gaps in our current health care system. They are the ones who are most likely to have precise reality-based prescriptions to fill those gaps and current concerns with our system.

We believe that the sense of arrogance that has sometimes pervaded Federal-State relations—in which we assumed that we knew what the solution was and it was only for others to accept our infinite wisdom—those days are over, and we need to have a respectful relationship.

Let me, Mr. President, just briefly review the principal titles of our legislation. I will submit the legislation for introduction as well as a section-by-section analysis of the proposal. But the bill contains a title which relates to insurance reform.

In this area, we are building on a very successful recent experience which related to problems including out outright fraud that existed in the sale of so-called Medigap insurance policies. These are the policies that extend the normal reach of Medicare. The way in which the Congress chose to go about dealing with the problem of Medigap insurance was to ask the State insurance commission to work together to develop a standard set of principles to govern those types of insurance policies. Each State must then be required to adopt the basic principles that have been developed by these State officials. Each State deserves the right to go beyond what the standard set of principles were.

We are proposing a similar policy as it relates to health insurance. We are going to call on the 50 insurance commissioners of America to develop the programs on portability, on preexisting conditions, on the other gaps in health insurance coverage that have caused such anxiety and loss of insurance coverage to American families.

The second title is State innovation. It has two basic approaches. One, we are going to seek relief for States from some of the shackles that have been imposed upon them for 20 years so that they will have the ability to innovate. We want to make it easier for States for instance to get waivers from a risk, easier for States to get waivers from Medicaid, easier for States to shape their own approach to what they believe will best meet the needs of their people. We are going to go beyond this in that we are going to provide grants, grants over the next 5 years totaling $50 billion to States which apply and which can demonstrate that they have a plan that will move toward the three objectives of increased coverage, cost control, and provision. We believe this will give a positive encouragement to the States to accelerate a process of innovation that has been asleep for 20 years.

Third, in the area of public health we are proposing for a significant increase in the Federal role in public health. The Federal Government used to be the primary level of government in public health. It is a partnership with the States. Our partnership has been faltering. States have been taking up a larger and larger share. With the States' financial constraints, one of the problems is we are going to see frays in our public health system. Tuberculosis, for instance, which is a disease that we thought had been eradicated, has made a resurgence and a significant part of the reason for that resurgence is laid to the fact that we have gaps in our public health service that have allowed that to occur.

We also are proposing, in the next title, increases in assistance to medical research. Again the States will have a major role since many of the most significant health care training and research institutions are hospitals and medical centers which are associated with State government. We also are proposing increased funding for the National Institutes of Health. We believe

that Americans want to have investments that will increase our knowledge, and therefore ability to arrest adverse health care conditions.

Finally, we come to what may be the bitter pill of that; that is, how we pay for it. We are proposing a $1 per unit increase in the tax on tobacco products as a means of financing these initiatives in State innovation, public health, in medical and health research. We believe this is appropriate in terms of the contribution that reduction in the use of these products will have on the health of America. It also will raise approximately $68 billion over the next 5 years which will be necessary in order to finance the various initiatives that we have outlined.

Finally, we have a provision that relates to fraud and abuse. I want to particularly commend Senator COHEN of Maine whose ideas are heavily involved in this particular title. He has done outstanding work in the area of Medicare fraud and abuse, and has helped to bring to the Nation's attention the shocking level of abuse in terms of inappropriate services, services not rendered, overbilled services which are estimated to be costing us $1 out of every $10 in our Medicare expenditures. But fraud and abuse is not limited to Medicare. It also occurs in other governmental programs such as CHAMPUS, which is the program for the Department of Defense. It occurs in Medicaid with the State-Federal partnership program, and it occurs in many private insurance programs. We believe that the frontal assault on fraud and abuse is an important element of this health care reform effort.

I close, Mr. President, by quoting a fellow Floridian, columnist and editorial writer of the St. Petersburg Times, Martin Dyckman, who stated that this approach that we are suggesting to health care reform is.

> * * * of course, is how most of this country's important social reform including public schools, child labor laws, anti-sweatshop legislation, wage-hour laws and workers' compensation, came into flower. They originated not in Congress but with the States. It is the genius of federalism.

We seek to unleash that genius to the benefit of all of the American people. As we will learn more about what policies actually contribute to increased coverage, containment of cost and the prevention of illness, we will improve the lives of individual citizens within their States. And with that experience, we will have the opportunity to make better policies across America that will improve the lives of all of our citizens.

Mr. President, during the long, arduous and extended debate over health care last session of Congress, Senator HATFIELD and I were concerned that Congress had become fixed on thinking about health care reform from a single, centralized, one-size-fits-all, national model. In the bipartisan rush to attempt to solve the Nation's problems and federalize health care, Congress overlooked what may be the best opportunity we have—State-led reform.

In fact, that has been the case for over two decades. In the early 1970's, many States were working on initiatives to develop health care infrastructure or were, as in the cases of Hawaii, Maine, and California, undertaking progressive reform proposals to expand coverage. Hawaii passed its Prepaid Health Care Act in 1974 and has been the only State to receive necessary implementation waivers from Congress. As a result, Hawaii has managed to cover 96 percent of its citizens and has costs below the national average.

Unfortunately, most other State reform initiatives have been stalled by the overriding national health reform efforts of President Nixon and Congress in 1974, the growing federalization of Medicaid policy throughout the period and the passage of the Employee Retirement Income Security Act or ERISA in 1974.

These three efforts to nationalize health care have worked together to stall or limit State health reform efforts over the past two decades. In fact, ironically, due to the very fact that very little experimentation or innovation occurred in the States over the last two decades, virtually all of the national health reform proposals—whether it was managed competition, single payer, employer or individual mandates, pay or play, vouchers, the expansion of Medicare or market reform—had as their centerpiece a variety of untested reform theories in American society. In short, past efforts to limit state flexibility paradoxically helped thwart Congress' reform efforts last year.

As a result, on September 22, 1994, Senator HATFIELD and I introduced legislation that would attempt to attain the goals of health reform—expanded coverage and access, cost containment and improved quality—with State innovation as an underlying theme. After working to improve the legislation over the recess, we are reintroducing the Health Partnership Act today. We introduce this legislation as a working document and encourage any and all comments to help further refine the proposal.

First, the legislation recognizes that, in a nation as diverse as ours, one solution or means cannot be formulated for the wide range of health programs and needs in our country. For example, Florida, Pennsylvania, Iowa, Rhode Island, and West Virginia have 50 percent more elderly per capita than do Alaska, Utah, Colorado, and Georgia. Addressing the long term care needs and specific health care problems associated with aging would clearly be a greater point of emphasis in the former States than in the latter.

As former Governors and as Senators from States that have enacted substantial health reform plans, Senator HATFIELD and I believe the States have demonstrated some tremendous creativity and ability to implement innovative health care initiatives often in the face of stiff resistance from the Federal Government.

As Supreme Court Justice Louis Brandies said in 1932,

> It is one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

To summarize the Health Partnership Act, the bill establishes increased coverage, cost containment, improved quality and decentralization as its overriding goals. Our proposal would achieve this through Federal-State partnerships in five areas: insurance reform, state innovation, public health, medical and health research, and fraud and abuse.

INSURANCE REFORM

The first title deals with insurance reform. Through recommendations from our Nation's State insurance commissioners, our bill would address the longstanding problems of portability, preexisting conditions, solvency standards, community rating, and other needed insurance market reforms.

The State insurance commissioners would establish a set of national minimum insurance standards that would be approved by the Secretary of Health and Human Services. This is modeled after the Baucus amendment to the Omnibus Budget Reconciliation Act of 1990 that related to the development of the largely successful Medicare supplemental insurance standards or Medigap. In our bill, States that wish to do beyond the minimum standards established by NAIC could proceed with more progressive reforms.

STATE INNOVATION

Title II is concerned State and local innovation. Both States and localities would be allowed to submit health reform projects that—if they meet the health reform goals of expanding coverage, cost containment and improving quality—would enable them to receive broad flexibility in the Medicaid Program, Public Health Service programs, the maternal child health block grant and the social services block grant.

To further improve the Federal-State partnership, our legislation would grant these waivers and greatly expanded flexibility through the vast reduction of process requirements and regulation. Instead, the Federal Government and States would jointly develop performance and accountability measures that specifically relate to the State's project. For example, if a State were to submit a children's health initiative as a health reform project, performance measures might include infant mortality, immunization rates or unnecessary pediatric hospitalization rates.

Eligible States would also have available $50 billion in grants to enact their reforms over a 5-year period.

The bill also gives states greater flexibility by clarifying the impact of

the ERISA preemption. While ERISA was intended to recognize the desire by multi-State corporations to have uniformity in their employee benefit programs, it has gone beyond what is required for that purpose. The result has been the preemption of an increasing number of State laws.

For example, it does not make sense to preclude States from having access to data, from establishing quality standards for HMO's and from raising revenue through providers to fund uncompensated care pools. In effect, States are prevented by ERISA from enacting some reforms that would reduce the numbers of uninsured, contain costs and ensuring, or enhancing quality. Our intention in the bill is to find a balance between the legitimate and proper interests on business and labor in ERISA and that of States.

Consequently, the bill provides for the establishment of an ERISA Review Commission to study the issues affected by ERISA and to make recommendations on points of compromise between States, business, and labor.

PUBLIC HEALTH

Title III promotes prevention, public health, cost effective treatment, and improved overall health through four distinct approaches: First, strengthening the partnership with and capacity of local and state public health departments to carry out core public health functions; second, expanding access to preventive and primary care services for vulnerable and medically underserved communities; third, supporting applied research on prevention and effective public health interventions, and fourth, addressing public health work force needs and access problems.

At a time when tuberculosis, AIDS and other public health problems such as E. coli increasingly threaten the public's health, as investment in our Nation's public health infrastructure as necessary and overdue.

Dr. C. Everett Koop and other members of the Health Project Consortium published an article in the New England Journal of Medicine in 1983 noting that 70 percent of all illness is preventable and that there are about 1 million deaths annually that are preventable. That amounts to in excess of $600 billion annually in costs. However, our Nation now invests less than 1 percent of our total health care costs on health care. The waste of both lives and money must be addressed.

As a result, our legislation would increase the investment in public health by $9 billion over 5 years.

MEDICAL AND HEALTH RESEARCH

Title IV emphasizes medical and health research. Our initiative recognizes the importance of medical and health research and would provide $6 billion over a 5-year period in increased funding for that function. This builds on the excellent track record of medical research in our Nation's State-supported research and medical centers. In addition, if finding the cure for diseases such as AIDS, Alzheimer's, and cancer is to be achieved, such an investment is critical.

FRAUD AND ABUSE

Title V is a section tackles the issue of fraud and abuse. Senator BILL COHEN, who has studied this issue at length and contributed to this section, recently said,

> As much as $100 billion is lost each year to fraud and abuse, driving up the cost of health care in America for million of patients and families—as well as for the American taxpayer. Losses over the last 5 years are almost four times the total costs to date of the entire savings and loan crisis.

One of the provisions establishes closer coordination of fraud investigation among the Federal, State, and private sector. This would positively impact State and local governments as providers, payers, and employers.

COST

The bill's costs over a 5-year period would be $65 billion which Senator HATFIELD and I propose to be financed with a $1 tax on tobacco products. This funding source, while providing funds for our proposal, would also discourage smoking and improve the overall health of Americans.

WHY STATE-LED REFORM?

Why federalism or state-led reform? First and most obvious, the Federal Government failed and will continue to fail to truly address the agreed upon goals of this nation in health care.

Second, the combination of Federal failure, hinderance of State flexibility through Medicaid regulations and ERISA, and anticipate budget cuts to Medicare and Medicaid this year would result in what I would call triple-negative health reform. We should break that downward spiral at the second point and grant State and local governments increased flexibility to improve our Nation's health care. The contrast would be further Federal inaction and abritrary budget cuts, neither prescriptions for improved health.

Third, the diversity in our Nation dictates federalism. As St. Petersburg columnist Martin Dyckman said in a column endorsing our approach,

> This, of course, is now most of this country's important social reform including public schools, child labor laws, anti-sweatshop legislation, wage-hour laws and workers' compensation, came into flower. They originated not in Congress but with the States. It is the genius of federalism.

Fourth, States have historically led in reform—Hawaii, Minnesota, Florida, New York, Maryland, Oregon, and Washington and others come to mind. States have led in reform because they can respond quicker to the rapid changing dynamics of health care. They are also more efficient. One look at the Medicare fraud problem in south Florida would shy anybody away from having Washington, DC, too involved in reform.

Fifth, doing nothing is unacceptable. State and local governments continue to bear the brunt and serve as much of our Nation's safety net. As last year's Advisory Committee on Intergovernmental Relations report entitled ''Local Government Responsibilities in Health care'' noted, ''Local governments spend an estimated $85 billion per year on health care services—about one of every eight dollars spent by local governments.''

Failing to recognize this important contribution and failure to address it will only increase this heavy burden. Uninsured rates will only continue to increase, costs will continue to explode while problems such as infant mortality, where the United States ranks 21st in the world, are not going away.

Finally, waiting for uniformity is a pipedream. As many of you know only too well. Medicaid regulation and ERISA have effectively preempted the ability of State and local government from enacting anything other than incremental reform for 20 years due to what everyone thought was impending national health care reform. Since that time, States have largely been held back from enacting reforms while Presidents Nixon, Ford, Carter, Reagan, Bush, and Clinton have all failed to enact comprehensive national health reform.

Therefore, the purpose of our bill is to free the States to be innovative to addressing their specific health care needs and problem while providing States the resources to encourage and accelerate the process. Mr. President, I believe the time for State-led reform is now.

Mr. President, I ask unanimous consent that the text of the bill and additional material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 308

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Partnership Act of 1995''.

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

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Americans support universal coverage. The people of this country agree that all Americans should be guaranteed access to affordable, high-quality health care.

(2) Although there is common agreement on the goal of universal coverage, there are many different ways to achieve this goal. The States can play an important role in achieving universal coverage for our population, demonstrating additional health reforms that may be needed on a national level to enhance access to affordable, high-quality health care. A number of States have already initiated health care reform that takes into account their special economic, demographic, and financial conditions. These State models combine unique reform innovations with the various strengths of their existing State health care systems, including market competition, employer pools and association plans, technology review and public health outreach projects. The States can also serve as testing grounds to identify effective alternatives for making the transition to universal coverage, while maintaining the strengths of the current health care system.

(3) Maintaining the high quality of health care Americans expect and controlling costs are also important goals of health care reform. As payers of health care, the States have a strong incentive to ensure that such States purchase high-quality, cost-effective services for the residents of such States. The States can develop and test alternative payment and delivery systems to ensure that these goals are achieved.

(4) In light of the success of various State-initiated reforms and in the absence of comprehensive Federal health reform, there are many health-related issues that should be addressed at the State level. As with social security and child labor protections, States can lead the way in testing ideas for national application or application in other States.

(5) The States should have the flexibility to test alternative health reforms with the objectives of increasing access to care, controlling health care costs, and maintaining or improving the quality of health care.

SEC. 3. DEFINITIONS.

Unless specifically provided otherwise, as used in this Act:

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

(2) PERFORMANCE MEASURES.—The term ''performance measures'' means measurable indicators that are used to assess progress towards achieving the broad goals of increasing access to care, controlling health care costs, and maintaining or improving the quality of health care.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, the Northern Marina Islands, and America Samoa.

