

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 1976

To guarantee access to affordable health care coverage, to provide for equality with respect to the provision of service in rural areas, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

MAY 5, 1993

Mr. THOMAS of Wyoming introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, the Judiciary, and Education and Labor

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## A BILL

To guarantee access to affordable health care coverage, to provide for equality with respect to the provision of service in rural areas, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Comprehensive Health and Rural Equality Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—GUARANTEED ACCESS TO AFFORDABLE HEALTH CARE  
COVERAGE

- Sec. 101. Requirement of health insurance coverage.
- Sec. 102. Registration of eligible uninsured individuals.
- Sec. 103. Eligibility for credit certificates.
- Sec. 104. Requirement for offering of MedEquality plans.
- Sec. 105. Definitions.

#### TITLE II—SMALL EMPLOYER INSURANCE REFORM

- Sec. 201. Establishment and enforcement of standards for small employer health insurance plans.
- Sec. 202. Preemption of State benefits mandates for plans that meet consumer protection standards.
- Sec. 203. Requirement for offering of basic, low cost plan (MedEquality plan).
- Sec. 204. Requirements relating to initial writing of policies.
- Sec. 205. Requirements relating to renewal.
- Sec. 206. Establishment of reinsurance mechanisms for high risk individuals.
- Sec. 207. Registration of all health benefit plans required.
- Sec. 208. Definitions.
- Sec. 209. Preemption from insurance mandates for qualified small employer purchasing groups.
- Sec. 210. Equalization of tax benefits for self-employed persons.
- Sec. 211. Managed care rights.

#### TITLE III—HEALTH CARE COST CONTAINMENT

##### Subtitle A—Denial of Certain Tax Deductions and Exclusion for Excess Benefits

- Sec. 301. Denial of employer tax deduction for providing health care coverage in excess of minimum benefits; denial of employee exclusion for such excess coverage.

##### Subtitle B—Medical Malpractice Reform

##### PART 1—GENERAL PROVISIONS

- Sec. 311. Federal reform of medical malpractice liability actions.
- Sec. 312. Definitions.
- Sec. 313. Effective date.

##### PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY

- Sec. 321. Statute of limitations.
- Sec. 322. Requirement for initial resolution of action through alternative dispute resolution.
- Sec. 323. Relation to alternative dispute resolution of Federal agencies.
- Sec. 324. Mandatory pretrial settlement conference.
- Sec. 325. Calculation and payment of damages.
- Sec. 326. Treatment of attorney's fees and other costs.
- Sec. 327. Joint and several liability.
- Sec. 328. Uniform standard for determining negligence.
- Sec. 329. Application of medical practice guidelines in malpractice liability actions.
- Sec. 330. Special provision for certain obstetric services.
- Sec. 331. Preemption.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

- Sec. 341. Basic requirements for ADR.
- Sec. 342. Certification of State systems.
- Sec. 343. Reports on implementation and effectiveness of alternative dispute resolution systems.

PART 4—OTHER REQUIREMENTS AND PROGRAMS

- Sec. 351. Permitting State professional societies to participate in disciplinary activities.

Subtitle C—Administrative Cost Savings

PART 1—STANDARDIZED CLAIMS PROCESSING

- Sec. 361. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 362. Application of standards.
- Sec. 363. Periodic review and revision of standards.
- Sec. 364. Health benefit plan defined.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

- Sec. 371. Medical data standards for hospitals and other providers.
- Sec. 372. Application of electronic data standards to certain hospitals.
- Sec. 373. Electronic transmission to Federal agencies.
- Sec. 374. Limitation on data requirements where standards are in effect.
- Sec. 375. Advisory commission.

PART 3—ADDITIONAL STANDARDS AND REQUIREMENTS

- Sec. 381. Standards relating to use of medicare and medicaid magnetized health benefit cards; secondary payor data bank.
- Sec. 382. Preemption of State quill pen laws.
- Sec. 383. Use of standard identification numbers.
- Sec. 384. Coordination of benefit standards.

Subtitle C—Estimates of Expenses Prior to Treatment

- Sec. 391. Requirement.

Subtitle D—Antitrust Exemptions

- Sec. 395. Permitting cooperative arrangements between hospitals.

TITLE IV—LONG-TERM CARE

Subtitle A—Treatment of Long-Term Care Insurance Plans

- Sec. 401. Qualified long-term care insurance treated as accident and health insurance for purposes of taxation of life insurance companies.
- Sec. 402. Qualified long-term care insurance treated as accident and health insurance for purposes of exclusion for benefits received under such insurance and for employer contributions for such insurance.

- Sec. 403. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for qualified long-term care insurance.
- Sec. 404. Exchange of life insurance policy for qualified long-term care policy not taxable.

Subtitle B—Treatment of Accelerated Death Benefits

- Sec. 411. Tax treatment of accelerated death benefits under life insurance contracts.
- Sec. 412. Tax treatment of companies issuing qualified accelerated death benefit riders.

TITLE V—INCENTIVES FOR PROVISION OF SERVICES IN RURAL AREAS

- Sec. 501. Deduction for medical school education loan interest incurred by doctors serving in medically underserved rural areas.
- Sec. 502. Requiring development of comprehensive plans for medically underserved rural populations.
- Sec. 503. Inclusion of transportation costs for physicians in underserved rural areas in the practice index under the medicare physician payment schedule.

1 **TITLE I—GUARANTEED ACCESS**  
 2 **TO AFFORDABLE HEALTH**  
 3 **CARE COVERAGE**

4 **SEC. 101. REQUIREMENT OF HEALTH INSURANCE COV-**  
 5 **ERAGE.**

6 (a) IN GENERAL.—Each eligible individual who does  
 7 not establish (in a manner specified by the Secretary) cov-  
 8 erage under a health insurance program (as defined in sec-  
 9 tion 105(2)) shall—

10 (1) register with the Secretary under section  
 11 102, and

12 (2) be enrolled under a MedEquality plan in ac-  
 13 cordance with this title.

14 (b) ENFORCEMENT THROUGH INFORMATION CON-  
 15 CERNING HEALTH COVERAGE SHOWN ON TAX RE-

1 TURN.—Section 6012 of the Internal Revenue Code of  
2 1986 is amended by redesignating subsection (e) as sub-  
3 section (f) and by inserting after subsection (d) the follow-  
4 ing new subsection:

5 “(e) HEALTH CARE COVERAGE.—Every person re-  
6 quired to file a return under this section for the taxable  
7 year shall include on such return a statement declaring  
8 whether or not the taxpayer and dependents of the tax-  
9 payer are covered under an accident or health plan as of  
10 the time such return is filed.”

11 **SEC. 102. REGISTRATION OF ELIGIBLE UNINSURED INDI-**  
12 **VIDUALS.**

13 (a) BY MAIL.—Each eligible individual who is not in-  
14 sured under a MedEquality plan or other health care plan  
15 shall register under this title, either as an individual or  
16 as a member of a family, by mailing a registration form  
17 to the Secretary.

18 (b) AVAILABILITY OF FORMS.—The Secretary shall  
19 make registration forms readily available at post offices  
20 and other suitable locations.

21 **SEC. 103. CREDIT CERTIFICATES.**

22 (a) CREDIT CERTIFICATES.—

23 (1) IN GENERAL.—Each individual, in a State  
24 with an agreement described in subsection (d)(2),  
25 determined to be a credit eligible individual (as de-

1        fined in subsection (b)) shall receive a credit certifi-  
2        cate the value of which may be applied towards pur-  
3        chase of a MedEquality plan through an employer or  
4        an insurer.