TITLE I—HEALTH INSURANCE REFORM

SEC. 1001. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Secretary shall request that the NAIC develop, not later than 6 months after the date of enactment of this Act, standards for health insurance plans with respect to—

(1) the renewability of coverage under such plans;

(2) the portability of coverage under such plans, including—

(A) limitations on the use of pre-existing conditions;

(B) the concept of an ''amnesty period'' during which limitations on pre-existing conditions would be suspended; and

(C) the advisability of open enrollment periods;

(3) guaranteed issue with respect to all health insurance coverage products;

(4) the establishment of an adjusted community rating system with adjustment factors limited to age (with no more than a 2:1 variation in premiums based on age) and geography;

(5) solvency standards for health insurance plans regulations under Federal and State law, including the development of risk-based capital standards for health plans, solvency standards for health plans, self-funded employer-sponsored health plans, and multi-employer welfare arrangements and association plans;

(6) stop-loss standards for self-funded health insurance plans and multi-employer welfare arrangements and association plans;

(7) the identification of minimum employer size for self-funding and the interrelationship between self-funding and the community-rated pool of enrollees; and

(8) any other areas determined appropriate by the Secretary, including enforcement of standards under this section.

(b) REVIEW.—Not later than 60 days after receipt of the standards developed by the NAIC under subsection (a), the Secretary shall complete a review of such standards. If the Secretary, based on such review, approves such standards, such standards shall apply with respect to all health insurance plans offered or operating in a State on and after the date specified in subsection (d) herein.

(c) FAILURE TO DEVELOP STANDARDS OR FAILURE TO APPROVE.—If the NAIC fails to develop standards within the 6-month period referred to in subsection (a), or the Secretary fails to approve any standards developed under such subsection, the Secretary shall develop, not later than 15 months after the date of enactment of this Act, standards applicable to health insurance plans, including standards related to the matter described in paragraphs (1) through (8) of subsection (a) (''Federal standards'') and such standards shall apply with respect to all health insurance plans offered or operating in a State on and after the date specified in subsection (d) herein.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the effective date specified in this subsection for a State is the date the State adopts the standards developed under this section or 1 year after the date the NAIC or the Secretary first adopts such standards, whichever is earlier.

(2) EXCEPTION.—In the case of a State which the Secretary, in consultation with the NAIC, identifies as—

(A) requiring State legislation (other than legislation appropriating funds) in order for health insurance policies to meet the standards developed under this section, but

(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(e) WORKING GROUP.—In promulgating standards under this section, the NAIC or Secretary shall consult with a working group composed or representatives of issuers of health insurance policies, consumer groups, health insurance beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(f) EFFECT ON STATE LAW.—Nothing in this section shall be construed to preempt any State law

to the extent that such State law implements more progressive reforms than those implemented under the standards developed under this section, as determined by the Secretary.

SEC. 1002. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1320c-3 note) is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of such Act (42 U.S.C. 1320c-3 note) is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy;

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

''(iii) the network offers sufficient access;

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of the matters described in subparagraph (D), and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I); and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).

''(D) The matters described in this subparagraph, with respect to a policy, are as follows:

''(i) The restrictions on payment under the policy for services furnished other than by or through the network.

''(ii) Out of area coverage under the policy.

''(iii) The policy's coverage of emergency services and urgently needed care.

''(iv) The availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy.''.

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

''(ii) If an individual described in clause (i) moves to a geographic area where the issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I), and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

SEC. 1003. EFFECTIVE DATES.

(a) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the NAIC makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by section 1002, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subsection (c), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this subsection (such changed Regulation referred to in this section as the ''1995 NAIC Model Regulation'').

(b) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in subsection (a), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subsection (c), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this subsection (such changed Regulation referred to in this section as the ''1995 Federal Regulation'').

(c) DATE SPECIFIED.—

(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is the earlier of—

(A) the date the State adopts the 1995 NAIC Model Regulation or the 1995 Federal Regulation; or

(B) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(2) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(B) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered, the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE II—STATE INNOVATION

Subtitle A—State Waiver Authority

SEC. 2001. STATE HEALTH REFORM PROJECTS.

(a) OBJECTIVES.—The objectives of the waiver programs approved under this section shall include, but not be limited to—

(1) achieving the goals of increased health coverage and access;

(2) containing the annual rate of growth in public and private health care expenditures;

(3) ensuring that patients receive high-quality, appropriate health care; and

(4) testing alternative reforms, such as building on the private health insurance system or creating new systems, to achieve the objectives of this Act.

(b) STATE HEALTH REFORM APPLICATIONS.—

(1) IN GENERAL.—A State, in consultation with local governments involved in the provision of health care, may apply for—

(A) an alternative State health program waiver under paragraph (2); or

(B) a limited State health care waiver under paragraph (3).

(2) ALTERNATIVE STATE HEALTH PROGRAM WAIVERS.—

(A) IN GENERAL.—In accordance with this paragraph, each State desiring to implement an alternative State health program may submit an application for waiver to the Secretary for approval.

(B) WAIVER REQUIREMENTS SPECIFIED.—A State that desires to receive a program waiver under this paragraph shall prepare and submit to the Secretary, as part of the application, a State health care plan that shall—

(i) provide and describe the manner in which the State will ensure that individuals residing within the State have expanded access to health care coverage;

(ii) describe the number and percentage of current uninsured individuals who will achieve coverage under the alternative State health program;

(iii) describe the benefits package that will be provided to all classes of beneficiaries under the alternative State health program;

(iv) identify Federal, State, or local programs that currently provide health care services in the State and describe how such programs could be incorporated into or coordinated with the alternative State health program, to the extent practicable;

(v) provide that the State will develop and implement health care cost containment procedures;

(vi) describe the public and private sector financing to be provided for the alternative State health program;

(vii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the alternative State health program;

(viii) describe how the State plan will ensure the financial solvency of the alternative State health program;

(ix) describe any changes in eligibility for public subsidies;

(x) provide assurances that Federal expenditures under the alternative State health program shall not exceed the Federal expenditures, other than expenditures made available under this Act, which would otherwise be made in the aggregate for the entire program period;

(xi) provide quality control assurances, agreements, and performance measures as required by the Secretary;

(xii) provide for the development and implementation of a State health care delivery system that provides increased access to care in areas of the State where there is an inadequate supply of health care providers;

(xiii) identify all Federal law waivers required to implement the alternative State health program, including such waivers necessary to achieve the access, cost containment, and quality goals of this Act and the alternative State health program; and

(xiv) provide that the State will prepare and submit the Secretary such reports as the Secretary may require to carry out program evaluations.

(C) PROJECT WAIVERS.—

(i) CRITERIA FOR SELECTION.—In selecting from among the applications for alternative State health program waivers, the Secretary shall be satisfied that each approved State alternative State health program—

(I) will not have a negative effect on quality of care;

(II) increase coverage of or access for the State's population; and

(III) will—

(aa) provide quality of care and premium comparisons directly to employers and individuals in an easy-to-use format,

(bb) contract with an external peer review organization to monitor the quality of health care plans, and

(cc) establish a mechanism within the State's grievance process that allows members of a health plan to disenroll at any time if it can be shown that such members were provided erroneous information that biased their health plan selection.

(ii) WAIVER APPROVAL.—The Secretary shall approve applications submitted by States that meet the access, cost containment, and quality goals established in this Act and shall waive to the extent necessary to conduct each alternative State health program any of the requirements of this Act, including, but not limited to, eligibility requirements; alternative data collection systems and sampling designs that focus on measuring health status, patient treatment outcomes, and patient satisfaction with health plans, rather than on the collection of 100 percent of patient encounters; and benefit designs; and any provisions of Federal law contained in the following:

(I) Titles V, XIX, and XX of the Social Security Act.

(II) Title XVIII of the Social Security Act, to the extent such a waiver is granted only for the operation of an all-payor system or a long-term care system.

(III) The Public Health Service Act.

(IV) Any other Federal law authorizing a Federal health care program that the Secretary identifies as providing health care services to qualified recipients.

(3) LIMITED STATE HEALTH CARE WAIVERS.—Each State which does not receive or apply for an approved application under paragraph (2) may apply for a limited State health care waiver. The Secretary shall award limited State health care waivers to ensure State demonstrations of health reforms that could address, but are not limited to addressing, the following issues that are likely to provide guidance for the development of additional national health reforms:

(A) Integration of acute and long-term care systems, including delivery and financing systems.

(B) Establishment of methodologies that limit expenditures or establish global budgets, including rate setting and provider reimbursements.

(C) Implementation of a quality management and improvement system.

(D) Strategies to improve the proper speciality and geographic distribution of the health care work force.

(E) Initiatives to improve the population's health status.

(F) Development of uniform health data sets that emphasize the measurement of patient satisfaction, treatment outcomes, and health status.

(G) Methods for coordinating or integrating State-funded programs that provide services for low-income individuals, including programs authorized by this Act.

(H) Programs to improve public health.

(I) Reforms intended to reduce health care fraud and abuse.

(J) Reforms to reduce the incidence of defensive medicine and practitioner liability costs associated with medical malpractice.

(K) Development of a uniform billing system.

(c) ADDITIONAL RULES REGARDING APPLICATIONS.—

(1) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing waiver applications under this section.

(2) INITIAL REVIEW.—The Secretary shall complete an initial review of each State application for a waiver under paragraph (2) or (3) of subsection (b) within 40 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Secretary shall issue a preliminary opinion concerning the likelihood that the application will be approved within such 40-day period and shall advise the State within such period of the need to submit additional information.

(3) FINAL DECISION.—The Secretary shall, within 90 days of the later of—

(A) the receipt of a State application for a waiver under paragraph (2) or (3) of subsection (b), or

(B) the date on which the Secretary receives additional information requested from a State under paragraph (1),

issue a final decision concerning such application.

(4) WAIVER PERIOD.—A State waiver may be approved for a period of 5 years and may be extended for subsequent 5-year periods upon approval by the Secretary, except that a shorter period may be requested by a State and granted by the Secretary.

(d) QUALIFICATION FOR FEDERAL FUNDS.—For purposes of this Act, a State with an approved alternative health care system under subsection (b)(2) shall be considered a participating State and shall maintain such status if such State meets the requirements established by the Secretary in the waiver approval and in this section.

(e) EVALUATION, MONITORING, AND COMPLIANCE.—

(1) STATE HEALTH REFORM ADVISORY COMMISSION.—

(A) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall establish, an appoint the members of, a 17-member State Health Reform Advisory Commission (hereafter in this subsection referred to as the ''Commission'') that shall—

(i) be comprised of members representing relevant participants in State programs, including representatives of State government, employers, consumers, providers, and insurers;

(ii) be responsible for monitoring the status and progress achieved under waivers granted under this section;

(iii) report to the public concerning progress made by States with respect to the performance measures and goals established under this Act and the State project application procedures, by region and State jurisdiction;

(iv) promote information exchange between States and the Federal Government; and

(v) be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State waivers on national employer groups, provider organizations, and insurers because of

differing State requirements under the waivers.

(B) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(C) CHAIRPERSON, MEETINGS.—

(i) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(ii) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(iii) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(D) POWERS OF THE COMMISSION.—

(i) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(ii) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(iii) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(iv) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(E) PERSONNEL MATTERS.—

(i) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(ii) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(iii) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(iv) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(v) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(F) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated from the Fund established under section 9551 of the Internal Revenue Code of 1986, $1,000,000 for each of the fiscal years 1996 through 2000.

(2) ANNUAL REPORTS BY STATES.—Each State that has received a waiver approval shall submit to the Secretary an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Secretary in the waiver approval and in this section.

(3) CORRECTIVE ACTION PLANS.—If a State is not in compliance, the Secretary shall develop, in conjunction with all the approved States, a corrective action plan.

(4) TERMINATION.—For good cause, the Secretary may revoke any waiver of Federal law granted under this section, and if necessary, may terminate any alternative State health program. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(5) EVALUATIONS BY SECRETARY.—The Secretary shall prepare and submit to the Committee on Finance and the Committee on Labor and Human Resources of the Senate and the Committee on Commerce and the Committee on Ways and Means of the House of Representatives annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving waiver approvals under this section;

(B) an evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents;

(ii) providing health care to State residents with special needs;

(iii) reducing or containing health care costs in the States; and

(iv) improving the quality of health care provided in the States; and

(C) recommendations regarding the advisability of increasing Federal financial assistance for State alternative State health program initiatives, including the amount and source of such assistance.

(f) STATE COMMISSIONS.—The Secretary shall encourage States to establish a State commission to gather, review and report to the public concerning the progress the State is making in meeting the project goals of improved access, cost containment and quality and established performance measures.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary may provide a grant to a State that has an application for a waiver approved under subsection (b)(2) to enable such State to carry out an alternative State health program in the State.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined pursuant to an allocation formula established by the Secretary.

(3) PERFORMANCE-BASED FUNDING ALLOCATION AND PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall—

(A) give priority to those State projects that the Secretary determines have the greatest opportunity to succeed in providing expanded health insurance coverage and access without penalizing those States that have been successful in expanding coverage and access through reform efforts in prior years;

(B) give priority to those State projects that the Secretary determines have the greatest opportunity to succeed in providing expanded health insurance coverage and in providing children, youth, and vulnerable populations with access to health care items and services; and

(C) attempt to link allocations to the State to the meeting of the goals and performance measures relating to health care coverage and access, health care costs, health care outcomes and vulnerable populations established under this Act through the State project application process.

(4) MAINTENANCE OF EFFORT.—A State, in utilizing the proceeds of a grant received under paragraph (1), shall maintain the expenditures of the State for health care coverage purposes at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received. The requirement of this paragraph shall not apply in the case of a State that desires to alter health care coverage funding levels within the scope of the State's alternative health program.

(5) REPORT.—At the end of the 5-year period beginning on the date on which the Secretary awards the first grant under paragraph (1), the State Health Reform Advisory Board established under subsection (e)(1) shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States receiving grants under paragraph (1) in meeting the goals of expanded access, cost containment and quality through performance measures established during the 5-year period of the grant. Such report shall contain the recommendation of the Board concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(h) LOCAL GOVERNMENT APPLICATIONS.—

(1) IN GENERAL.—Where a State fails to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Secretary for programs or projects under subsection (b). Such an application shall be subject to the requirements of this section.

(2) OTHER APPLICATIONS.—Subject to such additional guidelines as the Secretary may prescribe, a unit of local government may submit an application under this section, whether or not the State submits such an application, if such unit of local government can demonstrate unique demographic needs or a significant population size that warrants a substate waiver under subsection (b).

(i) AVAILABILITY OF FUNDS.—With respect to each of the calendar years 1996 through 2000, $10,000,000,000 shall be available for a calendar year to carry out this section from the Health Care Reform Trust Fund established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986. Amounts made available in a calendar year under this paragraph and not expended may be used in subsequent calendar years to carry out this section.

(j) CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS.—

Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F)(i) any premium payment made to a health insurer or health maintenance organization by a State agency in connection with

a demonstration project operated under the State medicaid program pursuant to section 1115 or the Health Partnership Act of 1995 with respect to individuals participating in such project; or

''(ii) any payment made by a health insurer or a health maintenance organization to a sales representative or a licensed insurance agent for the purpose of servicing, marketing, or enrolling individuals participating in such demonstration project in a health plan offered by such an insurer or organization.''.

Subtitle B—State Laws

PART A—EXISTING WAIVERS AND HAWAII PREPAID HEALTH CARE ACT

SEC. 2101. CONTINUANCE OF EXISTING FEDERAL LAW WAIVERS.

Nothing in this Act shall preempt any feature of a State health care system operating under a waiver granted before the date of the enactment of this Act under titles XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. or 1396 et seq.) or under an exemption from preemption under section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)).

SEC. 2102. PREEMPTION OF HAWAII PREPAID HEALTH CARE ACT.

Section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)) is amended to read as follows:

''(5)(A) Except as provided in subparagraphs (B) and (C), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. Chapter 393, as amended) or any insurance law of the State.

''(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any State tax law relating to employee benefits plans.