5            (2) VALUE OF CERTIFICATE.—

6            (A) SCALED TO INCOME.—The value of a  
7        credit certificate for an individual shall be  
8        scaled according to the income of the individual,  
9        in a manner specified by the Secretary so  
10       that—

11            (i) for individuals and families with  
12        income below the poverty level, the value  
13        equals the maximum value, and

14            (ii) for individuals and families with  
15        income more than 150 percent of the pov-  
16        erty level, there is no value to the credit  
17        certificate.

18            (B) LIMIT TO LOWEST PREMIUM  
19        CHARGED.—The value of the credit certificate  
20        under this section shall not exceed the cost of  
21        coverage under the least expensive MedEquality  
22        plan available for the type of coverage under  
23        which the individual is enrolled.

24            (3) APPLICATION OF CREDIT CERTIFICATE.—In  
25        accordance with regulations of the Secretary, upon

1 presentation of a credit certificate of an individual to  
2 a MedEquality plan, the plan shall reduce the value  
3 of the premium otherwise imposed and shall trans-  
4 mit to the State electronically such information as  
5 may be required in order for the State to provide for  
6 payment to the plan (in accordance with subsection  
7 (c)(1)(C)).

8 (b) CREDIT ELIGIBLE INDIVIDUAL DEFINED.—In  
9 this title, the term “credit eligible individual” means a eli-  
10 gible individual—

11 (1) whose income (as determined under section  
12 1612 of the Social Security Act for purposes of the  
13 supplemental security income program) does not ex-  
14 ceed 150 percent of the poverty level; and

15 (2) whose resources (as determined under sec-  
16 tion 1613 of such Act for purposes of the supple-  
17 mental security income program) do not exceed the  
18 maximum amount of resources that an individual  
19 may have and obtain benefits under that program.

20 (c) ELIGIBILITY DETERMINATION.—

21 (1) STATE RESPONSIBILITY.—States are re-  
22 sponsible—

23 (A) for determining if individuals are cred-  
24 it eligible individuals;

1 (B) in the case of credit eligible individ-  
2 uals, for determining the value of the credit cer-  
3 tificate and for the issues of certificates to such  
4 individuals; and

5 (C) for making payment to MedEquality  
6 plans for the value of certificates presented to  
7 them.

8 (2) APPLICATION.—

9 (A) IN GENERAL.—States shall provide  
10 that individuals seeking a determination that  
11 they are credit eligible individuals may apply  
12 for, and obtain, such a determination (and if  
13 found eligible, for a credit certificate under sub-  
14 section (a)) in conjunction with—

15 (i) applying for public welfare assist-  
16 ance (including assistance under title IV,  
17 or supplemental security income benefits  
18 under title XVI, of the Social Security  
19 Act), and

20 (ii) receiving medical services at a  
21 hospital emergency room.

22 (B) PERIODIC REAPPLICATIONS.—Individ-  
23 uals who are determined to be credit eligible in-  
24 dividuals are required to reapply for such deter-  
25 mination (and the determination of the amount

1 of the credit certificate) not less often than  
2 once every 6 months.

3 (3) USE OF SOCIAL SECURITY ADMINISTRA-  
4 TION.—At the request of a State, the Secretary may  
5 enter into an agreement with a State under which  
6 eligibility determinations under this section are con-  
7 ducted by the Social Security Administration on be-  
8 half of the State.

9 (d) PAYMENT TO STATES.—

10 (1) IN GENERAL.—From the amounts in the  
11 Treasury not otherwise appropriated, the Secretary  
12 shall provide for payments to States with an agree-  
13 ment in effect under paragraph (2) (on a quarterly  
14 basis in the same manner as payments are made to  
15 States under section 1903(d) of the Social Security  
16 Act) of amounts equal to the sum of—

17 (A) the Federal medical assistance percent-  
18 age (as defined in section 1905(a)(2) of such  
19 Act) amounts paid by the States for credit cer-  
20 tificates issued under subsection (c), and

21 (B) 60 percent of the reasonable adminis-  
22 trative expenses of the State in administering  
23 the certificate program under this title.

1           (2) AGREEMENTS.—An agreement under this  
2 paragraph is an agreement between the Secretary  
3 and a State which provides—

4           (A) for the State—

5                 (i) to carry out this title in the State  
6                 (including implementing section 104(b)),  
7                 and

8                 (ii) to comply with the applicable re-  
9                 quirements of section 502 (relating to com-  
10                prehensive plans for medically underserved  
11                rural populations); and

12           (B) for the Secretary to make payments to  
13 the State under paragraph (1).

14           (3) RELATION TO MEDICAID PROGRAM.—

15           (A) DUPLICATION.—Notwithstanding any  
16 other provision of law, such a State plan is not  
17 required to provide for benefits for services  
18 under such State plan to the extent the individ-  
19 ual is entitled to benefits for such services  
20 under a MedEquality plan.

21           (B) MEDICAID AS SECONDARY PAYOR.—  
22 State plans for medical assistance under title  
23 XIX of the Social Security Act shall, under sec-  
24 tion 1902(a)(25) of such Act, not make pay-  
25 ment for services to the extent that payment

1           may be made for such services under a  
2           MedEquality plan.

3           (e) NOTICE.—Whenever a credit certificate is issued  
4 under this section, the issuer shall notify the Commis-  
5 sioner of Internal Revenue concerning such issuance.

6 **SEC. 104. REQUIREMENT FOR OFFERING OF MEDEQUALITY**  
7 **PLANS.**

8           (a) IN GENERAL.—Each licensed insurance carrier in  
9 a State shall make available a MedEquality plan to all  
10 individuals residing in the State.

11          (b) ENFORCEMENT.—If a carrier in a State fails to  
12 comply with development of a MedEquality plan, the In-  
13 surance Commissioner of the State shall revoke the car-  
14 rier’s license to offer health insurance in the State.

15 **SEC. 105. DEFINITIONS.**

16          In this title:

17           (1) ELIGIBLE INDIVIDUAL.—The term “eligible  
18 individual” means an individual who (A) is a citizen  
19 or national of the United States, an alien lawfully  
20 admitted for permanent residence, or an alien other-  
21 wise permanently residing in the United States  
22 under color of law and (B) is residing in the United  
23 States.

24           (2) HEALTH INSURANCE PROGRAM.—The term  
25 “health insurance program” means any private or

1 public program, other than a MedEquality plan, that  
2 provides for benefits (through insurance or other-  
3 wise) that are not less than the benefits provided  
4 under a MedEquality plan, and includes the medi-  
5 care and medicaid programs (under titles XVIII and  
6 XIX of the Social Security Act), the Federal employ-  
7 ees health insurance program (under chapter 89 of  
8 title 5, United States Code), the program for the  
9 provision of medical and dental benefits under chap-  
10 ter 55 of title 10, United States Code, and the pro-  
11 gram for the provision of hospital care and medical  
12 services by the Department of Veterans Affairs  
13 under chapter 17 of title 38, United States Code.

14 (3) MEDEQUALITY PLAN.—The term  
15 “MedEquality plan” has the meaning given such  
16 term in section 203(b).

17 (4) POVERTY LEVEL.—The term “poverty  
18 level” means the official poverty line (as defined by  
19 the Office of Management and Budget, and revised  
20 annually in accordance with section 673(2) of the  
21 Omnibus Budget Reconciliation Act of 1981) appli-  
22 cable to a family of the size involved.