''(C) If the Secretary of Labor notifies the Governor of the State of Hawaii that as the result of an amendment to the Hawaii Prepaid Health Care Act enacted after the date of the enactment of this paragraph—

''(i) the proportion of the population with health care coverage under such Act is less than such proportion on such date, or

''(ii) the level of benefit coverage provided under such Act is less than the actuarial equivalent of such level of coverage on such date,

subparagraph (A) shall not apply with respect to the application of such amendment to such Act after the date of such notification.''.

PART B—ERISA REVIEW

SEC. 2110. SPECIFIC EXEMPTION FROM ERISA PREEMPTION.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph:

''(9) Upon application by a State, subsection (a) shall not apply to any State program that—

''(A) requires participation in an uncompensated care pool, including a program which imposes a tax on health care providers to fund an uncompensated care pool; or

''(B) provides for the imposition of a tax on health care providers as permitted under section 1903(w) of the Social Security Act.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to applications filed on and after the date of the enactment of this Act.

SEC. 2111. DISCRETIONARY EXEMPTIONS FROM ERISA PREEMPTIONS.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)), as amended by section 2110, is amended by adding at the end the following new paragraph:

''(10) Upon application by a State, subsection (a) shall not apply to any State program which the Secretary finds to be a State program implementing an exemption from subsection (a) established under section 2116 of the Health Partnership Act of 1995.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to applications filed on and after the date of the enactment of this Act.

SEC. 2112. PROCEDURES FOR ADOPTING DISCRETIONARY EXEMPTIONS.

(a) COMMISSION RECOMMENDATIONS.—The ERISA Review Commission shall—

(1) within 6 months after its establishment, make recommendations to the Secretary of Labor with respect to the issues described in subsection (c), and

(2) within 18 months after its establishment, make recommendations to the Secretary of Labor with respect to the issues described in subsection (d).

(b) ACTION BY SECRETARY OF LABOR.—

(1) IN GENERAL.—The Secretary of Labor shall, within 6 months of the receipt of any recommendation under subsection (a), implement the recommendation with or without modification or notify the Commission that the Secretary does not intend to implement the recommendation.

(2) NOTIFICATION.—The Secretary of Labor shall notify the appropriate committees of Congress of its decisions under this subsection.

(3) IMPLEMENTATION.—If the Secretary of Labor decides to implement any recommendation of the Commission, such recommendation shall take effect on—

(A) the 60th day after notification to the Congress under paragraph (2), or

(B) such later date as the Secretary of Labor determines appropriate.

(4) FAILURE TO IMPLEMENT.—If the Secretary of Labor under paragraph (1) elects not to implement the recommendations, the Secretary shall include in the notification to Congress under paragraph (2) the recommendations of the Commission.

(c) INITIAL ISSUES TO BE ACTED UPON.—The issues described in this subsection are as follows:

(1) UNIFORM DATA COLLECTION.—The establishment of uniform data collection with respect to use, cost, and quality information and to require common claims processing.

(2) MINIMUM BENEFITS.—The authority of the States to establish interim minimum benefits packages until the implementation of any recommendation under subsection (d)(4), including an exemption for self-insured plans which provide benefits which are actuarially equivalent to the minimum benefits package.

(3) MINIMUM SIZE.—The application of the preemption rules only to self-insured employers which have more than a minimum number of employees.

(4) MANAGED CARE.—The authority of the States to regulate the quality of managed care plans which contract with self-insured plans.

(5) STATE HEALTH CARE FINANCING PROGRAMS.—The establishment of State programs which—

(i) provide for the imposition of a broad-based, nondiscriminatory premium tax, or a broad-based, nondiscriminatory tax on health services, the proceeds of which are used to increase health insurance coverage of State residents or to pay for the uncompensated care of such residents, or

(ii) provide for the imposition of a tax on employers to provide for health care coverage of their employees, but only if the program allows a credit to employers for health care coverage provided by the employers to their employees.

(6) RATE SETTING.—A requirement that the State participate in a hospital reimbursement system or other system which sets rates for health care providers in the State.

(d) OTHER ISSUES.—The issues described in this subsection are as follows:

(1) MANDATES.—The authority of States to require employers to pay for or offer health benefits.

(2) REMEDIES.—The authority of the Federal Government of the States to provide remedies and consumer protections to beneficiaries of self-insured plans.

(3) PURCHASING COOPERATIVES.—The authority of the States to require self-insured plans to participate in purchasing cooperatives and risk adjustment systems.

(4) UNIFORM BENEFITS.—The development of a national uniform benefits plan applicable to all health plans, including self-insured plans.

(5) UNRESOLVED ISSUES.—Those issues unresolved under subsection (c).

SEC. 2113. OPERATION OF THE COMMISSION.

(a) MEMBERSHIP.—

(1) IN GENERAL.—The ERISA Review Commission shall be composed of 17 members. Members shall be appointed not later than 90 days after the date of the enactment of this Act.

(2) CHAIRPERSON.—The President shall designate 1 individual described in paragraph (1) who shall serve as Chairperson of the Commission.

(b) COMPOSITION.—The membership of the Commission shall include—

(1) 9 individuals appointed by the President, 3 of whom shall be Federal officials representing the Departments of Labor, Health and Human Services, and the Treasury, 2 of whom shall represent business, 2 of whom shall represent labor, and 2 of whom shall represent State and local governments,

(2) 4 appointed by the Majority Leader of the Senate, in consultation with the Minority Leader, 2 of whom shall represent business and 2 of whom shall represent State and local governments, and

(3) 4 appointed by the Majority Leader of the House of Representatives, in consultation with the Minority Leader, 2 of whom shall represent business and 2 of whom shall represent State and local governments.

(c) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

(d) VACANCIES.—

(1) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner as the original appointment.

(2) NO IMPAIRMENT OF FUNCTION.—A vacancy in the membership of the Commission does not impair the authority of the remaining members to exercise all of the powers of the Commission.

(3) ACTING CHAIRPERSON.—The Commission may designate a member to act as Chairperson during any period in which there is no Chairperson designated by the President.

(e) MEETINGS; QUORUM.—

(1) MEETINGS.—The Chairperson shall preside at meetings of the Commission, and in the absence of the Chairperson, the Commission shall elect a member to act as Chairperson pro tempore.

(2) QUORUM.—Nine members of the Commission shall constitute a quorum thereof.

(f) ADMINISTRATIVE PROVISIONS.—

(1) PAY AND TRAVEL EXPENSES.—

(A) PAY.—Each member shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(B) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in

lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(2) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Commission shall, without regard to section 5311(b) of title 5, United States Code, appoint an Executive Director.

(B) PAY.—The Executive Director shall be paid at a rate equivalent to a rate for the Senior Executive Service.

(3) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for level GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this Act.

(4) OTHER AUTHORITY.—

(A) CONTRACT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(B) LEASES AND PROPERTY.—The Commission may lease space and acquire personal property to the extent funds are available.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Fund established under section 9551 of the Internal Revenue Code of 1986, $1,000,000 for the operation of the Commission.

(h) EXPIRATION.—The Commission shall terminate 2 years after the date on which all of its members are appointed.

TITLE III—PUBLIC HEALTH AND RURAL AND UNDERSERVED ACCESS IMPROVEMENT

SEC. 3001. SHORT TITLE.

This title may be cited as the ''Public Health and Rural and Underserved Access Improvement Act of 1995''.

SEC. 3002. ESTABLISHMENT OF NEW TITLE XXVII REGARDING PUBLIC HEALTH PROGRAMS.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following title:

''TITLE XXVII—PUBLIC HEALTH PROGRAMS IMPROVEMENT

''Subtitle A—Core Functions of Public Health Programs

''PART 1—FORMULA GRANTS TO STATES

''SEC. 2711. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this subtitle, there are authorized to be appropriated from the Health Care Reform Trust Fund established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986 (hereafter referred to in this title as the ''Fund''), $200,000,000 for fiscal year 1996, $350,000,000 for fiscal year 1997, $500,000,000 for fiscal year 1998, $650,000,000 for fiscal year 1999, and $700,000,000 for fiscal year 2000.

''SEC. 2712. FORMULA GRANTS TO STATES FOR CORE HEALTH FUNCTIONS.

''(a) IN GENERAL.—In the case of each State that submits to the Secretary an application in accordance with section 2715 for a fiscal year, the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall make a grant to the State for carrying out the activities described in subsection (c). The award shall consist of the allotment determined under section 2716 for the State.

''(b) GENERAL PURPOSE.—The purpose of this subtitle is to provide for improvements in the health status of the public through carrying out the activities described in subsection (b) toward attaining the Healthy People 2000 Objectives (as defined in section 2799). A funding agreement for a grant under subsection (a) is that—

''(1) the grant will be expended for such activities; and

''(2) the activities will be carried out by the State in collaboration with local public health departments, health education and training centers, neighborhood health centers, and other community health providers.

''(c) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—Subject to the purpose described in subsection (b), the activities referred to in subsection (a) are the following:

''(1) Data collection, and analytical activities, related to population-based status and outcomes monitoring, including the following:

''(A) The regular collection and analysis of public health data (including the 10 leading causes of death and their costs to society).

''(B) Vital statistics.

''(C) Personal health services data.

''(D) The supply and distribution of health professionals.

''(2) Activities to reduce environmental risk and to assure the safety of housing, schools, workplaces, day-care centers, food and water, including the following activities:

''(A) Monitoring the overall public health status and safety of communities.

''(B) Assessing exposure to high lead levels and other environmental contaminants; and activities for abatement of toxicant hazards, including lead-related hazards.

''(C) Monitoring the quality of community water supplies used for consumption or for recreational purposes.

''(D) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

''(E) Monitoring indoor and ambient air quality and related risks to vulnerable populations.

''(F) Assuring recreation, worker, and school safety.

''(G) Enforcing public health safety and sanitary codes.

''(H) Monitoring community access to appropriate health services.

''(I) Other activities relating to promoting and protecting the public health of communities.

''(3) Investigation, control, and public-awareness activities regarding adverse health conditions (such as emergency treatment preparedness, community efforts to reduce violence, outbreaks of communicable diseases within communities, chronic disease and dysfunction exposure-related conditions, toxic environmental pollutants, occupational and recreational hazards, motor vehicle accidents, and other threats to the health status of individuals).

''(4) Public information and education programs to reduce risks to health (such as use of tobacco;, alcohol and other drugs; unintentional injury from accidents, including motor vehicle accidents; sexual activities that increase the risk to HIV transmission and sexually transmitted diseases; poor diet; physical inactivity; stress-related illness; mental health problems; genetic disorders; and low childhood immunization levels).

''(5) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions (such as metabolic diseases in newborns, provide assessments of blood lead levels and other environmental toxicants, diagnose and contact tracing of sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies).

''(6) Training and education of new and existing health professionals in the field of public health, with special emphasis on epidemiology, biostatistics, health education, public health administration, public health nursing and dentistry, environmental and occupational health sciences, public health nutrition, social and behavioral health sciences, operations research, and laboratory technology.

''(7) Leadership, policy development and administration activities, including assessing needs and the supply and distribution of health professionals; the setting of public health standards; the development of community public health policies; and the development of community public health coalitions.

''(d) RESTRICTIONS ON USE OF GRANT.—

''(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

''(A) to provide inpatient services;

''(B) to make cash payments to intended recipients of health services;

''(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

''(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

''(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

''(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not expend more than 20 percent of the grant for administrative expenses with respect to the grant.

''(e) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

''SEC. 2713. NUMBER OF FUNCTIONS; PLANNING.

''(a) NUMBER OF FUNCTIONS.—Subject to subsection (b), a funding agreement for a grant under section 2712 is that the State involved will carry out each of the activities described in subsection (c) of such section.

''(b) PLANNING.—In making grants under section 2712, the Secretary shall for each State designate a period during which the State is to engage in planning to meet the responsibilities of the State under subsection (a). The period so designated may not exceed 18 months. With respect to such period for a State, a funding agreement for a grant under section 2712 for any fiscal year containing any portion of the period is that, during the period, the State will expend the grant only for such planning.

''SEC. 2714. SUBMISSION OF INFORMATION; REPORTS.

''(a) SUBMISSION OF INFORMATION.—The Secretary may make a grant under section 2712 only if the State involved submits to the Secretary the following information:

''(1) A description of the relationship between community health providers, public

and private health plans, and the public health system of the State.

''(2) A description of existing deficiencies in the public health system at the State level and the local level, using standards under the Healthy People 2000 Objectives.

''(3) A description of public health priorities identified at the State level and local levels, including the 10 leading causes of death and their respective direct and indirect costs to the State and the Federal Government.

''(4) Measurable outcomes and process objectives (using criteria under the Healthy People 2000 Objectives) which indicate improvements in health status as a result of the activities carried out under section 2712(c).

''(5) Information regarding each such activity, which—

''(A) identifies the amount of State and local funding expended on each such activity for the fiscal year preceding the fiscal year for which the grant is sought; and

''(B) provides a detailed description of how additional Federal funding will improve each such activity by both the State and local public health agencies.

''(6) A description of activities under section 2712(c) to be carried out at the local level, and a specification for each such activity of—

''(A) the communities in which the activity will be carried out and any collaborating agencies; and

''(B) the amount of the grant to be expended for the activity in each community so specified.

''(7) A description of how such activities have been coordinated with activities supported under title V of the Social Security Act (relating to maternal and child health).

''(b) REPORTS.—A funding agreement for a grant under section 2712 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report describing—

''(1) the purposes for which the grant was expended;

''(2) the health status of the population of the State, as measured by criteria under the Healthy People 2000 Objectives; and

''(3) the progress achieved and obstacles encountered in using uniform data sets under such Objectives.

''SEC. 2715. APPLICATION FOR GRANT.

''The Secretary may make a grant under section 2712 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 2712(c), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

''SEC. 2716. DETERMINATION OF AMOUNT OF ALLOTMENT.

''For purposes of section 2712, the allotment under this section for a State for a fiscal year shall be determined through a formula established by the Secretary on the basis of the population, economic indicators, and health status of each State. Such allotment shall be the product of—

''(1) a percentage determined under the formula; and

''(2) the amount appropriated under section 2711 for the fiscal year, less any amounts reserved under section 2717.

''SEC. 2717. ALLOCATIONS FOR CERTAIN ACTIVITIES.

''Of the amounts made available under section 2711 for a fiscal year for carrying out this part, the Secretary may reserve not more than 15 percent for carrying out the following activities:

''(1) Technical assistance with respect to planning, development, and operation of activities under section 2712(b), including provision of biostatistical and epidemiological expertise, provision of laboratory expertise, and the development of uniform data sets under the Health People 2000 Objectives.

''(2) Development and operation of a national information network among State and local health agencies for utilizing such uniform data sets.

''(3) Program monitoring and evaluation of activities carried out under section 2712(b).

''(4) Development of a unified electronic reporting mechanism to improve the efficiency of administrative management requirements regarding the provision of Federal grants to State public health agencies.

''PART 2—COMPREHENSIVE EVALUATION OF DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS

''SEC. 2718. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this part, there are authorized to be appropriated from the Fund, $100,000,000 for fiscal year 1996, and $150,000,000 for each of the fiscal years 1997 through 2000.

''SEC. 2719. EVALUATION OF PROGRAMS.

''(a) GRANTS.—The Secretary may make grants to, or enter into cooperative agreements or contracts with, eligible entities for the purpose of enabling such entities to carry out evaluations of the type described in subsection (c). The Secretary shall carry out this section acting through the Director of the Centers for Disease Control and Prevention, subject to subsection (g).

''(b) REQUIREMENTS.—

''(1) ELIGIBLE ENTITIES.—To be eligible to receive an award of a grant, cooperative agreement, or contract under subsection (a), an entity must—

''(A) be a public, nonprofit, or private entity or a university;

''(B) prepare and submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require, including a plan for the conduct of the evaluation under the grant;

''(C) provide assurances that any information collected while conducting evaluations under this section will be maintained in a confidential manner with respect to the identities of the individuals from which such information is obtained; and

''(D) meet any other requirements that the Secretary determines to be appropriate.

''(2) TYPES OF ENTITIES.—In making awards under subsection (a), the Secretary shall consider applications from entities proposing to conduct evaluations using community programs, managed care programs, State and county health departments, public education campaigns, school programs, and other appropriate programs. The Secretary shall ensure that not less than 25 percent of the amounts appropriated under section 2718 for a fiscal year are used for making such awards to entities that will use the amounts to conduct evaluations in the workplace.

''(c) USE OF FUNDS.—

''(1) EVALUATIONS.—An award under subsection (a) shall be used to—

''(A) conduct evaluations to determine the extent to which clinical preventive services, health promotion and unintentional injury prevention activities, and interpersonal and community violence prevention activities, achieve short-term and long-term health care cost reductions and health status improvement with respect to the Healthy People 2000 Objectives; and

''(B) evaluate other areas determined appropriate by the Secretary.

''(2) INCLUSION OF CERTAIN POPULATION GROUPS.—In carrying out this section, the Secretary shall ensure that data concerning women, children, minorities, older individuals with different income levels, retirees, and individuals from diverse geographical backgrounds, are obtained.

''(3) MINIMUM SERVICES.—The evaluations that the Secretary may provide for under this section include (but are not limited to) evaluations of programs that provide one or more of the following services:

''(A) Blood pressure screening and control (to detect and control hypertension and coronary health disease).

''(B) Early cancer screening.

''(C) Blood cholesterol screening and control.

''(D) Smoking cessation programs.

''(E) Substance abuse programs.

''(F) Dietary and nutrition counseling, including nutrition.

''(G) Physical fitness counseling.

''(H) Stress management.

''(I) Diabetes education and screening.

''(J) Intraocular pressure screening.

''(K) Monitoring of prescription drug use.

''(L) Violence and injury prevention programs.

''(M) Health education.

''(N) Immunization rates.

''(4) ENVIRONMENTAL DATA.—Evaluations conducted under this section may consider the health effects and cost-effectiveness of certain environmental programs, including fluoridation programs, traffic safety programs, pollution control programs, accident prevention programs, and antismoking programs.

''(5) PUBLIC POLICIES.—Evaluations conducted under this section may consider the effects of prevention-oriented social and economic policies on improvement of health status and their long-term cost effectiveness.

''(6) USE OF EXISTING DATA.—In conducting evaluations under this section, entities shall use existing data and health promotion and screening programs where practicable.

''(7) COOPERATION.—In providing for an evaluation under this section, the Secretary shall encourage the recipient of the award and public and private entities with relevant expertise (including State and local agencies) to collaborate for purposes of conducting the evaluation.

''(d) SITES.—Recipients of awards under subsection (a) shall select evaluation sites under the award that present the greatest potential for new and relevant knowledge. Such recipients, in selecting such sites, shall ensure that—

''(1) the sites provide evidence of pilot testing, process evaluation, formative evaluation, availability assessment strategies and results;

''(2) the sites provide evidence of a clear definition of the program and protocols for the implementation of the evaluation; and

''(3) the sites provide evidence of valid, appropriate and feasible assessment methods and tools and a willingness to use common data items and instruments across such sites.

''(e) REPORTING REQUIREMENTS.—Not later than 1 year after an entity first receives an award under subsection (a), and not less than once during each 1-year period thereafter for which such an award is made to the entity, the entity shall prepare and submit to the Secretary a report containing a description of the activities under this section conducted during the period for which the report is prepared, and the findings derived as a result of such activities.

''(f) TERM OF EVALUATIONS.—Evaluations conducted under this section shall be for a period of not less than 3 years and may continue as necessary to permit the grantee to adequately measure the full benefit of the evaluations.

''(g) DISSEMINATION AND GUIDELINES.—

''(1) CONSULTATION.—The Secretary shall carry out this subsection acting through the Director of the Centers for Disease Control and Prevention and the Administrator for Health Care Policy and Research.

''(2) GUIDELINES.—The Secretary shall, where feasible and practical, develop and issue practice guidelines that are based on the results of evaluations conducted under this section. The practice guidelines shall be developed by the Secretary utilizing expert practitioners to assist in the development and implementation of these guidelines.

''(3) DATA.—

''(A) IN GENERAL.—The Secretary shall collect, store, analyze, and make available data related to the formulation of the guidelines that is provided to the Centers for Disease Control and Prevention by entities conducting evaluations under this section.

''(B) USE OF DATA.—The Secretary shall—

''(i) identify activities that prevent disease, illness, injury and disability, and promote good health practices; ascertain their cost-effectiveness; and identify their potential to overall health status with respect to Healthy People 2000 Objectives;

''(ii) disseminate practice guidelines to State and county health departments, State insurance departments, insurance companies, employers, professional medical organizations, and others determined appropriate by the Secretary; and

''(iii) provide information with respect to recidivism rates of participation in the evaluations.

''(4) DISSEMINATION.—The Secretary may disseminate information collected from evaluations under this section.

''(h) LIMITATION.—Amounts appropriated for carrying out this section shall not be utilized to provide services.

''Subtitle B—Opportunities for Education and Training in Public Health

''PART 1—SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REGARDING SERVICE IN PUBLIC HEALTH POSITIONS

''SEC. 2721. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this part, there are authorized to be appropriated from the Fund, $50,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2722. SCHOLARSHIP PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Secretary awards scholarships to individuals described in subsection (b) for the purpose of assisting the individuals with the costs of attending public and nonprofit private schools of public health (or other public or nonprofit private institutions providing graduate or specialized training in public health).

''(b) ELIGIBLE INDIVIDUALS.—An individual referred to in subsection (a) is any individual meeting the following conditions:

''(1) The individual is enrolled (or accepted for enrollment) at a school or other institution referred to in subsection (a) as a full-time or part-time student in a program providing training in a health profession in a field of public health (including the fields of epidemiology, biostatistics, environmental health, health administration and planning, behavioral sciences, maternal and child health, occupational safety, public health nursing, nutrition, and toxicology).

''(2) The individual enters into the contract required pursuant to subsection (d) as a condition of receiving the scholarship (relating to an agreement to provide services in approved public health positions, as defined in section 2724).

''(c) ELIGIBLE SCHOOLS.—For fiscal year 1996 and subsequent fiscal years, the Secretary may make an award of a scholarship under subsection (a) only if the Secretary determines that—

''(1) the school or other institution with respect to which the award is to be provided has coordinated the activities of the school or institution with relevant activities of the Health Resources and Services Administration and the Centers for Disease Control and Prevention; and

''(2) not fewer than 60 percent of the graduates of the school or institution are in public health positions determined by the Secretary to be consistent with the needs of the United States regarding such professionals.

''(d) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this section or section 2724, the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an award of a scholarship under subsection (a) to the same extent and in the same manner as such provisions apply to an award of a scholarship under section 338A.

''SEC. 2723. LOAN REPAYMENT PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Federal Government enters into agreements to repay all or part of the educational loans of individuals meeting the following conditions:

''(1) The individual involved is a graduate of a school or other institution described in section 2722(a).

''(2) The individual meets the applicable legal requirements to provide services as a public health professional (including a professional in any of the fields specified in section 2722(b)(1)).

''(3) The individual enters into the contract required pursuant to subsection (b) as a condition of the Federal Government repaying such loans (relating to an agreement to provide services in approved public health positions, as defined in section 2724).

''(b) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this section or section 2724, the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an agreement regarding repayment under subsection (a) to the same extent and in the same manner as such provisions apply to an agreement regarding repayment under section 338B.

''(c) AMOUNT OF REPAYMENTS.—For each year for which an individual contracts to serve in an approved public health position pursuant to subsection (b), the Secretary may repay not more than $20,000 of the principal and interest of the educational loans of the individual.

''SEC. 2724. APPROVED PUBLIC HEALTH POSITIONS.

''(a) POSITION REGARDING POPULATIONS WITH SIGNIFICANT NEED FOR SERVICES.—

''(1) IN GENERAL.—With respect to the programs under this part, the obligated service of a program participant pursuant to sections 2722(d) and 2723(b) shall be provided through an assignment, to an entity described in subsection (b), for a position in which the participant provides services as a public health professional to a population determined by the Secretary to have a significant unmet need for the services of such a professional.

''(2) PERIOD OF SERVICE.—For purposes of sections 2722(d) and 2723(d), the period of obligated service is the following, as applicable to the program participant involved:

''(A) In the case of scholarships under section 2722 for full-time students, the greater of—

''(i) 1 year for each year for which such a scholarship is provided; or

''(ii) 2 years.

''(B) In the case of scholarships under section 2722 for part-time students, a period determined by the Secretary on the basis of the number of hours of education or training received under the scholarship, considering the percentage constituted by the ratio of such number to the number of hours for a full-time student in the program involved.

''(C) In the case of the loan repayments under section 2723, such period as the Secretary and the participant may agree, except that the period may not be less than 2 years.

''(b) APPROVAL OF ENTITIES FOR ASSIGNMENT OF PROGRAM PARTICIPANTS.—The entities referred to in subsection (a) are public and nonprofit private entities approved by the Secretary as meeting such requirements for the assignment of a program participant as the Secretary may establish. The entities that the Secretary may so approve include State and local departments of health, public hospitals, community and neighborhood health clinics, migrant health clinics, community-based health-related organizations, certified regional poison control centers, purchasing cooperatives regarding health insurance, and any other public or nonprofit private entity.

''(c) DEFINITIONS.—For purposes of this part:

''(1) The term 'approved public health position', with respect to a program participant, means a position to which the participant is assigned pursuant to subsection (a).

''(2) The term 'program participant' means an individual who enters into a contract pursuant to section 2722(b)(2) or 2723(a)(3).

''SEC. 2725. ALLOCATION OF FUNDS; SPECIAL CONSIDERATIONS.

''(a) ALLOCATIONS REGARDING NEW PARTICIPANTS IN SCHOLARSHIP PROGRAM.—Of the amounts appropriated under section 2721 for a fiscal year, the Secretary shall obligate not less than 30 percent for the purpose of providing awards for scholarships under section 2722 to individuals who have not previously received such scholarships.

''(b) SPECIAL CONSIDERATION FOR CERTAIN INDIVIDUALS.—In making awards of scholarships under section 2722 and making repayments under section 2723, the Secretary shall give special consideration to individuals who are in the armed forces of the United States or who are veterans of the armed forces.

''PART 2—EDUCATIONAL INSTITUTIONS REGARDING PUBLIC HEALTH

''SEC. 2731. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this part from the Fund, there are authorized to be appropriated from the Fund, $100,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2732. GRANTS FOR EXPANDING CAPACITY OF INSTITUTIONS.

''(a) IN GENERAL.—The Secretary may make grants to institutions described in subsection (b) for the purpose of expanding the educational capacities of the institutions through recruiting and retaining faculty, curriculum development, and coordinating the activities of the institutions regarding education, training, and field placements.

''(b) RELEVANT INSTITUTIONS.—The institutions referred to in subsection (a) are public and nonprofit private—

''(1) schools of public health;

''(2) departments of community and preventive medicine that—

''(A) are within schools of medicine and schools of osteopathic medicine; and

''(B) have established formal arrangements with schools of public health in order to award joint degrees in public health and another health profession; and

''(3) schools of nursing or dentistry that have established formal arrangements with schools of public health in order to carry out educational programs in public health at the schools of nursing or dentistry, respectively.

''(c) REQUIREMENTS REGARDING CURRICULUM DEVELOPMENT.—A funding agreement for a grant under subsection (a) for an institution is that, to the extent determined to be appropriate by the Secretary, the curriculum of institution will include the following:

''(1) Subject to subsection (d)(1), part-time nondegree programs for public health professionals who need further training in fields of public health.

''(2) With respect to the program of community health advisors established in part 5 of subtitle E, a program to train individuals to serve as supervisors under such part (including training and evaluating the community health advisors), which program is carried out in collaboration with local public health departments and health education and training centers.

''(d) ADDITIONAL REQUIREMENTS.—Funding agreements for a grant under subsection (a) for an institution are as follows:

''(1) In developing the curriculum under the grant, the institution will consult with the health departments in the State involved, and will follow the relevant priorities of such departments.

''(2) The institution will, as appropriate in the determination of the Secretary, coordinate the activities of the institution under the grant with relevant activities of the Health Resources and Services Administration and the Centers for Disease Control and Prevention.

''SEC. 2733. COORDINATION OF GRANT ACTIVITIES WITH NATIONAL PRIORITIES.

''The Secretary shall—

''(1) determine the needs of the United States regarding the education and geographic distribution of public health professionals;

''(2) determine priorities among such needs; and

''(3) in making grants under section 2732, ensure that the curricula developed under such section, and the expertise of the faculty recruited and retained under such section, are consistent with such priorities.

''SEC. 2734. CERTAIN REQUIREMENTS FOR GRANTS.

''For fiscal year 1997 and subsequent fiscal years, the Secretary may make a grant under section 2732 only if the institution involved is in compliance with the following:

''(1) The institution has coordinated the activities of the school or institution with relevant activities of the Health Resources and Services Administration and the Centers for Disease Control and Prevention.

''(2) A significant number of the faculty of the institution has served as practitioners in public health.

''(3) The institution has consulted with public health departments and public hospital systems in the State involved in order to develop a curriculum that reflects the needs and priorities of the State regarding the public health.

''(4) The institution has coordinated the activities of the institution with the activities of the health departments and of community groups.

''(5) The institution carries out a program for part-time students to receive training in fields of public health.

''(6) Not less than 60 percent of the graduates of the school or institution are in public health positions determined by the Secretary to be consistent with the needs of the United States regarding such professionals.

''PART 3—EXPANSION OF COMPETENCY IN PUBLIC HEALTH

''SEC. 2736. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this section, there is authorized to be appropriated from the Fund, $60,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2737. GRANTS TO STATES.

''(a) STATES LACKING ADEQUATE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to States in which there is one or no program of training in a field of public health but in which there are 1 or more schools of medicine, osteopathic medicine, nursing, dentistry, social work, pharmacy, or health administration. A funding agreement for such a grant is that the purpose of the grant is for the State involved to assist 1 or more of such schools in developing and integrating public health curricula for the schools.

''(2) SPECIAL CONSIDERATIONS IN MAKING GRANTS.—In making grants under paragraph (1), the Secretary shall give special consideration to States that agree to consult with 1 or more schools of public health in carrying out the purpose described in such subsection.

''(b) STATES WITH NONACCREDITED SCHOOLS.—The Secretary may make grants to States in which there are 1 or more nonaccredited schools of public health. A funding agreement for such a grant is that the purpose of the grant is for the State involved to assist 1 or more of such schools in improving the schools.

''(c) AMOUNT OF GRANT; LIMITATION REGARDING INDIVIDUAL EDUCATIONAL ENTITIES.—

''(1) AMOUNT.—The amount of a grant under this section to a State may not exceed $6,000,000.

''(2) LIMITATION.—A funding agreement for a grant under this section for a State is that, with respect to the school involved, the State will not provide more than 2 years of assistance to the school from grants under this section.

''PART 4—AREA HEALTH EDUCATION CENTERS

''SEC. 2738. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''(a) ADDITIONAL FUNDING.—For the purpose of carrying out programs under section 746, there are authorized to be appropriated from the Fund, $35,000,000 for each of the fiscal years 1996 through 2000.

''(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

''PART 5—HEALTH EDUCATION TRAINING CENTER

''SEC. 2739. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''(a) ADDITIONAL FUNDING.—For the purpose of carrying out Health Education Training Center programs, there are authorized to be appropriated from the Fund, $20,000,000 for each of the fiscal years 1996 through 2000.