23 (5) SECRETARY.—The term “Secretary” means  
24 the Secretary of Health and Human Services.

1           (6) STATE.—The term “State” includes the  
2           District of Columbia, Puerto Rico, the Virgin Is-  
3           lands, Guam, and American Samoa.

4           **TITLE II—SMALL EMPLOYER**  
5           **INSURANCE REFORM**

6           **SEC. 201. ESTABLISHMENT AND ENFORCEMENT OF STAND-**  
7                                   **ARDS FOR SMALL EMPLOYER HEALTH INSUR-**  
8                                   **ANCE PLANS.**

9           (a) ESTABLISHMENT OF GENERAL STANDARDS.—

10           (1) ROLE OF NAIC.—The Secretary of Health  
11           and Human Services shall request the National As-  
12           sociation of Insurance Commissioners to develop,  
13           within 1 year after the date of the enactment of this  
14           Act, model regulations that specify standards with  
15           respect to each of the following:

16                           (A) The requirement, under section  
17                           203(a), that small employer carriers offer  
18                           MedEquality plans.

19                           (B) The basic benefits to be included in  
20                           MedEquality plans under section 203(b).

21                           (C) The requirements of guaranteed issue  
22                           of MedEquality plans under section 203(c).

23                           (D) The requirements of sections 204 and  
24                           205(b).

1           (E) The requirements of subsections (a)  
2           and (c) of section 205.

3           If the NAIC develops such regulations specifying  
4           such standards within such period, the Secretary  
5           shall review such standards to determine if they  
6           meet such requirements. Such review shall be com-  
7           pleted within 6 months after the date the regulations  
8           are developed. Unless the Secretary determines with-  
9           in such period that the standards do not meet the  
10          requirements, such standards shall serve as the  
11          standards under this section.

12          (2) CONTINGENCY.—If the NAIC does not de-  
13          velop such model regulations within such period or  
14          the Secretary determines that such regulations do  
15          not meet the requirements described in paragraph  
16          (1), the Secretary shall inform the NAIC of the spe-  
17          cific deficiencies and request the NAIC to develop  
18          such model regulations in conformity with paragraph  
19          (1).

20          (3) EFFECTIVE DATE.—The standards provided  
21          under this subsection—

22                 (A) shall apply to small employer health  
23                 benefit plans offered in a State on or after the  
24                 date the standards are implemented in the  
25                 State under subsection (b)(1), and

1 (B) with respect to the requirements re-  
2 ferred to in paragraph (1)(D), shall apply to  
3 small employer health benefit plans renewed on  
4 or after 3 years after the date such standards  
5 are implemented in the State under subsection  
6 (b)(1).

7 (b) APPLICATION OF STANDARDS THROUGH  
8 STATES.—

9 (1) APPLICATION OF ALL STANDARDS TO NEW  
10 PLANS.—

11 (A) IN GENERAL.—Each State shall sub-  
12 mit to the Secretary, by the deadline specified  
13 in subparagraph (B), a report on the implemen-  
14 tation and enforcement of the standards estab-  
15 lished under subsection (a) with respect to  
16 small employer health benefit plans offered not  
17 later than such deadline.

18 (B) DEADLINE FOR REPORT.—

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

24 (ii) EXCEPTION FOR LEGISLATION.—

25 In the case of a State which the Secretary

1 identifies, in consultation with the NAIC,  
2 as—

3 (I) requiring State legislation  
4 (other than legislation appropriating  
5 funds) in order for carriers and health  
6 benefit plans offered to small employ-  
7 ers to meet the standards established  
8 under subsection (a), but

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

13 the date specified in this subparagraph is  
14 the first day of the first calendar quarter  
15 beginning after the close of the first legis-  
16 lative session of the State legislature that  
17 begins on or after January 1, 1994. For  
18 purposes of the previous sentence, in the  
19 case of a State that has a 2-year legislative  
20 session, each year of such session shall be  
21 deemed to be a separate regular session of  
22 the State legislature.

23 (2) APPLICATION OF CONSUMER PROTECTION  
24 TO ALL PLANS.—Each State shall submit to the Sec-  
25 retary, by not later than 4 years after the date

1 standards are established under subsection (a), a re-  
2 port on the implementation and enforcement of the  
3 standards established under subparagraphs (D) and  
4 (E) subsection (a)(1) with respect to small employer  
5 health benefit plans renewed not later than 4 years  
6 after the date such standards were established.

7 (3) MORE STRINGENT STATE STANDARDS PER-  
8 MITTED.—A State may implement standards that  
9 are more stringent than the standards established  
10 under subsection (a).

11 (4) ENFORCEMENT.—If the Secretary deter-  
12 mines that a State has failed to submit a report by  
13 the deadline under paragraph (1) or (2) or finds  
14 that the State no longer is carrying out its respon-  
15 sibility under the respective paragraph, the Sec-  
16 retary shall notify the State and provide the State  
17 a period of 30 days in which to submit such report  
18 or to carry out its responsibilities under the respec-  
19 tive paragraph. If, after such 30-day period, the Sec-  
20 retary finds that such a failure has not been cor-  
21 rected, the Secretary shall provide for such mecha-  
22 nism for the implementation and enforcement of the  
23 standards established under subsection (a) in the  
24 State as the Secretary determines to be appropriate.  
25 Such standards shall apply to health benefit plans

1 offered or renewed on or after 3 months after the  
2 applicable deadlines established under subpara-  
3 graphs (A) through (C) of subsection (a)(3).

4 **SEC. 202. PREEMPTION OF STATE BENEFITS MANDATES**  
5 **FOR PLANS THAT MEET CONSUMER PROTEC-**  
6 **TION STANDARDS.**

7 (a) FINDING.—Congress finds that health benefit  
8 plans offered with respect to small employers affect inter-  
9 state commerce.

10 (b) PREEMPTION.—In the case of a small employer  
11 health benefit plan that meets the standards with respect  
12 to the requirements referred to in subparagraphs (D) and  
13 (E) of section 201(a)(1), no provision of State law shall  
14 apply that requires the offering, as part of the health ben-  
15 efit plan with respect to such an employer, of any services,  
16 category of care, or services of any class or type of pro-  
17 vider.

18 **SEC. 203. REQUIREMENT FOR OFFERING OF BASIC, LOW**  
19 **COST PLAN (MEDEQUALITY PLAN).**

20 (a) IN GENERAL.—Each small employer carrier  
21 which makes available in a State any small employer  
22 health benefit plan shall make available to each small em-  
23 ployer in the State a MedEquality plan (as defined in sub-  
24 section (b)).

25 (b) MEDEQUALITY PLAN DEFINED.—

1           (1) IN GENERAL.—In this title, except as pro-  
2           vided in paragraph (2), the term “MedEquality  
3           plan” means a health benefits plan that—

4                   (A) is designed to provide only basic hos-  
5                   pital, medical, surgical, preventive, and diag-  
6                   nostic benefits, specified under standards under  
7                   section 201(a)(1)(B), so as to make it afford-  
8                   able to small employers;

9                   (B) includes cost-sharing that provides an  
10                  appropriate incentive to avoid unnecessary care  
11                  while avoiding excessive cost-sharing by individ-  
12                  uals with catastrophic illnesses;

13                  (C) is guaranteed issue (as described in  
14                  subsection (c));

15                  (D) meets the standards established under  
16                  subparagraphs (D) and (E) of section  
17                  201(a)(1) (relating to the requirements of sec-  
18                  tions 204 and 205); and

19                  (E) provides for cost-containment in ac-  
20                  cordance with the model made applicable under  
21                  subsection (d) in the State in which the plan is  
22                  issued.