''(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

''Subtitle C—Regional Poison Control Centers

''SEC. 2741. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this subtitle, there is authorized to be appropriated from the Fund, $50,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2742. GRANTS FOR REGIONAL CENTERS.

''(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for centers to carry out activities regarding—

''(1) the prevention and treatment of poisoning; and

''(2) such other activities regarding the control of poisons as the Secretary determines to be appropriate.

''(b) REGIONAL CONSIDERATIONS.—In making grants under subsection (a), the Secretary shall determine the need in each of the principal geographic regions of the United States for a center under such subsection, and shall make the grants according to priorities established by the Secretary on the basis of the extent of such need in each of the regions. In carrying out the preceding sentence, the Secretary shall ensure that no two centers receive grants for the same geographic service area.

''(c) MATCHING FUNDS.—

''(1) IN GENERAL.—With respect to the costs of an entity in providing for centers under subsection (a), the Secretary may make a grant under such subsection only if the State in which the center is to operate, or other public entities in the State, agree to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount determined by the Secretary.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''SEC. 2743. REQUIREMENTS REGARDING CERTIFICATION.

''(a) IN GENERAL.—Subject to subsection (b), the Secretary may make a grant under section 2742 only if the center involved has been certified by a professional organization in the field of poison control, and the Secretary has approved the organization as having in effect standards for certification that reasonably provide for the protection of the public health with respect to poisoning. In carrying out the preceding sentence, the Secretary shall consider the standards established by the American Association of Poison Control Centers.

''(b) TEMPORARY WAIVER.—The Secretary may waive the requirement of subsection (a) for a center for a period not exceeding 1 year.

''SEC. 2744. GENERAL PROVISIONS.

''(a) DURATION OF GRANT.—The period during which payments are made under a grant under section 2742 may not exceed 3 years. The provision of such payments is subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. The preceding sentence may not be construed as establishing a limitation on the number of such grants that may be made to an entity.

''(b) STUDY REGARDING NEED FOR CENTERS.—

''(1) IN GENERAL.—The Secretary shall conduct a study of each of the centers for which a grant under section 2742 has been provided.

The purpose of the study shall be to determine the effectiveness of the centers in carrying out the activities described in such section and the extent to which the activities have been carried out in a cost-effective manner.

''(2) ALTERNATIVES TO CENTERS.—In carrying out the study under paragraph (1), the Secretary shall determine the extent to which the activities described in section 2742 can be effectively carried out through means other than centers under such section. The alternative means considered by the Secretary under the preceding sentence shall include the alternative of requiring public and private health plans to carry out such activities.

''(3) DATE CERTAIN FOR COMPLETION.—Not later than November 1, 1996, the Secretary shall submit to the Congress a report describing the findings made in the study under paragraph (1).

''(4) NOTICE TO CENTERS.—Not later than February 1, 1997, the Secretary shall notify each grantee under section 2742 whether the Secretary considers the continued operation of the center involved to be necessary in meeting the needs of the geographic region involved for the activities described in such section.

''Subtitle D—School-Related Health Services

''SEC. 2746. AUTHORIZATION OF APPROPRIATIONS FROM FUND.

''(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subtitle, there are authorized to be appropriated from the Fund, $100,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $300,000,000 for fiscal year 1998, $400,000,000 for fiscal year 1999, and $500,000,000 for fiscal year 2000.

''(b) FUNDING FOR PLANNING AND DEVELOPMENT GRANTS.—Of amounts made available under this section, not to exceed $10,000,000 for each of fiscal years 1996 and 1997 may be utilized to carry out section 2749.

''SEC. 2747. ELIGIBILITY FOR GRANTS.

''(a) IN GENERAL.—

''(1) PLANNING AND DEVELOPMENT GRANTS.—Entities eligible to apply for and receive grants under section 2749 are—

''(A) State health agencies that apply on behalf of local community partnerships; or

''(B) local community partnerships in States in which health agencies have not successfully applied.

''(2) OPERATIONAL GRANTS.—Entities eligible to apply for and receive grants under section 2750 are—

''(A) a qualified State as designated under subsection (c) that apply on behalf of local community partnerships; or

''(B) local community partnerships in States that are not designated under subparagraph (A).

''(b) LOCAL COMMUNITY PARTNERSHIPS.—

''(1) IN GENERAL.—A local community partnership under subsection (a)(1)(B) and (a)(2)(B) is an entity that, at a minimum includes—

''(A) a local health care provider, which may be a local public health department, with experience in delivering services to children and youth or medically underserved populations;

''(B) local educational agency on behalf of one or more public schools; and

''(C) one community based organization located in the community to be served that has a history of providing services to at-risk children and youth.

''(2) RURAL COMMUNITIES.—In rural communities, local partnerships should seek to include, to the fullest extent practicable, providers and community based organizations with experience in serving the target population.

''(3) PARENT AND COMMUNITY PARTICIPATION.—An applicant described in subsection (a) shall, to the maximum extent feasible, involve broad-based community participation (including parents of the youth to be served).

''(c) QUALIFIED STATE.—A qualified State under subsection (a)(2)(A) is a State that, at a minimum—

''(1) demonstrates an organizational commitment (including a strategic plan) to providing a broad range of health, health education and support services to at-risk youth; and

''(2) has a memorandum of understanding or cooperative agreement jointly entered into by the State agencies responsible for health and education regarding the planned delivery of health and support services in school-based or school-linked centers.

''SEC. 2748. PREFERENCES.

''In making grants under sections 2749 and 2750, the Secretary shall give priority to applicants whose-communities to be served show the most substantial level of need for health services among children and youth.

''SEC. 2749. PLANNING AND DEVELOPMENT GRANTS.

''(a) IN GENERAL.—The Secretary may make grants during fiscal years 1996 and 1997 to entities eligible under section 2747 to develop school-based or school-linked health service sites.

''(b) USE OF FUNDS.—Amounts provided under a grant under this section may be used for the following:

''(1) Planning for the provision of school health services, including—

''(A) an assessment of the need for health services among youth in the communities to be served;

''(B) the health services to be provided and how new services will be integrated with existing services;

''(C) assessing and planning for the modernization and expansion of existing facilities and equipment to accommodate such services; and

''(D) an affiliation with relevant health plans.

''(2) Recruitment and training of staff for the administration and delivery of school health services.

''(3) The establishment of local community partnerships as described in section 2747(b).

''(4) In the case of States, the development of memorandums of understanding or cooperative agreements for the coordinated delivery of health and support services through school health service sites.

''(5) Other activities necessary to assume operational status.

''(c) APPLICATION FOR GRANTS.—To be eligible to receive a grant under this section an entity described in section 2747(a) shall submit an application in a form and manner prescribed by the Secretary.

''(d) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

''(e) AMOUNT AVAILABLE FOR DEVELOPMENT GRANT.—The Secretary may award not to exceed—

''(1) $150,000 to entities under section 2747(a)(1)(A) and to localities planning for a citywide or countywide school health services delivery system; and

''(2) $50,000 to entities under section 2747(a)(1)(B).

''SEC. 2759. GRANTS FOR OPERATION OF SCHOOL HEALTH SERVICES.

''(a) IN GENERAL.—The Secretary may make grants to eligible entities described in section 2747(a)(2) that submit applications consistent with the requirements of this section, to pay the cost of operating school-based or school-linked health service sites.

''(b) USE OF GRANT.—Amounts provided under a grant under this section may be used for the following—

''(1) health services, including diagnosis and treatment of simple illnesses and minor injuries;

''(2) preventive health services, including health screenings follow-up health care, mental health, and preventive health education;

''(3) enabling services and other necessary support services;

''(4) training, recruitment, and compensation of health professionals and other staff necessary for the administration and delivery of school health services; and

''(5) referral services, including the linkage of individuals to health plans, and community-based health and social service providers.

''(c) APPLICATION FOR GRANT.—To be eligible to receive a grant under this section an entity described in section 2747(a)(2) shall submit an application in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information—

''(1) a description of the services to be furnished by the applicant;

''(2) the amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from health plans and other sources;

''(3) a description of local community partnerships, including parent and community participation;

''(4) a description of the linkages with other health and social service providers; and

''(5) such other information as the Secretary determines to be appropriate.

''(d) ASSURANCES.—In order to receive a grant under this section, an applicant must meet the following conditions—

''(1) school health service sites will, directly or indirectly, provide a broad range of health services, in accordance with the determinations of the local community partnership, that may include—

''(A) diagnosis and treatment of simple illnesses and minor injuries;

''(B) preventive health services, including health screenings and follow-up health care, mental health and preventive health education;

''(C) enabling services; and

''(D) referrals (including referrals regarding mental health and substance abuse) with follow-up to ensure that needed services are received;

''(2) the applicant provides services recommended by the health provider, in consultation with the local community partnership, and with the approval of the local education agency;

''(3) the applicant provides the services under this subsection to adolescents, and other school age children and their families as deemed appropriate by the local partnership;

''(4) the applicant maintains agreements with community-based health care providers with a history of providing services to such populations for the provision of health care services not otherwise provided directly or during the hours when school health services are unavailable;

''(5) the applicant establishes an affiliation with relevant health plans and will establish reimbursement procedures and will make every reasonable effort to collect appropriate reimbursement for services provided;

''(6) the applicant agrees to supplement and not supplant the level of State or local funds under the direct control of the applying State or participating local education or

health authority expended for school health services as defined by this Act;

''(7) services funded under this Act will be coordinated with existing school health services provided at a participating school; and

''(8) for applicants in rural areas, the assurances required under paragraph (4) shall be fulfilled to the maximum extent possible.

''(e) STATE LAWS.—Notwithstanding any other provision in this subtitle, no school based health clinic may provide services, to any minor, when to do so is a violation of State laws or regulations pertaining to informed consent for medical services to minors.

''(f) LIMITATION ON ADMINISTRATIVE FUNDS.—In the case of a State applying on behalf of local educational partnerships, the applicant may retain not more than 5 percent of grants awarded under this subpart for administrative costs.

''(g) DURATION OF GRANT.—A grant under this section shall be for a period determined appropriate by the Secretary.

''(h) AMOUNT OF GRANT.—The annual amount of a grant awarded under this section shall not be more than $200,000 per school-based or school-linked health service site.

''(i) FEDERAL SHARE.—

''(1) IN GENERAL.—Subject to paragraph (3), a grant for services awarded under this section may not exceed—

''(A) 90 percent of the non-reimbursed cost of the activities to be funded under the program for the first 2 fiscal years for which the program receives assistance under this section; and

''(B) 75 percent of the non-reimbursed cost of such activities for subsequent years for which the program receives assistance under this section.

The remainder of such costs shall be made available as provided in paragraph (2).

''(2) FORM OF NON-FEDERAL SHARE.—The non-Federal share required by paragraph (1) may be in cash or in-kind, fairly evaluated, including facilities, equipment, personnel, or services, but may not include amounts provided by the Federal Government. In-kind contributions may include space within school facilities, school personnel, program use of school transportation systems, outposted health personnel, and extension of health provider medical liability insurance.

''(3) WAIVER.—The Secretary may waive the requirements of paragraph (1) for any year in accordance with criteria established by regulation. Such criteria shall include a documented need for the services provided under this section and an inability of the grantee to meet the requirements of paragraph (1) despite a good faith effort.

''(j) TRAINING AND TECHNICAL ASSISTANCE.—Entities that receive assistance under this section may use not to exceed 10 percent of the amount of such assistance to provide staff training and to secure necessary technical assistance. To the maximum extent feasible, technical assistance should be sought through local community-based entities. The limitation contained in this subsection shall apply to individuals employed to assist in obtaining funds under this subtitle. Staff training should include the training of teachers and other school personnel necessary to ensure appropriate referral and utilization of services, and appropriate linkages between class-room activities and services offered.

''(k) REPORT AND MONITORING.—The Secretary will submit to the Committee on Labor and Human Resources in the Senate and the Committee on Commerce in the House of Representatives a biennial report on the activities funded under this Act, consistent with the ongoing monitoring activities of the Department. Such reports are intended to advise the relevant Committees of the availability and utilization of services, and other relevant information about program activities.

''Subtitle E—Expansion of Rural and Underserved Areas Access to Health Services

''PART 1—COMMUNITY AND MIGRANT HEALTH CENTERS

''SEC. 2756. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''(a) IN GENERAL.—For the purpose of carrying out this part, there is authorized to be appropriated from the Fund, $100,000,000 for each of the fiscal years 1996 through 2000.

''(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) for the purpose described in such subsection are in addition to any other authorizations of appropriations that are available for such purpose.

''SEC. 2757. GRANTS TO COMMUNITY AND MIGRANT HEALTH CENTERS.

''(a) IN GENERAL.—The Secretary shall make grants in accordance with this section to migrant health centers and community health centers.

''(b) USE OF FUNDS.—

''(1) DEVELOPMENT, OPERATION, AND OTHER PURPOSES REGARDING CENTERS.—Subject to paragraph (2), grants under subsection (a) to migrant health centers and community health centers may be made only in accordance with the conditions upon which grants are made under sections 329 and 330, respectively.

''(2) REQUIRED FINANCIAL RESERVES.—The Secretary may authorize migrant health centers and community health centers to expend a grant under subsection (a) to establish and maintain financial reserves required for purposes of health plans.

''(c) DEFINITIONS.—For purposes of this subtitle, the terms 'migrant health center' and 'community health center' have the meanings given such terms in sections 329(a)(1) and 330(a), respectively.

''PART 2—NATIONAL HEALTH SERVICE CORPS

''SEC. 2781. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

''(a) ADDITIONAL FUNDING; GENERAL CORPS PROGRAM; ALLOCATIONS REGARDING NURSES.—For the purpose of carrying out subpart II of part D of title III, and for the purpose of carrying out subsection (c), there are authorized to be appropriated from the Fund, $100,000,000 for each of the fiscal years 1996 through 2000.

''(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

''(c) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—Of the amounts appropriated under subsection (a), the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program under section 338A, or in the Loan Repayment Program under section 338B, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 30 percent.

''(d) AVAILABILITY OF FUNDS.—An appropriation under this section for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under an authorization under subsection (a) for another fiscal year; but no funds may be made available from any appropriation under this section for obligation under sections 331 through 335, section 336A, and section 337 before the fiscal year involved.

''PART 3—SATELLITE CLINICS REGARDING PRIMARY HEALTH CARE

''SEC. 2783. AUTHORIZATION OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this part, there is authorized to be appropriated from the Fund, $50,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2783A. GRANTS TO STATES FOR DEVELOPMENT AND OPERATION OF SATELLITE CLINICS.

''(a) IN GENERAL.—With respect to outpatient health centers that are providers of comprehensive health services, the Secretary may make grants to States for the purpose of assisting such centers in developing or operating facilities that—

''(1) provide clinical preventive services, treatment of minor illnesses and injuries, family planning services, and referrals for health services, mental health services, and health-related social services; and

''(2) are located at a distance from the center sufficient to increase the extent to which individuals in the geographic area involved have access to the services specified in paragraph (1).

''(b) CERTAIN REQUIREMENTS.—The Secretary may make a grant under subsection (a) only if the State agrees that the health facility for which the grant is made, once in operation, will meet the following conditions:

''(1) The clinical preventive services provided by the facility will include routine preventive services, including family planning services, for pregnant and postpartum women and for children, including health screenings and immunizations.

''(2) The principal providers of health services at the facility, and the principal managers of the facility, will be nurse practitioners, physician assistants, or nurse clinicians, subject to applicable law.

''(3) The outpatient health center operating the facility will serve as a referral center for physician services and will provide for the ongoing monitoring of the activities of the facility.

''(c) MATCHING FUNDS.—The Secretary may make a grant under subsection (a) only if the State involved agrees to make non-Federal contributions toward the costs of developing and operating the health facilities involved.