23           (2) SPECIAL RULES FOR HEALTH MAINTEN-  
24           NANCE ORGANIZATIONS.—With respect to a carrier  
25           that is a Federally-qualified health maintenance or-

1 organization (as defined in section 1301(a) of the Pub-  
2 lic Health Service Act), the term “MedEquality  
3 plan” means a plan of the type described in para-  
4 graph (1) but with benefits that are consistent with  
5 the requirements for the plans of such an organiza-  
6 tion under title XIII of such Act. With respect to a  
7 carrier that is not such a Federally-qualified health  
8 maintenance organization but which is recognized  
9 under State law as a health maintenance organiza-  
10 tion, the term “MedEquality plan” means a plan of  
11 the type described in paragraph (1) but with bene-  
12 fits that are consistent with the requirements of  
13 State law for the plans of such an organization.

14 (3) REVIEW OF MINIMUM BENEFIT STAND-  
15 ARDS.—The NAIC is requested to periodically review  
16 the standards for minimum benefits described in  
17 paragraph (1)(A). The NAIC is requested to submit  
18 to the Secretary and the Congress its recommenda-  
19 tions on changes that should be made in such stand-  
20 ards.

21 (c) GUARANTEED ISSUE FOR MEDEQUALITY  
22 PLANS.—

23 (1) IN GENERAL.—Each MedEquality plan in a  
24 State—

1 (A) subject to paragraph (2), must accept  
2 every small employer in the State that applies  
3 for coverage under the plan;

4 (B) subject to paragraphs (2) and (3),  
5 must accept for enrollment every individual who  
6 is a full-time employee (or, in the case of family  
7 enrollment with respect to such an employee,  
8 the employee's spouse and the employee's de-  
9 pendents who are under 19 years of age or who  
10 are full-time students and under 21 years of  
11 age) who applies for enrollment on a timely  
12 basis; and

13 (C) subject to paragraphs (2) and (3), may  
14 not place any restriction on the eligibility of an  
15 individual to enroll, so long as such an individ-  
16 ual is a full-time employee or the employee's  
17 spouse or dependent described in subparagraph  
18 (B).

19 (2) SPECIAL RULES FOR HEALTH MAINTENANCE  
20 ORGANIZATIONS.—In the case of a  
21 MedEquality plan offered by a health maintenance  
22 organization, the plan shall—

23 (A) limit the employers that may apply for  
24 coverage to those with eligible individuals resid-  
25 ing in the service area of the plan,

1 (B) limit the individuals who may be en-  
2 rolled under the plan to those who reside in the  
3 service area of the plan, and

4 (C) within the service area of the plan,  
5 deny coverage to such employers if the plan  
6 demonstrates that—

7 (i) it will not have the capacity to de-  
8 liver services adequately to enrollees of any  
9 additional groups because of its obligations  
10 to existing group contract holders and en-  
11 rollees, and

12 (ii) it is applying this subparagraph  
13 uniformly to all employers without regard  
14 to the health status, claims experience, or  
15 duration of coverage of those employers  
16 and their employees.

17 (3) EXCEPTION FOR CERTAIN LATE ENROLL-  
18 EES.—

19 (A) IN GENERAL.—Except as provided in  
20 this paragraph, paragraph (1)(B) shall not  
21 apply to an eligible employee or dependent who  
22 fails to enroll in a health benefit plan during an  
23 initial enrollment period, if such period is at  
24 least 30 days long.

1 (B) EXCEPTION FOR THOSE WITH PRE-  
2 VIOUS EMPLOYER COVERAGE.—Subparagraph  
3 (A) shall not apply to an individual who—

4 (i) was covered under another em-  
5 ployer health benefit plan at the time of  
6 the individual's initial enrollment period,

7 (ii) stated at the time of initial enroll-  
8 ment period that coverage under another  
9 employer health benefit plan was the rea-  
10 son for declining enrollment,

11 (iii) lost coverage under another em-  
12 ployer health benefit plan as a result of  
13 termination of employment, the termi-  
14 nation of the other plan's coverage, death  
15 of a spouse, or divorce, and

16 (iv) requests enrollment within 30  
17 days after termination of coverage under  
18 another employer health benefit plan.

19 (C) EXCEPTION FOR OPEN ENROLL-  
20 MENT.—Subparagraph (A) shall not apply to  
21 an individual who—

22 (i) is employed by an employer which  
23 offers multiple health benefit plans, and

24 (ii) elects a different plan during an  
25 open enrollment period.

1 (D) EXCEPTION FOR COURT ORDERS.—  
2 Subparagraph (A) shall not apply to a spouse  
3 or minor child if a court has ordered coverage  
4 be provided for the spouse or child under a cov-  
5 ered employee's health benefit plan and request  
6 for such coverage is made within 30 days after  
7 issuance of such court order.

8 (d) COST CONTAINMENT STANDARDS.—

9 (1) DEVELOPMENT OF MODELS.—

10 (A) ROLE OF NAIC.—The Secretary shall  
11 request the NAIC to develop, within 1 year  
12 after the date of the enactment of this Act,  
13 models for cost-containment features in  
14 MedEquality plans. Such models shall include a  
15 managed care plan (described in paragraph (3))  
16 and any combination of such models the NAIC  
17 finds appropriate. If the NAIC develops such  
18 models within such period, the Secretary shall  
19 review such models to determine if they provide  
20 for effective cost-containment. Such review shall  
21 be completed within 6 months after the date the  
22 models are developed. Unless the Secretary de-  
23 termines within such period that such a model  
24 does not provide effective cost-containment,

1 such remaining models shall serve as the mod-  
2 els under this subsection.

3 (B) CONTINGENCY.—If the NAIC does not  
4 develop such models within such period or the  
5 Secretary determines that all such models do  
6 not provide for effective cost-containment, the  
7 Secretary shall inform the NAIC of the specific  
8 deficiencies and request the NAIC to develop  
9 such models in conformity with paragraph (1).

10 (2) SELECTION OF COST-CONTAINMENT MODEL  
11 BY STATE.—By not later than 2 years after the date  
12 of the enactment of this Act, each State shall specify  
13 the cost-containment model (developed under para-  
14 graph (1)) that will be applied under subsection (a)  
15 to MedEquality plans issued in the State.

16 (3) MANAGED CARE PLAN DEFINED.—For pur-  
17 poses of paragraph (1), the term “managed care  
18 plan” includes (but is not limited to) any plan  
19 that—

20 (A) arranges with selected providers for  
21 the furnishing of health care services,

22 (B) provides explicit standards for the se-  
23 lection of such providers,

24 (C) has formal programs for ongoing qual-  
25 ity assurance and utilization review, and

1 (D) provides significant financial incentives  
2 for beneficiaries to use providers and proce-  
3 dures associated with the plan.

4 (d) ROLE OF STATE INSURANCE COMMISSIONER.—

5 The commissioner or superintendent of insurance of each  
6 State shall be responsible for determining that the pre-  
7 mium charged for each MedEquality plan is reasonable  
8 and not excessive in relation to the benefits.