''(d) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

''(e) LIMITATION ON AMOUNT OF ASSISTANCE PER FACILITY.—With respect to a health facility for which one or more grants under subsection (a) are made, the Secretary may not provide more than an aggregate $250,000 for the development and operation of the facility.

''PART 4—COMMUNITY HEALTH ADVISORS

''SEC. 2784. AUTHORIZATION OF APPROPRIATIONS FROM FUND.

''For the purpose of carrying out this part, there is authorized to be appropriated from the Fund, $100,000,000 for each of the fiscal years 1996 through 2000.

''SEC. 2785. FORMULA GRANTS REGARDING COMMUNITY HEALTH ADVISOR PROGRAMS.

''(a) FORMULA GRANTS.—

''(1) IN GENERAL.—In the case of each State (or entity designated by a State under subsection (b)) that submits to the Secretary an application in accordance with section 2788 for a fiscal year, the Secretary of Health and

Human Services, acting through the Director of the Centers for Disease Control and Prevention and in coordination with the heads of the agencies specified in paragraph (2), shall make an award of financial assistance to the State or entity for the development and operation of community health advisor programs under section 2786(b). The award shall consist of the allotment determined under section 2789 with respect to the State, subject to section 2794.

''(2) COORDINATION WITH OTHER AGENCIES.—The agencies referred to in paragraph (1) regarding coordination are the Health Resources and Services Administration, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Education and Training Center.

''(b) DESIGNATED ENTITIES.—With respect to the State involved, an entity other than the State may receive an award under subsection (a) only if the entity—

''(1) is a public or nonprofit private academic organization (or other public or nonprofit private entity); and

''(2) has been designated by the State to carry out the purpose described in such subsection in the State and to receive amounts under such subsection in lieu of the State.

''(c) ROLE OF STATE AGENCY FOR PUBLIC HEALTH.—A funding agreement for an award under subsection (a) is that—

''(1) if the applicant is a State, the award will be administered by the State agency with the principal responsibility for carrying out public health programs; and

''(2) if the applicant is an entity designated under subsection (b), the award will be administered in consultation with such State agency.

''(d) STATEWIDE RESPONSIBILITIES; LIMITATION ON EXPENDITURES.—

''(1) STATEWIDE RESPONSIBILITIES.—A funding agreement for an award under subsection (a) is that the applicant involved will—

''(A) operate a clearinghouse to maintain and disseminate information on community health advisor programs (and similar programs) in the State, including information on developing and operating such programs, on training individuals to participate in the programs, and on evaluation of the programs;

''(B) collaborate with schools of public health to provide to community health advisor programs in the State technical assistance in training and supervising community health advisors under section 2787(g)(1); and

''(C) coordinate the activities carried out in the State under the award, including coordination between the various community health advisor programs and coordination between such programs and related activities of the State and of other public or private entities.

''(2) LIMITATION.—A funding agreement for an award under subsection (a) is that the applicant involved will not expend more than 15 percent of the award in the aggregate for carrying out paragraph (1) and for the expenses of administering the award with respect to the State involved, including the process of receiving payments from the Secretary under the award, allocating the payments among the entities that are to develop and operate the community health advisor programs involved, and monitoring compliance with the funding agreements made under this subtitle by the applicant.

"SEC. 2786. REQUIREMENTS REGARDING COMMUNITY HEALTH ADVISOR PROGRAMS.

''(a) PURPOSE OF AWARD; HEALTHY PEOPLE 2000 OBJECTIVES.—

''(1) IN GENERAL.—Subject to paragraph (2), a funding agreement for an award under section 2785 for an applicant is that the purpose of the award is, through community health advisor programs under subsection (b), to assist the State involved in attaining the Healthy People 2000 Objectives.

''(2) AUTHORITY REGARDING SELECTION OF PRIORITY OBJECTIVES.—With respect to compliance with the agreement made under paragraph (1), an applicant receiving an award under section 2785 may, from among the various Healthy People 2000 Objectives, select one or more Objectives to be given priority in the operation of a community health advisor program of the applicant, subject to the applicant selecting such priorities in consultation with the entity that is to carry out the program and the local health department involved.

''(b) REQUIREMENTS FOR PROGRAMS.—

''(1) IN GENERAL.—A funding agreement for an award under section 2785 for an applicant is that, in expending the award, the purpose described in subsection (a)(1) will be carried out in accordance with the following:

''(A) For each community for which the purpose is to be carried out, the applicant will establish a program in accordance with this subsection.

''(B) The program will be carried out in a community only if the applicant has, under section 2787(a), identified the community as having a significant need for the program.

''(C) The program will be operated by a public or nonprofit private entity with experience in providing health or health-related social services to individuals who are underserved with respect to such services.

''(D) The services of the program, as specified in paragraph (2), will be provided principally by community health advisors (as defined in subsection (d)).

''(2) AUTHORIZED PROGRAM SERVICES.—For purposes of paragraph (1)(D), the services specified in this paragraph for a program are as follows:

''(A) The program will collaborate with health care providers and related entities in order to facilitate the provision of health services and health-related social services (including collaborating with local health departments, community health centers, public hospital systems, migrant health centers, rural health clinics, hospitals, physicians and nurses, providers of health education, pre-school facilities for children, elementary and secondary schools, and providers of social services).

''(B) The program will provide public education on health promotion and on the prevention of diseases, illnesses, injuries, and disabilities, and will facilitate the appropriate use of available health services and health-related social services.

''(C) The program will provide health-related counseling.

''(D) The program will provide referrals for available health services and health-related social services.

''(E) For the purpose of increasing the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs, the following conditions will be met:

''(i) The program will assist individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs.

''(ii) The program will provide such other services as the Secretary determines to be appropriate, which services may include (but are not limited to) transportation and translation services.

''(F) The program will provide outreach services to inform the community of the availability of the services of the program.

''(c) PRIORITY FOR MEDICALLY UNDERSERVED COMMUNITIES.—A funding agreement for an award under section 2785 is that the applicant involved will give priority to developing and operating community health advisor programs for medically underserved communities.

''(d) DEFINITION OF COMMUNITY HEALTH ADVISOR.—For purposes of this part, the term 'community health advisor' means an individual—

''(1) who has demonstrated the capacity to carry out one or more of the authorized program services;

''(2) who, for not less than 1 year, has been a resident of the community in which the community health advisor program involved is to be operated; and

''(3) is a member of a socioeconomic group to be served by the program.

"SEC. 2787. ADDITIONAL AGREEMENTS.

''(a) IDENTIFICATION OF COMMUNITY NEEDS.—A funding agreement for an award under section 2785 is that the applicant involved will—

''(1) identify the needs of the community involved for the authorized program services, including the identifying the resources of the community that are available for carrying out the program;

''(2) in identifying such needs, consult with members of the community, with individuals and programs that provide health services in the community, and with individuals and programs that provide health-related social services in the community; and

''(3) consider such needs in carrying out a community health advisor program for the community.

''(b) MATCHING FUNDS.—

''(1) IN GENERAL.—With respect to the cost of carrying out a community health advisor program, a funding agreement for an award under section 2785 is that the applicant involved will make available (directly or through donations from public or private entities) non-Federal contributions toward such cost in an amount that is not less than 25 percent of such cost.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—

''(A) Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(B) With respect to the State in which the community health advisor program involved is to be carried out, amounts provided by the State in compliance with subsection (c) shall be included in determining the amount of non-Federal contributions under paragraph (1).

''(c) MAINTENANCE OF EFFORT.—With respect to the purposes for which an award under section 2785 is authorized in this subtitle to be expended, the Secretary may make such an award only if the State involved agrees to maintain expenditures of non-Federal amounts for such purposes at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which such an award is made with respect to the State.

''(d) CULTURAL CONTEXT OF SERVICES.—A funding agreement for an award under section 2785 for an applicant is that the services of the community health advisor program involved will be provided in the language and cultural context most appropriate for the individuals served by the program, and that for such purpose the community health advisors of the program will include an appropriate number of advisors who are fluent in both English and not less than one of the other relevant languages.

''(e) NUMBER OF PROGRAMS PER AWARD; PROGRAMS FOR URBAN AND RURAL AREAS.—A

funding agreement for an award under section 2785 for an applicant is that the number of community health advisor programs operated in the State with the award will be determined by the Secretary, except that (subject to section 2786(b)(1)(B)) such a program will be carried out in not less than one urban area of the State, and in not less than one rural area of the State.

''(f) ONGOING SUPERVISION OF ADVISORS.—A funding agreement for an award under section 2785 is that the applicant involved will ensure that each community health advisor program operated with the award provides for the ongoing supervision of the community health advisors of the program, and that the individuals serving as supervisors in the program will include 1 or more public health nurses with field experience and managerial experience.

''(g) CERTAIN EXPENDITURES.—

''(1) TRAINING; CONTINUING EDUCATION.—Funding agreements for an award under section 2785 include the following:

''(A) The applicant involved will ensure that, for each community health advisor program operated with the award, a program is carried out to train community health advisors to provide the authorized program services, including practical experiences in providing services for health promotion and disease prevention.

''(B) The program of training will provide for the continuing education of the community health advisors.

''(C) Not more than 15 percent of the award will be expended for the program of training.

''(2) COMPENSATION.—With respect to compliance with the agreements made under this subtitle, the purposes for which an award under section 2785 may be expended include providing compensation for the services of community health advisors.

''(h) REPORTS TO SECRETARY; ASSESSMENT OF EFFECTIVENESS.—Funding agreements for an award under section 2785 for an applicant include the following:

''(1) The applicant will ensure that, for each fiscal year for which a community health advisor program receives amounts from the award, the program will prepare a report describing the activities of the program for such year, including—

''(A) a specification of the number of individuals served by the program;

''(B) a specification of the entities with which the program has collaborated in carrying out the purpose described in section 2786(a)(1); and

''(C) an assessment of the extent of the effectiveness of the program in carrying out such purpose.

''(2) Such reports will include such additional information regarding the applicant and the programs as the Secretary may require.

''(3) The applicant will prepare the reports as a single document and will submit the document to the Secretary not later than February 1 of the fiscal year following the fiscal year for which the reports were prepared.

''SEC. 2788. APPLICATION FOR ASSISTANCE; STATE PLAN.

''For purposes of section 2785, an application is in accordance with this section if—

''(1) the application is submitted not later than the date specified by the Secretary;

''(2) the application contains each funding agreement described in this subtitle;

''(3) the application contains a State plan describing the purposes for which the award is to be expended in the State, including a description of the manner in which the applicant will comply with each such funding agreement; and

''(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle.

''SEC. 2789. DETERMINATION OF AMOUNT OF ALLOTMENT.

''(a) IN GENERAL.—For purposes of section 2785, the allotment under this section with respect to a State for a fiscal year is the sum of the respective amounts determined for the State under subsection (b) and subsection (c).

''(b) AMOUNT RELATING TO POPULATION.—For purposes of subsection (a), the amount determined under this subsection is the product of—

''(1) an amount equal to 50 percent of the amount appropriated under section 2784 for the fiscal year and available for awards under section 2785; and

''(2) the percentage constituted by the ratio of—

''(A) the number of individuals residing in the State involved; to

''(B) the sum of the respective amounts determined for each State under subparagraph (A).

''(c) AMOUNT RELATING TO POVERTY LEVEL.—For purposes of subsection (a), the amount determined under this subsection is the product of—

''(1) the amount determined under subsection (b)(1); and

''(2) the percentage constituted by the ratio of—

''(A) the number of individuals residing in the State whose income is at or below an amount equal to 200 percent of the official poverty line; to

''(B) the sum of the respective amounts determined for each State under subparagraph (A).

''SEC. 2790. QUALITY ASSURANCE; COST-EFFECTIVENESS.

''The Secretary shall establish guidelines for assuring the quality of community health advisor programs (including quality in the training of community health advisors) and for assuring the cost-effectiveness of the programs. A funding agreement for an award under section 2785 is that the applicant involved will carry out such programs in accordance with the guidelines.

''SEC. 2791. EVALUATIONS; TECHNICAL ASSISTANCE.

''(a) EVALUATIONS.—The Secretary shall conduct evaluations of community health advisor programs and disseminate information developed as result of the evaluations to the States. In conducting such evaluations, the Secretary shall determine whether the programs are in compliance with the guidelines established under section 2790.

''(b) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of awards under section 2785 with respect to the planning, development, and operation of community health advisor programs.

''(c) GRANTS AND CONTRACTS.—The Secretary may carry out this section directly or through grants, cooperative agreements, or contracts.

''(d) LIMITATION ON EXPENDITURES.—Of the amounts appropriated under section 2784 for a fiscal year, the Secretary may reserve not more than 10 percent for carrying out this section.

''SEC. 2792. RULE OF CONSTRUCTION REGARDING PROGRAMS OF INDIAN HEALTH SERVICE.

''This subtitle may not be construed as requiring the Secretary to modify or terminate the program carried out by the Director of the Indian Health Service and designated by such Director as the Community Health Representative Program. The Secretary shall ensure that support for such Program is not supplanted by awards under section 2785. In communities in which both such Program and a community health advisor program are being carried out, the Secretary shall ensure that the community health advisor program works in cooperation with, and as a complement to, the Community Health Representative Program.

''SEC. 2793. DEFINITIONS.

''For purposes of this subtitle:

''(1) The term 'authorized program services', with respect to a community health advisor program, means the services specified in section 2786(b)(2).

''(2) The term 'community health advisor' has the meaning given such term in section 2786(d).

''(3) The term 'community health advisor program' means a program carried out under section 2786(b).

''(4) The term 'financial assistance', with respect to an award under section 2785, means a grant, cooperative agreement, or a contract.

''(5) The term 'funding agreement' means an agreement required as a condition of receiving an award under section 2785.

''(6) The term 'official poverty line' means the official poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981, which poverty line is applicable the size of the family involved.

''(7) The term 'State involved', with respect to an applicant for an award under section 2785, means the State in which the applicant is to carry out a community health advisor program.

''SEC. 2794. EFFECT OF INSUFFICIENT APPROPRIATIONS FOR MINIMUM ALLOTMENTS.

''(a) IN GENERAL.—If the amounts made available under section 2784 for a fiscal year are insufficient for providing each State (or entity designated by the State pursuant to section 2785, as the case may be) with an award under section 2785 in an amount equal to or greater than the amount specified in section 2789(a)(2), the Secretary shall, from such amounts as are made available under subsection (a), make such awards on a discretionary basis.

''(b) RULE OF CONSTRUCTION.—For purposes of subsection (a), awards under section 2785 are made on a discretionary basis if the Secretary determines which States (or entities designated by States pursuant to such section, as the case may be) are to receive such awards, subject to meeting the requirements of this subtitle for such an award, and the Secretary determines the amount of such awards.

''Subtitle F—General Provisions

''SEC. 2798. REQUIREMENT REGARDING ACCREDITATION OF SCHOOLS, DEPARTMENTS, AND PROGRAMS.

''Except as indicated otherwise in this title:

''(1) A reference in this title to a school of public health, a school of nursing, or any other entity providing education or training in a health profession (whether a school, department, program, or other entity) is a reference to the entity as defined under section 799 or 853.

''(2) If an entity is not defined in either of such sections, the reference in this title to the entity has the meaning provided by the Secretary, except that the Secretary shall require for purposes of this title that the entity be accredited for the provision of the education or training involved.

"SEC. 2799. RELATION TO OTHER FUNDS.

''Notwithstanding any other provision of law, the authorizations of appropriations established in this title are in addition to any other authorizations of appropriations that are available for the purposes described with respect to such appropriations in this title.

"SEC. 2799A. DEFINITIONS.

''(a) IN GENERAL.—For purposes of this title:

''(1) The term 'Healthy People 2000 Objectives' means the objectives established by the Secretary toward the goals of increasing the span of healthy life, reducing health disparities among various populations, and providing access to preventive services, which objectives apply to the health status of the population of the United States for the year 2000.

''(2) The term 'medically underserved community' means—

''(A) a community that has a substantial number of individuals who are members of a medically underserved population, as defined in section 330; or

''(B) a community a significant portion of which is a health professional shortage area designated under section 332.''.

TITLE IV—MEDICAL AND HEALTH RESEARCH

SEC. 4001. SHORT TITLE.

This title may be cited as the ''Medical and Health Research Act of 1995''.

SEC. 4002. FINDINGS.

The Congress finds the following:

(1) Nearly 4 of 5 peer reviewed research projects deemed worthy of funding by the National Institutes of Health are not funded.

(2) Less than 2 percent of the nearly one trillion dollars our Nation spends on health care is devoted to health research, while the defense industry spends 15 percent of its budget on research.

(3) Public opinion surveys have shown that Americans want more Federal resources put into health research and support by having a portion of their health insurance premiums set aside for this purpose.

(4) Ample evidence exists to demonstrate that health research has improved the quality of health care in the United States. Advances such as the development of vaccines, the cure of many childhood cancers, drugs that effectively treat a host of diseases and disorders, a process to protect our Nation's blood supply from the HIV virus, progress against cardiovasculor disease including heart attack and stroke, and new strategies for the early detection and treatment of diseases such as colon, breast, and prostate cancer clearly demonstrates the benefits of health research.

(5) Among the most effective methods to control health care costs are prevention and cure of disease and disability, thus, health research which holds the promise of cure and prevention of disease and disability is a critical component of any comprehensive health care reform plan.

(6) The state of our Nation's research facilities at the National Institutes of Health and at universities is deteriorating significantly. Renovation and repair of these facilities are badly needed to maintain and improve the quality of research.

(7) Because the Omnibus Budget Reconciliation Act of 1993 freezes discretionary spending for the next 5 years, the Nation's investment in health research through the National Institutes of Health is likely to decline in real terms unless corrective legislative action is taken.

(8) A health research fund is needed to maintain our Nation's commitment to health research and to increase the percentage of approved projects which receive funding at the National Institutes of Health to at least 33 percent.

SEC. 4003. NATIONAL FUND FOR HEALTH RESEARCH.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States an account, to be known as the ''National Fund for Health Research'' (hereafter referred to in this section as the ''Fund''), consisting of such amounts as are transferred to the Fund under subsection (b) and any interest earned on investment of amounts in the Fund.

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—With respect to each of the 5 full calendar years beginning after the date of enactment of this Act, the Secretary of the Treasury shall transfer to the Fund an amount equal to the applicable amount under paragraph (2).

(2) APPLICABLE AMOUNT.—The applicable amount under this paragraph is—

(A) with respect to amounts in the Health Care Reform Trust Fund established under section 9551(a)(2)(A) of the Internal Revenue Code of 1986, $1,200,000,000 for each calendar year described in paragraph (1); and

(B) with respect to amounts received in the Treasury under section 6097 of the Internal Revenue Code of 1986, 100 percent of the amounts received under such section in each calendar year described in paragraph (1).

(3) DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS.—

(A) IN GENERAL.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to returns and records) is amended by adding at the end the following new part:

''PART IX—DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS FOR THE NATIONAL FUND FOR HEALTH RESEARCH

''Sec. 6097. Amounts for the National Fund for Health Research.

"SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR HEALTH RESEARCH.

''(a) IN GENERAL.—Every individual (other than a nonresident alien) may designate that—

''(1) a portion (not less than $1) of any overpayment of the tax imposed by chapter 1 for the taxable year, and

''(2) a cash contribution (not less than $1), be paid over to the National Fund for Health Research established under section 4003 of the Health Partnership Act of 1995. In the case of a joint return of a husband and wife, each spouse may designate one-half of any such overpayment of tax (not less than $2).

''(b) MANNER AND TIME OF DESIGNATION.—Any designation under subsection (a) may be made with respect to any taxable year only at the time of filing the original return of the tax imposed by chapter 1 for such taxable year. Such designation shall be made either on the 1st page of the return or on the page bearing the taxpayer's signature.

''(c) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this section, any overpayment of tax designated under subsection (a) shall be treated as being refunded to the taxpayer as of the last day prescribed for filing the return of tax imposed by chapter 1 (determined with regard to extensions) or, if later, the date the return is filed.

''(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—No amount designated pursuant to subsection (a) shall be allowed as a deduction under section 170 or any other section for any taxable year.

''(e) TERMINATION.—This section shall not apply to taxable years beginning in a calendar year after a determination by the Secretary that the sum of all designations under subsection (a) for taxable years beginning in the second and third calendar years preceding the calendar year is less than $5,000,000.''.

(B) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Part IX. Designation of overpayments and contributions for the National Fund for Health Research.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to taxable years beginning after December 31, 1995.

(c) EXPENDITURES FROM FUND.—

(1) IN GENERAL.—The Secretary of the Treasury shall pay annually, within 30 days after the President signs an appropriations Act for the Departments of Labor, Health and Human Services, and Education and related agencies, or by the end of the first quarter of the fiscal year, to the Secretary of Health and Human Services on behalf of the National Institutes of Health, an amount equal to the amount in the National Fund for Health Research at the time of such payment, to enable the Secretary to carry out the purpose of section 404F of the Public Health Service Act, less any administrative expenses which may be paid under paragraph (3).

(2) PURPOSES FOR EXPENDITURES FROM FUND.—Part A of title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by adding at the end the following new section:

"SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND FOR HEALTH RESEARCH.

''(a) IN GENERAL.—From amounts received for any fiscal year from the National Fund for Health Research, the Secretary of Health and Human Services shall distribute—

''(1) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

''(A) for carrying out the responsibilities of the Office of the Director, National Institutes of Health, including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of the Alternative Medicine and the Office of Rare Diseases Research; and

''(B) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

''(2) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

''(3) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV with respect to health information communications; and

''(4) the remainder of such amounts during any fiscal year to member institutes of the National Institutes of Health and centers in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each member institute and center for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and centers of the National Institutes of Health for the fiscal year.

''(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.''.

(3) ADMINISTRATIVE EXPENSES.—Amounts in the National Fund for Health Research shall

be available to pay the administrative expenses of the Department of the Treasury directly allocable to—

(A) modifying the individual income tax return forms to carry out section 6097 of the Internal Revenue Code of 1986;

(B) carrying out this section with respect to such Fund; and

(C) processing amounts received under this section and transferring such amounts to such Fund.

(4) TRIGGER AND RELEASE OF FUND MONIES.—No expenditures shall be made pursuant to section 4003(c) during any fiscal year in which the annual amount appropriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

(d) BUDGET ENFORCEMENT.—Amounts contained in the National Fund for Health Research shall be excluded from, and shall not be taken into account for purposes of, any budget enforcement procedures under the Congressional Budget Act of 1974 or the Balanced Budget Emergency Deficit Control Act of 1985.

TITLE V—FRAUD AND ABUSE

SEC. 5001. SHORT TITLE.

This Act may be cited as the ''Health Fraud and Abuse Reduction Act of 1995''.

Subtitle A—All-Payer Fraud and Abuse Control Program

SEC. 5101. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1996, the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary''), acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) REGULATIONS.—

(A) IN GENERAL.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

(i) IN GENERAL.—Such standards shall include standards relating to the disclosure of ownership information described in clause (ii) by any entity providing health care services and items.

(ii) OWNERSHIP INFORMATION DESCRIBED.—The ownership information described in this clause includes—

(I) a description of such items and services provided by such entity;

(II) the names and unique physician identification numbers of all physicians with a financial relationship (as defined in section 1877(a)(2) of the Social Security Act) with such entity;

(III) the names of all other individuals with such an ownership or investment interest in such entity; and

(IV) any other ownership and related information required to be disclosed by such entity under section 1124 or section 1124A of the Social Security Act, except that the Secretary shall establish procedures under which the information required to be submitted under this subclause will be reduced with respect to health care provider entities that the Secretary determines will be unduly burdened if such entities are required to comply fully with this subclause.

(4) AUTHORIZATION OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary, the Attorney General, the Director of the Federal Bureau of Investigation, and the Inspectors General of the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated additional amounts, from the Health Care Fraud and Abuse Account described in subsection (b) of this section, as may be necessary to enable the Secretary, the Attorney General, and such Inspectors General to conduct investigations and audits of allegations of health care fraud and abuse and otherwise carry out the program established under paragraph (1) in a fiscal year.

(5) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise the authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (relating to subpoenas and administration of oaths) with respect to the activities under the all-payer fraud and abuse control program established under this subsection to the same extent as such Inspector General may exercise such authorities to perform the functions assigned by such Act.

(6) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this title shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978.

(7) HEALTH PLAN DEFINED.—For the purposes of this subsection, the term ''health plan'' shall have the meaning given such term in section 1128(i) of the Social Security Act.

(b) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby established an account to be known as the ''Health Care Fraud and Abuse Control Account'' (in this section referred to as the ''Anti-Fraud Account''). The Anti-Fraud Account shall consist of—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Anti-Fraud Account as provided in subsection (a)(4), sections 5441(b) and 5442(b), and title XI of the Social Security Act; and

(iii) such amounts as are transferred to the Anti-Fraud Account under subparagraph (C).

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(C) TRANSFER OF AMOUNTS.—

(i) IN GENERAL.—The Secretary of the Treasury shall transfer to the Anti-Fraud Account an amount equal to the sum of the following:

(I) Criminal fines imposed in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

(ii) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act (except as otherwise provided by law).

(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

(iv) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(2) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available to carry out the health care fraud and abuse control program established under subsection (a) (including the administration of the program), and may be used to cover costs incurred in operating the program, including costs (including equipment, salaries and benefits, and travel and training) of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

(iii) financial and performance audits of health care programs and operations;

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of this subtitle.

(B) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(3) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(4) USE OF FUNDS BY INSPECTOR GENERAL.—

(A) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

(B) CREDITING.—Funds received by the Inspector General or the Inspectors General of the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

SEC. 5102. APPLICATION OF CERTAIN FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST ANY HEALTH PLAN.

(a) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by adding at the end the following: ''OR HEALTH PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

''(f) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(b) HEALTH PLAN DEFINED.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

''(i) HEALTH PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health plan' means a plan that provides health benefits, whether through directly, through insurance, or otherwise, and includes a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 5201. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud Prevention Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud Prevention Act of 1995, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 5202. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 5203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity—

''(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

''(B) against which a civil monetary penalty has been assessed under section 1128A; or

''(C) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 5204. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 5205. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C.

1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1996, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 5206. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1996.

Subtitle C—Civil Monetary Penalties

SEC. 5301. CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In subsection (a)(1), by inserting ''or of any health plan (as defined in section 1128(i)),'' after ''subsection (i)(1)),''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraphs:

''(3) With respect to amounts recovered arising out of a claim under a health plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Care Fraud Prevention Act of 1995 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse Control Account established under section 101(b) of such Act.''.

(3) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health plan'' after ''or XX''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting the following: ''claimed, including any person who repeatedly presents or causes to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person repeatedly knows or should know is not medically necessary; or''.

(e) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

(f) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) of the Social Security Act (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting the following: ''up to $10,000 for each instance''.

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

(i) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraph (1)(D);

(B) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(D) by inserting after paragraph (3) the following new paragraph:

''(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all third party payors to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary; or

''(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations.''.

Subtitle D—Payments for State Health Care Fraud Control Units

SEC. 5401. ESTABLISHMENT OF STATE FRAUD UNITS.

(a) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The Governor of each State shall, consistent with State law, establish and maintain in accordance with subsection (b) a State agency to act as a Health Care Fraud and Abuse Control Unit for purposes of this subtitle.

(b) DEFINITION.—In this section, a ''State Fraud Unit'' means a Health Care Fraud and Abuse Control Unit designated under subsection (a) that the Secretary certifies meets the requirements of this subtitle.

SEC. 5402. REQUIREMENTS FOR STATE FRAUD UNITS.

(a) IN GENERAL.—The State Fraud Unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from any State agency with principal responsibility for the administration of any Federally-funded or mandated health care program;

(3) meet the other requirements of this section.

(b) SPECIFIC REQUIREMENTS DESCRIBED.—The State Fraud Unit shall—

(1) be a Unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

(2) if it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, (A) assure its referral of suspected criminal violations to the appropriate authority or authorities in the State for prosecution, and (B) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

(3) have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any Federally-funded or mandated health care programs.

(c) STAFFING REQUIREMENTS.—The State Fraud Unit shall—

(1) employ attorneys, auditors, investigators and other necessary personnel; and

(2) be organized in such a manner and provide sufficient resources as is necessary to promote the effective and efficient conduct of State Fraud Unit activities.

(d) COOPERATIVE AGREEMENTS; MEMORANDA OF UNDERSTANDING.—The State Fraud Unit shall have cooperative agreements with—

(1) Federally-funded or mandated health care programs;

(2) similar Fraud Units in other States, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor; and

(3) the Secretary.

(e) REPORTS.—The State Fraud Unit shall submit to the Secretary an application and an annual report containing such information as the Secretary determines to be necessary to determine whether the State Fraud Unit meets the requirements of this section.

(f) FUNDING SOURCE; PARTICIPATION IN ALL-PAYER PROGRAM.—In addition to those sums expended by a State under section 5404(a) for purposes of determining the amount of the Secretary's payments, a State Fraud Unit may receive funding for its activities from other sources, the identity of which shall be reported to the Secretary in its application or annual report. The State Fraud Unit shall participate in the all-payer fraud and abuse control program established under section 5101.

SEC. 5403. SCOPE AND PURPOSE.

The State Fraud Unit shall carry out the following activities:

(1) The State Fraud Unit shall conduct a statewide program for the investigation and prosecution (or referring for prosecution) of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any Federally-funded or mandated health care programs;

(2) The State Fraud Unit shall have procedures for reviewing complaints of the abuse or neglect of patients of facilities (including patients in residential facilities and home health care programs) that receive payments under any Federally-funded or mandated health care programs, and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the State or for referring the complaints to other State agencies for action.

(3) The State Fraud Unit shall provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any Federally-funded or mandated health care program and that are discovered by the State Fraud Unit in carrying out its activities.

SEC. 5404. PAYMENTS TO STATES.

(a) MATCHING PAYMENTS TO STATES.—Subject to subsection (c), for each year for which a State has a State Fraud Unit approved under section 5402(b) in operation the Secretary shall provide for a payment to the State for each quarter in a fiscal year in an amount equal to the applicable percentage of the sums expended during the quarter by the State Fraud Unit.

(b) APPLICABLE PERCENTAGE DEFINED.—

(1) IN GENERAL.—In subsection (a), the ''applicable percentage'' with respect to a State for a fiscal year is—

(A) 90 percent, for quarters occurring during the first 3 years for which the State Fraud Unit is in operation; or

(B) 75 percent, for any other quarters.

(2) TREATMENT OF STATES WITH MEDICAID FRAUD CONTROL UNITS.—In the case of a State with a State medicaid fraud control in operation prior to or as of the date of the enactment of this Act, in determining the number of years for which the State Fraud Unit under this subtitle has been in operation, there shall be included the number of years for which such State medicaid fraud control unit was in operation.

(c) LIMIT ON PAYMENT.—Notwithstanding subsection (a), the total amount of payments made to a State under this section for a fiscal year may not exceed the amounts as authorized pursuant to section 1903(b)(3) of the Social Security Act.

TITLE VI—REVENUE PROVISIONS

SEC. 6000. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Financing Provisions

PART I—INCREASE IN TAX ON TOBACCO PRODUCTS

SEC. 6001. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended—

(1) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$62 per thousand'', and

(2) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$130.20 per thousand''.