9 **SEC. 204. REQUIREMENTS RELATING TO INITIAL WRITING**  
10 **OF POLICIES.**

11 (a) LIMITATIONS ON TREATMENT OF PRE-EXISTING  
12 CONDITIONS.—

13 (1) IN GENERAL.—A carrier may not impose  
14 (or require an employer to impose through a waiting  
15 period for coverage under a health benefit policy or  
16 similar requirement) a limitation or exclusion of ben-  
17 efits under a small employer health benefit plan re-  
18 lating to treatment of a condition based on the fact  
19 that the condition preexisted the effectiveness of the  
20 policy if—

21 (A) the condition relates to a condition  
22 that did not exist within 6 months before the  
23 date of coverage under the plan, or

1 (B) the limitation or exclusion extends over  
2 more than 12 months after the date of coverage  
3 under the plan.

4 (2) PREVIOUS SATISFACTION OF PREEXISTING  
5 CONDITION REQUIREMENT.—

6 (A) IN GENERAL.—In addition, each car-  
7 rier shall waive any period applicable to a pre-  
8 existing condition for similar benefits with re-  
9 spect to an individual to the extent that the in-  
10 dividual was covered for the condition under a  
11 small employer health benefit plan that was in  
12 effect before the date of the enrollment under  
13 the carrier's plan.

14 (B) CONTINUOUS COVERAGE REQUIRED.—  
15 Subparagraph (A) shall no longer apply if there  
16 is a continuous period of more than 60 days on  
17 which the individual was not covered under an  
18 employer health benefit plan.

19 (b) LIMITS ON PREMIUMS.—

20 (1) LIMIT ON VARIATION OF INDEX RATES BE-  
21 TWEEN BLOCKS OF BUSINESS.—

22 (A) IN GENERAL.—As a standard under  
23 section 202, the index rate for a rating period  
24 for any block of business of a small employer  
25 carrier may not exceed the index rate for any

1 other block of business by more than 20 per-  
2 cent.

3 (B) EXCEPTIONS.—Subparagraph (A)  
4 shall not apply to a block of business if—

5 (i) the block is one for which the car-  
6 rier does not reject, and never has rejected,  
7 small employers included within the defini-  
8 tion of employers eligible for the block of  
9 business or otherwise eligible employees  
10 and dependents who enroll on a timely  
11 basis, based upon their claim experience or  
12 health status,

13 (ii) the carrier does not involuntarily  
14 transfer, and never has involuntarily trans-  
15 ferred, a health benefit plan into or out of  
16 the block of business, and

17 (iii) the block of business is currently  
18 available for purchase.

19 (2) LIMIT ON VARIATION OF PREMIUM RATES  
20 WITHIN A BLOCK OF BUSINESS.—For a block of  
21 business of a small employer carrier, as a standard  
22 under section 202 the premium rates charged during  
23 a rating period to small employers with similar de-  
24 mographic or other relevant characteristics (not re-  
25 lating to claims experience, health status, or dura-

1       tion of coverage) for the same or similar coverage,  
2       or the rates which could be charged to such employ-  
3       ers under the rating system for that block of busi-  
4       ness, shall not vary from the index rate by more  
5       than 25 percent of the index rate.

6           (3) LIMIT ON PERMISSIBLE RATE VARI-  
7       ATIONS.—Subject to paragraphs (1) and (2), as a  
8       standard under section 202, a carrier may establish  
9       rate variations based on factors such as geography,  
10      demography, and industry and plan design.

11          (4) LIMIT ON TRANSFER OF EMPLOYERS  
12      AMONG BLOCKS OF BUSINESS.—As a standard under  
13      section 202, a small employer carrier may not invol-  
14      untarily transfer a small employer into or out of a  
15      block of business. A small employer carrier may not  
16      offer to transfer a small employer into or out of a  
17      block of business unless such offer is made to trans-  
18      fer all small employers in the block of business with-  
19      out regard to demographic characteristics, claim ex-  
20      perience, health status, or duration since issue.

21          (5) DEFINITIONS.—In this subsection:

22            (A) BASE PREMIUM RATE.—The term  
23            “base premium rate” means, for each block of  
24            business for each rating period, the lowest pre-  
25            mium rate charged or which could have been

1 charged under a rating system for that block of  
2 business by the small employer carrier to small  
3 employers with similar demographic or other  
4 relevant characteristics (not relating to claims  
5 experience, health status, or duration of cov-  
6 erage) for health benefit plans with the same or  
7 similar coverage.

8 (B) BLOCK OF BUSINESS.—The term  
9 “block of business” means, with respect to a  
10 carrier, all (or a distinct group of) small em-  
11 ployers as shown on the records of the carrier.

12 (C) RULES FOR ESTABLISHING BLOCKS OF  
13 BUSINESS.—For purposes of subparagraph  
14 (B)—

15 (i) a carrier may establish, subject to  
16 clause (ii), a distinct group of small em-  
17 ployers on the basis that the applicable  
18 health benefit plans either—

19 (I) are marketed and sold  
20 through individuals and organizations  
21 which are not participating in the  
22 marketing or sale of other distinct  
23 groups of small employers for the car-  
24 rier,

1 (II) have been acquired from an-  
2 other carrier as a distinct group, or

3 (III) are provided through an as-  
4 sociation with membership of not less  
5 than 100 small employers which has  
6 been formed for purposes other than  
7 obtaining insurance;

8 (ii) a carrier may not establish more  
9 than 2 groupings under each block of busi-  
10 ness because the carrier uses managed-care  
11 techniques which are expected to produce  
12 substantial variation in health care costs;  
13 and

14 (iii) notwithstanding clauses (i) and  
15 (ii), a Commissioner of Insurance of a  
16 State may, upon application, approve addi-  
17 tional distinct groups upon a finding that  
18 such approval would enhance the efficiency  
19 and fairness of the small employer market-  
20 place.

21 (D) INDEX RATE.—The term “index rate”  
22 means, with respect to a block of business, the  
23 arithmetic average of the applicable base pre-  
24 mium rate and the corresponding highest pre-  
25 mium rate for the block.

1 (c) FULL DISCLOSURE OF RATING PRACTICES.—At  
2 the time a carrier offers a health benefit plan to a small  
3 employer, the carrier shall fully disclose to the employer  
4 rating practices for small employer health benefit plans,  
5 including rating practices for different industries, popu-  
6 lations, and benefit designs.

7 (d) ACTUARIAL CERTIFICATION.—Each carrier shall  
8 file annually with the State commissioner of insurance a  
9 written statement by a member of the American Academy  
10 of Actuaries (or other individual acceptable to the commis-  
11 sioner) that, based upon an examination by the individual  
12 which includes a review of the appropriate records and of  
13 the actuarial assumptions of the carrier and methods used  
14 by the carrier in establishing premium rates for applicable  
15 small employer health benefit plans—

16 (1) the carrier is in compliance with the appli-  
17 cable provisions of this section, and

18 (2) the rating methods are actuarially sound.

19 Each carrier shall retain a copy of such statement for ex-  
20 amination at its principal place of business.

21 (e) REGISTRATION AND REPORTING.—Each carrier  
22 that issues any small employer health benefit plan in a  
23 State shall be registered or licensed with the State com-  
24 missioner of insurance and shall comply with any report-

1 ing requirements of the commissioner relating to such a  
2 plan.

3 (f) USE OF MINIMUM PARTICIPATION REQUIRE-  
4 MENT.—A carrier may condition issuance, or renewal, of  
5 a health benefit plan to a small employer on the enroll-  
6 ment of a minimum number (or percentage) of its full-  
7 time employees, in accordance with standards established  
8 to carry out this section. Such standards shall require that  
9 any such conditions be imposed uniformly on employers  
10 of the same size.

11 **SEC. 205. REQUIREMENTS RELATING TO RENEWAL.**

12 (a) RENEWABILITY.—A carrier may not cancel a  
13 small employer health benefit plan or deny renewal of cov-  
14 erage under such a plan other than—

15 (1) for nonpayment of premiums,

16 (2) for fraud or other misrepresentation by the  
17 insured,

18 (3) for noncompliance with plan provisions,

19 (4) for failure to maintain (in accordance with  
20 standards established under section 204(f)) the  
21 number of enrollees under the plan at the number  
22 (or percentage) required under the plan,

23 (5) for misuse of a provider network provision,

24 or



1 small employers who are enrolled under a small em-  
2 ployer health benefit plan that meets the standards  
3 with respect to the requirements referred to in sub-  
4 paragraphs (D) and (E) of section 201(a)(1) and for  
5 whom a carrier is at risk of incurring high costs  
6 under the plan. Such models shall include models  
7 based on each of the following:

8 (A) A voluntary prospective reinsurance  
9 option.

10 (B) A retrospective reinsurance option.

11 (C) An allocation option.

12 (D) A pooled employee option.

13 (E) A designated carrier option.

14 (F) A mandatory reinsurance option.

15 If the NAIC develops such models within such pe-  
16 riod, the Secretary shall review such models to deter-  
17 mine if they provide for an effective reinsurance  
18 mechanism. Such review shall be completed within 6  
19 months after the date the models are developed. Un-  
20 less the Secretary determines within such period  
21 that such a model is not an effective reinsurance  
22 mechanism, such remaining models shall serve as  
23 the models under this section.

24 (2) CONTINGENCY.—If the NAIC does not de-  
25 velop such models within such period or the Sec-

1       retary determines that all such models do not pro-  
2       vide for an effective reinsurance mechanism, the  
3       Secretary shall inform the NAIC of the specific defi-  
4       ciencies and request the NAIC to develop such mod-  
5       els in conformity with paragraph (1).

6       (b) REQUIREMENT OF IMPLEMENTATION OF REIN-  
7       SURANCE MECHANISMS.—

8             (1) IN GENERAL.—By not later than 2 years  
9       after the date of the enactment of this Act, each  
10       State shall establish one or more reinsurance mecha-  
11       nisms by not later than the deadline specified in sec-  
12       tion 201(b)(1)(B) of this Act.

13            (2) DEFAULT.—If the Secretary determines  
14       that a State has failed to establish any reinsurance  
15       mechanism under paragraph (1), the Secretary shall  
16       establish one or more such mechanisms with respect  
17       to that State. The authority provided under the pre-  
18       vious sentence shall expire upon the Secretary's de-  
19       termination that the State has provided, by law, for  
20       establishment of a reinsurance mechanism that  
21       meets the requirement of paragraph (1).

22       (c) CONSTRUCTION.—Nothing in this section shall be  
23       construed as to prohibit reinsurance arrangements, wheth-  
24       er on a State or regional basis, not required under this  
25       section.

1 **SEC. 207. REGISTRATION OF ALL HEALTH BENEFIT PLANS**  
2 **REQUIRED.**

3 Notwithstanding any other provision of law, each  
4 State commissioner or superintendent of insurance may,  
5 under State law, require each employer health benefit plan  
6 (including a self-insured plan) to be registered with such  
7 official, if the plan is not otherwise required to be reg-  
8 istered or licensed with the official under section 204(e),  
9 and to provide the official with such information on the  
10 plan as may be necessary to carry out section 206.

11 **SEC. 208. DEFINITIONS.**

12 In this subtitle:

13 (1)(A) The term “carrier” means any entity  
14 which provides health insurance or health benefits in  
15 a State, and includes a licensed insurance company,  
16 a prepaid hospital or medical service plan, a health  
17 maintenance organization, a multiple employer wel-  
18 fare arrangement or employee benefits plan (as de-  
19 fined under the Employee Retirement Income Secu-  
20 rity Act of 1974), or any other entity providing a  
21 plan of health insurance subject to State insurance  
22 regulation.

23 (B) The term “small employer carrier” means  
24 a carrier with respect to the issuance of a small em-  
25 ployer health benefit plan.

1           (2) The term “health benefit plan” means any  
2 hospital or medical expense incurred policy or certifi-  
3 cate, hospital or medical service plan contract, or  
4 health maintenance subscriber contract, but does not  
5 include—

6           (A) accident-only, credit, dental, or disabil-  
7 ity income insurance,

8           (B) coverage issued as a supplement to li-  
9 ability insurance,

10          (C) worker’s compensation or similar in-  
11 surance, or

12          (D) automobile medical-payment insur-  
13 ance.

14          (3) The term “NAIC” means the National As-  
15 sociation of Insurance Commissioners.

16          (4) The term “Secretary” means the Secretary  
17 of Health and Human Services.

18          (5)(A) The term “small employer” means an  
19 entity actively engaged in business which, on at least  
20 50 percent of its working days during the preceding  
21 year, employed at least 3, but fewer than 50, full-  
22 time employees. For purposes of determining if an  
23 employer is a small employer, rules similar to the  
24 rules of subsections (b) and (c) of section 414 of the  
25 Internal Revenue Code of 1986 shall apply.

1 (B) The term “full-time employee” means, with  
2 respect to an employer, an individual who normally  
3 is employed for at least 30 hours per week by the  
4 employer.

5 (6) The term “small employer health benefit  
6 plan” means a health benefit plan which provides  
7 coverage to one or more full-time employees of a  
8 small employer.

9 (7) The term “State” means the 50 States, the  
10 District of Columbia, and Puerto Rico.

11 (8) The term “State commissioner of insur-  
12 ance” includes a State superintendent of insurance.

13 **SEC. 209. PREEMPTION FROM INSURANCE MANDATES FOR**  
14 **QUALIFIED SMALL EMPLOYER PURCHASING**  
15 **GROUPS.**

16 (a) QUALIFIED SMALL EMPLOYER PURCHASING  
17 GROUP DEFINED.—For purposes of this section, an asso-  
18 ciation is a qualified small employer purchasing group if—

19 (1) the association submits an application to  
20 the Secretary of Health and Human Services at such  
21 time and in such form as the Secretary may require;  
22 and

23 (2) on the basis of information contained in the  
24 application and any other information the Secretary  
25 may require, the Secretary determines that—

1 (A) the association is administered solely  
2 under the authority and control of its mem-  
3 ber employers,

4 (B) the association's membership consists  
5 solely of employers with not more than 100 em-  
6 ployees (except that an employer member of the  
7 group may retain its membership in the group  
8 if, after the Secretary determines that the asso-  
9 ciation meets the requirements of this para-  
10 graph, the number of employees of the employer  
11 member increases to more than 100),

12 (C) with respect to each State in which its  
13 members are located, the association consists of  
14 not fewer than 100 employers, and

15 (D) at the time the association submits its  
16 application, the health benefit plans with re-  
17 spect to the employer members of the associa-  
18 tion are in compliance with applicable State  
19 laws relating to health benefit plans.

20 (b) PREEMPTION FROM INSURANCE MANDATES.—

21 (1) FINDING.—Congress finds that employer  
22 purchasing groups organized for the purpose of ob-  
23 taining health insurance for employer members af-  
24 fect interstate commerce.

1           (2) PREEMPTION OF STATE MANDATES.—In the  
2 case of a qualified small employer purchasing group  
3 described in subsection (a), no provision of State law  
4 shall apply that requires the offering, as part of the  
5 health benefit plan with respect to an employer  
6 member of such a group, of any services, category  
7 of care, or services of any class or type of provider.