(b) CIGARS.—Subsection (a) of section 5701 is amended—

(1) by striking ''$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)'' in paragraph (1) and inserting ''$51.13 per thousand'', and

(2) by striking ''equal to'' and all that follows in paragraph (2) and inserting ''equal to 66 percent of the price for which sold but not more than $155 per thousand.''

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended by striking ''0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)'' and inserting ''3.88 cents''.

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended by striking ''1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)'' and inserting ''7.76 cents''.

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 is amended—

(1) by striking ''36 cents (30 cents on snuff removed during 1991 or 1992)'' in paragraph (1) and inserting ''$13.69'', and

(2) by striking ''12 cents (10 cents on chewing tobacco removed during 1991 or 1992)'' in paragraph (2) and inserting ''$5.45''.

(f) PIPE TOBACCO.—Subsection (f) of section 5701 is amended by striking ''67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)'' and inserting ''$17.35''.

(g) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

''(h) APPLICATION TO TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

''(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

''(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

''(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Health Partnership Act of 1995.

''(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of this subsection shall be taken into account in determining the amount of any

exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

''(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Health Partnership Act of 1995.

''(4) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection.''

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1995.

(i) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on each tax-increase date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on any tax-increase date, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date which is 3 months after the tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or his delegate.

(C) TAX-INCREASE DATE.—The term ''tax-increase date'' means January 1, 1996, and July 1, 1997.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 6002. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: ''Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.''

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

''(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

''(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

''(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.''.

(3) Subsection (a) of section 5761 is amended by striking ''subsection (b)'' and inserting ''subsection (b) or (c)''.

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking ''The penalty imposed by subsection (b)'' and inserting ''The penalties imposed by subsections (b) and (c)''.

(5)(A) Subpart F of chapter 52 is amended by adding at the end the following new section:

''SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

''(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

''(b) CROSS REFERENCE.—

''For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).''.

(B) The table of sections for subpart F of chapter 52 is amended by adding at the end the following new item:

''Sec. 5754. Restriction on importation of previously exported tobacco products.''.

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting ''or importer'' after ''manufacturer''.

(2) The heading of subsection (b) of section 5763 is amended by inserting ''QUALIFIED IMPORTERS,'' after ''MANUFACTURERS,''.

(3) The heading for subchapter B of chapter 52 is amended by inserting ''**and Importers**'' after ''**Manufacturers**''.

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting ''and importers'' after ''manufacturers''.

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking ''EMPLOYEE USE OR'' in the heading, and

(B) by striking ''for use or consumption by employees or'' in the text.

(2) Subsection (e) of section 5723 is amended by striking ''for use or consumption by their employees, or for experimental purposes'' and inserting ''for experimental purposes''.

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking ''and manufacturers may similarly remove such articles for use of the United States;''.

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking ''On each book or set of cigarette papers containing more than 25 papers,'' and inserting ''On cigarette papers,''.

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting ''under section 5704'' after ''internal revenue bond''.

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking ''or'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

''(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or''.

(h) SPECIAL RULES RELATING TO PUERTO RICO AND THE VIRGIN ISLANDS.—Section 7652 is amended by adding at the end the following new subsection:

''(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Health Partnership Act of 1995.''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1995.

SEC. 6003. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 701, is amended by redesignating subsections (g) and (h) as subsections (h) and (i) and by inserting after subsection (f) the following new subsection:

''(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of $17.35 per pound (and a proportionate tax at the like rate on all fractional parts of a pound).''.

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

''(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.''.

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking ''and pipe tobacco'' and inserting ''pipe tobacco, and roll-your-own tobacco''.

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking ''or pipe tobacco'' and inserting ''pipe tobacco, or roll-your-own tobacco'', and

(B) by striking paragraph (1) and inserting the following new paragraph:

''(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for the person's own personal consumption or use, and''.

(3) The chapter heading for chapter 52 is amended to read as follows:

''CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES''.

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

''CHAPTER 52. Tobacco products and cigarette papers and tubes.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after December 31, 1995.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before January 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

Subtitle B—Health Care Reform Trust Fund

SEC. 6101. ESTABLISHMENT OF HEALTH CARE REFORM TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to establishment of trust funds) is amended by adding at the end the following new part:

''PART II—HEALTH CARE TRUST FUNDS

''Sec. 9551. Health Care Reform Trust Fund

''SEC. 9551. HEALTH CARE REFORM TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Reform Trust Fund', consisting of such amounts as may be appropriated or credited to the Health Care Reform Trust Fund as provided in this section.

''(b) TRANSFERS TO THE TRUST FUND.—There are hereby appropriated to the Health Care Reform Trust Fund amounts received in the Treasury under section 5701 (relating to taxes on tobacco products) to the extent attributable to the increases in such taxes as the result of the enactment of subtitle A of title VI of the Health Partnership Act of 1995.

''(c) EXPENDITURES.—Amounts in the Health Care Reform Trust Fund are appropriated as provided for in sections 2001 and 4003 of the Health Partnership Act of 1995, and title XXVII of the Public Health Service Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

''(d) OTHER RULES.—

''(1) INSUFFICIENT FUNDS.—If, for any fiscal year, the sum of the amounts required to be allocated under subsection (c) exceeds the amounts received in the Health Care Reform Trust Fund, then each of such amounts required to be so allocated shall be reduced to an amount which bears the same ratio to such amount as the amounts received in the trust fund bear to the amounts required to be so allocated (without regard to this paragraph).

''(2) ALLOCATION OF EXCESS FUNDS AND INTEREST.—Amounts received in the Health Care Reform Trust Fund in excess of the amounts required to be allocated under subsection (c), for any fiscal year shall be allocated ratably on the basis of the amounts allocated for the fiscal year (without regard to this paragraph).''.

(b) CONFORMING AMENDMENT.—Subchapter A of chapter 98 is amended by inserting after the subchapter heading the following new items:

''Part I. General trust funds.

''Part II. Health care trust fund.

''PART I—GENERAL TRUST FUNDS''.

GRAHAM-HATFIELD HEALTH PARTNERSHIP ACT

Purpose: To proceed with health care reform that increases access, controls costs and improves the quality of health care in states through state innovation, public health, medical research, insurance reform and control of fraud and abuse.

States are making significant progress to reform their health care delivery systems. In light of the inability of Congress to enact comprehensive reform, this bill would provide the states with the flexibility to continue their reform efforts. It would also provide limited federal funding to assist states in this effort.

The bill includes the following provisions:

TITLE I—HEALTH INSURANCE REFORM

Establishment of National Minimum Standards.—Congress would direct the National Association of Insurance Commissioners (NAIC) to develop national minimum standards with respect to renewability, portability, guaranteed issue, community rating, solvency and stop-loss. The Secretary of Health and Human Services (HHS) would review the standards developed by NAIC. Upon approval, these national minimum standards would be established for the states, but they would be given authority to enact and implement more progressive reforms than those specified. This is modeled after the Baucus Amendment to OBRA–90 relating to the development of Medicare Supplemental Insurance Standards or Medigap.

Medicare Select.—The 1990 Medigap legislation created 10 standard Medicare supplemental benefit packages that could be offered nationwide. Managed care networks could offer these benefits to Medicare beneficiaries in 15 states. This program, Medicare Select, provides supplemental coverage to hundreds of thousands of Medicare beneficiaries, but the program will expire on June 30, 1995. This provision would reauthorize the program and extend it to all 50 states.

TITLE II—STATE INNOVATION

State Innovative Health Reform Projects.—States interested in enacting health reform proposals that achieve the goals of increased health coverage and access, control costs and maintain or improve the quality of health care could submit their projects to the Secretary for Medicaid, Maternal Child Health Block Grant, Social Services Block Grant and Public Health Service Act waivers and approval. An approved state innovative project that can demonstrate the ability to meet the goals of health reform would receive grant monies from the federal government to encourage and help states funds the projects. $50 billion will be made available to states over a five-year period.

Limited State Health Care Waivers.—States would also be allowed to pursue more limited state health care waivers that are likely to increase administrative efficiencies or provide guidance for the development of improved health delivery systems. The waiver application for both the comprehensive and limited waiver projects would be placed on an expedited approval process.

Evaluation, Monitoring and Compliance.—The Secretary and an established State Health Reform Advisory Board would be responsible for monitoring the waiver projects. Waiver projects could be terminated by the Secretary for good cause and states would not be allowed to supplant state funding with grants received under this program.

Lessons from the States/Report to Congress.—At the end of the five-year period, the Board would report to Congress on the progress made by states with respect to expanding health insurance coverage and cost containment. The Board would also make recommendations to Congress concerning any further action Congress should take concerning health care reform from the information and experiences drawn from the states.

Existing State Laws.—States that have existing Medicaid and Medicare waivers are continued and not preempted by this Act. Hawaii would be granted a continued exemption from ERISA preemption.

ERISA Review.—To allow states to move forward with meaningful comprehensive health care reform while fully recognizing the needs of employers in administering self-funded plans across state lines, an ERISA Review Commission is established to find common ground, clarify what is permissible under ERISA and ensure the interests of self-insured plans are addressed. The Commission will be composed of representatives from state and local government, business, labor and the federal government.

TITLE III—PUBLIC HEALTH, RURAL AND UNDERSERVED ACCESS IMPROVEMENT

Core Functions of Public Health.—Core functions are those activities and programs that emphasize population-based health

measures such as the investigation and control of threats to the health of communities such as communicable diseases (tuberculosis, HIV, measles, influenza), environmental hazards (air pollution, radon, radiation, waste and sewage disposal), toxic pollutants (lead-based paint, contaminated drinking water) and emerging patterns of acute and chronic disease and injury (food borne poisoning, cancer, heart disease).

Other Programs.—Funding is also made available for comprehensive evaluation of disease prevention and health promotion programs, Schools of Public Health, Area Health Education Centers, Health Education Training Centers, Regional Poison Control Centers, school-related health services, Community and Migrant Health Centers, the National Health Service Corps, satellite primary car clinics and community health advisors.

Funding.—This title is allocated $9 billion over a five-year period.

TITLE IV—MEDICAL RESEARCH

National Institute of Health (NIH) Funding.—$6 billion would be allocated over a five-year period under this title to expand our national commitment to health research. Monies are allocated to the NIH Institutes and Centers on the same basis as annual appropriations. Five percent of the monies will be directed to extramural construction and renovation of research facilities, the National Library of Medicine and the Office of the Director.

TITLE V—FRAUD AND ABUSE

Federal-State-Private Sector Coordination.—This title tracks much of the language from Senator Bill Cohen's ''Health Care Fraud Prevention Act of 1995''. An improved federal-state-private sector collaboration to combat fraud and abuse would be established. Moreover, certain existing criminal and civil penalties would be expanded to eliminate waste in the health care system.

TITLE VI—FINANCING PROVISIONS

Tobacco Tax.—The bill will be financed through a $1 tax on tobacco products. This tax is expected to raise $65 billion over five years.

NOT INCLUDED—MEDICAID AND MEDICARE CUTS

There are no Medicaid and Medicare cuts included in the Graham-Hatfield proposal.

THE HEALTH PARTNERSHIP ACT

Mr. HATFIELD. Mr. President, on the first day of the 104th Congress, I introduced a package of five bills—my legislative priorities for the coming session. At that time, I stated that one of my main priorities during the 104th Congress will be to look for ways to redefine Federal programs to enhance the efforts toward reform already underway in the States. The three bills I introduced on that first day are designed to decrease the burden of Federal compliance and oversight measures in key policy areas. In exchange for loosening the Federal regulatory straitjacket, we will transform accountability from paperwork requirements to performance-based results. I call this the flexibility factor in Government and it entails finding a path through every Federal agency where innovation at the State and local levels is nurtured and rewarded.

It is in that context today that I join my good friend and colleague from Florida, Mr. GRAHAM, in introducing the Health Partnership Act of 1995. This bill is very similar to the legislation we introduced at the end of the 103d Congress when it became apparent that efforts to pass comprehensive reform would fail. Rather than federalizing health care, this bill would encourage the States to innovate and help build the best approaches to addressing our health care problems—a return to the true essence of federalism.

To date, six States have enacted comprehensive health care reform proposals—Hawaii, Massachusetts, Oregon, Minnesota, Florida, and Washington. In addition, 44 States have enacted small group insurance reform; 44 have enacted data collection systems, and 41 have Medicaid managed care experiments underway.

Although many reforms are underway, States have often had to struggle with the Federal Government to move forward with their reform plans. Securing the necessary waivers from the Federal Government has become an increasingly burdensome process. For example, it took nearly 3 years and two administrations for Oregon to obtain the Medicaid waivers it needed to implement its Medicaid expansion. This expansion has provided health care for nearly 100,000 additional Oregonians since its implementation in February 1994. And although there have been problems that came with implementation, the overwhelming majority of Oregonians continue to support the Oregon health plan.

Mr. President, I am fortunate to come from a State which is willing to look at new and innovative approaches to reform in the public and private sectors. Recently, Oregon was granted a welfare waiver to implement their Jobs Plus Program. Oregon has also recently signed a memorandum of understanding with the administration to move forward with the Oregon Option, a partnership designed to deliver Government services in a better and more efficient manner. We are also hopeful that our State will be designed an ''edflex partnership State'' by Secretary Riley as soon as the Goals 2000 process is in place. This designation will allow our State to waive Federal law in certain areas in which the State has already demonstrated a commitment to change. Frankly, it seems like I am spending much of my time these days pursuing waivers of Federal law for my State—nearly all of the innovation that has come forth from my State in recent years has required a Federal waiver for implementation. Oregon is willing to persevere—but not all States are.

Due to the arduous process a State must go through to obtain Federal waivers to enact comprehensive health care reform, many States have held off in attempting comprehensive reform. In addition, one of the biggest barriers to State reform is the Employee Retirement Income Security Act [ERISA]. This Federal law is one of the broadest Federal laws on the books, and it has effectively prevented States from enacting reform that achieves universal coverage. ERISA waivers can only be granted by the Congress and have been few and far between—only Hawaii has one and it was granted 20 years ago.

The issue of ERISA reform is a sensitive one. On one hand, States feel that ERISA preemption is a major roadblock to their reform efforts. States argue that ERISA prevents them from reaching a significant percentage of the insurance market in order to fully implement reform proposals that increase access to health care and control costs. On the other hand, business, especially employers with businesses in many different States, argue that they need uniformity in the administration of their employee health benefit plans. They argue that their ability to manage their health care costs and assure that all employees are getting equal benefits will be undermined by State health care reform if the ERISA preemption is lifted.

Both sides raise compelling arguments, but where does that leave us? In the absence of comprehensive national reform, the status quo is not acceptable. Thus, in the bill we are introducing today, we have included a mechanism which will hopefully lead to a fair and equitable resolution of this problem. In order to allow States to move forward with meaningful comprehensive health care reform, while fully recognizing the needs of employers in administering self-funded plans across State lines, an ERISA Review Commission is established to find common ground, clarify what is permissible under ERISA and ensure the interest of self-insured plans are addressed. This limited duration Commission will be charged with making recommendations on ERISA reform to the Secretary of Labor, and will be composed of representatives from State and local government, business, labor, and the Federal Government.

We consider this piece of our bill as work in progress. We firmly believe that the dialog between the two sides must begin. And we look forward to finding ways to improve and expand upon the proposal we put forward in today's legislation.

I have long advocated that we look to the States to help develop the database we need to determine the appropriate Federal role in health care reform. In my opinion, this is the essence of the federalism on which our country was founded. With no consensus on comprehensive reform in Congress, we should turn to the States to lay the foundation for reform. All of the ideas that we debated last session—from insurance reform to universal coverage to malpractice reform—are being tested in our States. We should then distill the information and data obtained from these innovations and use it to reach consensus on national reform.