8           (3) PREEMPTION OF TAXES ON PREMIUMS.—In  
9 the case of a qualified small employer purchasing  
10 group described in subsection (a), no provision of  
11 State or local law shall apply that requires a pro-  
12 vider of insurance to pay a tax on premiums received  
13 from employer members of the group under a health  
14 benefit plan obtained by the group from the insurer  
15 for its employer members.

16           (4) PREEMPTION OF PROVISIONS RELATING TO  
17 MANAGED CARE.—In the case of a qualified small  
18 employer purchasing group described in subsection  
19 (a), the following provisions of State law are pre-  
20 empted and may not be enforced against the health  
21 benefit plan with respect to an employer member of  
22 such a group:

23           (A) RESTRICTIONS ON REIMBURSEMENT  
24 RATES OR SELECTIVE CONTRACTING.—Any law  
25 that restricts the ability of a carrier to nego-

1           tiate reimbursement rates with providers or to  
2           contract selectively with one provider or a lim-  
3           ited number of providers.

4           (B) RESTRICTIONS ON DIFFERENTIAL FI-  
5           NANCIAL INCENTIVES.—Any law that limits the  
6           financial incentives that a health benefit plan  
7           may require a beneficiary to pay when a  
8           nonplan provider is used on a nonemergency  
9           basis.

10          (C) RESTRICTIONS ON UTILIZATION RE-  
11          VIEW METHODS.—(i) Any law that—

12               (I) prohibits utilization review of any  
13               or all treatments and conditions;

14               (II) requires that such review be made  
15               by a resident of the State in which the  
16               treatment is to be offered or by an individ-  
17               ual licensed in such State, or by a physi-  
18               cian in any particular specialty or with any  
19               board certified specialty of the same medi-  
20               cal specialty as the provider whose services  
21               are being rendered;

22               (III) requires the use of specified  
23               standards of health care practice in such  
24               reviews or requires the disclosure of the  
25               specific criteria used in such reviews;

1 (IV) requires payments to providers  
2 for the expenses of responding to utiliza-  
3 tion review requests; or

4 (V) imposes liability for delays in per-  
5 forming such review.

6 (ii) Nothing in clause (i)(II) shall be con-  
7 strued as prohibiting a State from requiring  
8 that utilization review be conducted by a li-  
9 censed health care professional, or requiring  
10 that any appeal from such a review be made by  
11 a licensed physician or by a licensed physi-  
12 cian in any particular specialty or with any  
13 board certified specialty of the same medical  
14 specialty as the provider whose services are  
15 being rendered.

16 (c) EFFECTIVE DATE.—This section shall take effect  
17 60 days after the date of the enactment of this Act.

18 **SEC. 210. EQUALIZATION OF TAX BENEFITS FOR SELF-EM-**  
19 **PLOYED PERSONS.**

20 (a) INCREASE IN DEDUCTION.—Paragraph (1) of  
21 section 162(l) of the Internal Revenue Code of 1986 (re-  
22 lating to special rules for health insurance costs of self-  
23 employed individuals) is amended—

1 (1) by striking “25 percent” and inserting “the  
2 applicable percentage (determined in accordance  
3 with the following table)”’,

4 (2) by striking the period at the end and insert-  
5 ing a colon, and

6 (3) by adding at the end thereof the following  
7 table:

<b>“In the case of taxable years beginning in:</b>	<b>The applicable percentage is:</b>
1994 .....	25
1995 or 1996 .....	50
1997 or thereafter .....	100.”

8 (b) DEDUCTION MADE PERMANENT.—Subsection (l)  
9 of section 162 of such Code is amended by striking para-  
10 graph (6).

11 (c) DEDUCTION LIMITED TO MEDEQUALITY PLANS  
12 OR EQUIVALENT PLANS.—Subsection (l) of section 162  
13 of such Code is amended by adding at the end thereof  
14 the following new paragraph:

15 “(6) DEDUCTION LIMITED TO MEDEQUALITY  
16 PLANS OR EQUIVALENT PLANS.—No deduction shall  
17 be allowed under paragraph (1) for insurance which  
18 is not a MedEquality plan (within the meaning of  
19 section 203(b) of the Comprehensive Health and  
20 Rural Equality Act of 1993 or an equivalent plan  
21 (as defined by the Secretary).”

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 1993.

4 **SEC. 211. MANAGED CARE RIGHTS.**

5 (a) PREEMPTION OF STATE LAW PROVISIONS.—The  
6 following provisions of State law are preempted and may  
7 not be enforced:

8 (1) RESTRICTIONS ON REIMBURSEMENT RATES  
9 OR SELECTIVE CONTRACTING.—Any law that re-  
10 stricts the ability of a carrier to negotiate reimburse-  
11 ment rates with providers or to contract selectively  
12 with one provider or a limited number of providers.

13 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-  
14 CIAL INCENTIVES.—Any law that limits the financial  
15 incentives that a health benefit plan may require a  
16 beneficiary to pay when a non-plan provider is used  
17 on a non-emergency basis.

18 (3) RESTRICTIONS ON UTILIZATION REVIEW  
19 METHODS.—Any law that—

20 (A) prohibits utilization review of any or  
21 all treatments and conditions,

22 (B) requires that such review be made (i)  
23 by a resident of the State in which the treat-  
24 ment is to be offered or by an individual li-  
25 censed in such State, or (ii) by a physician in

1 any particular specialty or with any board cer-  
2 tified specialty of the same medical specialty as  
3 the provider whose services are being rendered,

4 (C) requires the use of specified standards  
5 of health care practice in such reviews or re-  
6 quires the disclosure of the specific criteria used  
7 in such reviews,

8 (D) requires payments to providers for the  
9 expenses of responding to utilization review re-  
10 quests, or

11 (E) imposes liability for delays in perform-  
12 ing such review.

13 Nothing in subparagraph (B) shall be construed as  
14 prohibiting a State from (i) requiring that utilization  
15 review be conducted by a licensed health care profes-  
16 sional or (ii) requiring that any appeal from such a  
17 review be made by a licensed physician or by a li-  
18 censed physician in any particular specialty or with  
19 any board certified specialty of the same medical  
20 specialty as the provider whose services are being  
21 rendered.

22 (b) GAO STUDY.—

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

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

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

9 **TITLE III—HEALTH CARE COST**  
10 **CONTAINMENT**

11 **Subtitle A—Denial of Certain Tax**  
12 **Deductions and Exclusion for**  
13 **Excess Benefits**

14 **SEC. 301. DENIAL OF EMPLOYER TAX DEDUCTION FOR PRO-**  
15 **VIDING HEALTH CARE COVERAGE IN EXCESS**  
16 **OF MINIMUM BENEFITS; DENIAL OF EM-**  
17 **PLOYEE EXCLUSION FOR SUCH EXCESS COV-**  
18 **ERAGE.**

19 (a) DENIAL OF DEDUCTION.—Section 162 of the In-  
20 ternal Revenue Code of 1986 (relating to trade or business  
21 expenses) is amended by redesignating subsection (m) as  
22 subsection (n) and by inserting after subsection (l) the fol-  
23 lowing new subsection:

24 “(m) EXPENSES FOR PROVIDING HEALTH CARE IN  
25 EXCESS OF MINIMUM BENEFITS.—No deduction shall be

1 allowed under this chapter for expenses incurred to pro-  
2 vide health care for any employee of the taxpayer (or any  
3 beneficiary of such employee) to the extent such expenses  
4 are attributable to benefits that are not within the basic  
5 benefits included in MedEquality plans under section  
6 203(b) of the Comprehensive Health and Rural Equality  
7 Act of 1993.”

8 (b) DENIAL OF EXCLUSION.—The text of section 106  
9 of such Code is amended to read as follows:

10 “(a) IN GENERAL.—Gross income of an employee  
11 does not include employer-provided coverage under an ac-  
12 cident or health plan.

13 “(b) NO EXCLUSION FOR HEALTH CARE COVERAGE  
14 IN EXCESS OF MINIMUM BENEFITS.—Subsection (a) shall  
15 not apply to the extent coverage is provided for benefits  
16 that are not within the basic benefits included in  
17 MedEquality plans under section 203(b) of the Com-  
18 prehensive Health and Rural Equality Act of 1993.”

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to taxable years beginning on or  
21 after the first day of the second calendar year beginning  
22 after the date of the enactment of this Act, but shall not  
23 apply to taxable years beginning before the date the basic  
24 benefits, to be included in MedEquality plans under sec-

1 tion 203(b) of this Act, have become effective under sec-  
2 tion 203(a)(3) of this Act.

## 3 **Subtitle B—Medical Malpractice** 4 **Reform**

### 5 **PART 1—GENERAL PROVISIONS**

#### 6 **SEC. 311. FEDERAL REFORM OF MEDICAL MALPRACTICE**

##### 7 **LIABILITY ACTIONS.**

8 (a) CONGRESSIONAL FINDINGS.—

9 (1) EFFECT ON INTERSTATE COMMERCE.—

10 Congress finds that the health care and insurance  
11 industries are industries affecting interstate com-  
12 merce and the medical malpractice litigation systems  
13 existing throughout the United States affect inter-  
14 state commerce by contributing to the high cost of  
15 health care and premiums for malpractice insurance  
16 purchased by health care providers.

17 (2) EFFECT ON FEDERAL SPENDING.—Con-

18 gress finds that the medical malpractice litigation  
19 systems existing throughout the United States have  
20 a significant effect on the amount, distribution, and  
21 use of Federal funds because of—

22 (A) the large number of individuals who  
23 receive health care benefits under programs op-  
24 erated or financed by the Federal Government;

1 (B) the large number of individuals who  
2 benefit because of the exclusion from Federal  
3 taxes of the amounts spent by their employers  
4 to provide them with health insurance benefits;

5 (C) the large number of health care provid-  
6 ers and health care professionals who provide  
7 items or services for which the Federal Govern-  
8 ment makes payments; and

9 (D) the large number of such providers  
10 and professionals who have received direct or  
11 indirect financial assistance from the Federal  
12 Government because of their status as such  
13 professionals or providers.

14 (b) APPLICABILITY.—This subtitle shall apply with  
15 respect to any medical malpractice liability claim and to  
16 any medical malpractice liability action brought in any  
17 State or Federal court, except that this subtitle shall not  
18 apply to—

19 (1) a claim or action for damages arising from  
20 a vaccine-related injury or death to the extent that  
21 title XXI of the Public Health Service Act applies to  
22 the action; or

23 (2) a claim or action in which the plaintiff's  
24 sole allegation is an allegation of an injury arising  
25 from the use of a medical product.

1 (c) PREEMPTION OF STATE LAW.—Subject to section  
2 331, this subtitle supersedes State law only to the extent  
3 that State law differs from any provision of law estab-  
4 lished by or under this subtitle. Any issue that is not gov-  
5 erned by any provision of law established by or under this  
6 subtitle shall be governed by otherwise applicable State or  
7 Federal law.

8 (d) FEDERAL COURT JURISDICTION NOT ESTAB-  
9 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
10 this subtitle shall be construed to establish any jurisdiction  
11 in the district courts of the United States over medical  
12 malpractice liability actions on the basis of sections 1331  
13 or 1337 of title 28, United States Code.

14 **SEC. 312. DEFINITIONS.**

15 As used in this subtitle:

16 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
17 TEM; ADR.—The term “alternative dispute resolution  
18 system” or “ADR” means a system established by  
19 a State that provides for the resolution of medical  
20 malpractice liability claims in a manner other than  
21 through medical malpractice liability actions.

22 (2) CLAIMANT.—The term “claimant” means  
23 any person who alleges a medical malpractice liabil-  
24 ity claim, or, in the case of an individual who is de-

1       ceased, incompetent, or a minor, the person on  
2       whose behalf such a claim is alleged.

3               (3) ECONOMIC DAMAGES.—The term “economic  
4       damages” means damages paid to compensate an in-  
5       dividual for losses for hospital and other medical ex-  
6       penses, lost wages, lost employment, and other pecu-  
7       niary losses.

8               (4) HEALTH CARE PROFESSIONAL.—The term  
9       “health care professional” means any individual who  
10      provides health care services in a State and who is  
11      required by State law or regulation to be licensed or  
12      certified by the State to provide such services in the  
13      State.

14              (5) HEALTH CARE PROVIDER.—The term  
15      “health care provider” means any organization or  
16      institution that is engaged in the delivery of health  
17      care services in a State and that is required by State  
18      law or regulation to be licensed or certified by the  
19      State to engage in the delivery of such services in  
20      the State.

21              (6) INJURY.—The term “injury” means any ill-  
22      ness, disease, or other harm that is the subject of  
23      a medical malpractice liability action or claim.

24              (7) MEDICAL MALPRACTICE LIABILITY AC-  
25      TION.—The term “medical malpractice liability ac-

1       tion” means a civil action (other than an action in  
2       which the plaintiff’s sole allegation is an allegation  
3       of an intentional tort) brought in a State or Federal  
4       court against a health care provider or health care  
5       professional (regardless of the theory of liability on  
6       which the action is based) in which the plaintiff al-  
7       leges a medical malpractice liability claim.

8           (8)   MEDICAL   MALPRACTICE   LIABILITY  
9       CLAIM.—The term “medical malpractice liability  
10      claim” means a claim in which the claimant alleges  
11      that injury was caused by the provision of (or the  
12      failure to provide) health care services.

13          (9)   MEDICAL   PRODUCT.—The term “medical  
14      product” means a device (as defined in section  
15      201(h) of the Federal Food, Drug, and Cosmetic  
16      Act) or a drug (as defined in section 201(g)(1) of  
17      the Federal Food, Drug, and Cosmetic Act).

18          (10)   NONECONOMIC   DAMAGES.—The term  
19      “noneconomic damages” means damages paid to  
20      compensate an individual for losses for physical and  
21      emotional pain, suffering, inconvenience, physical  
22      impairment, mental anguish, disfigurement, loss of  
23      enjoyment of life, loss of consortium, and other  
24      nonpecuniary losses, but does not include punitive  
25      damages.

1           (11) SECRETARY.—The term “Secretary”  
2 means the Secretary of Health and Human Services.

3           (12) STATE.—The term “State” means each of  
4 the several States, the District of Columbia, the  
5 Commonwealth of Puerto Rico, the Virgin Islands,  
6 Guam, and American Samoa.

7 **SEC. 313. EFFECTIVE DATE.**

8           (a) IN GENERAL.—Except as provided in subsection  
9 (b) and sections 330 and 351, this subtitle shall apply with  
10 respect to claims accruing or actions brought on or after  
11 the expiration of the 3-year period that begins on the date  
12 of the enactment of this Act.

13           (b) EXCEPTION FOR STATES REQUESTING EARLIER  
14 IMPLEMENTATION OF REFORMS.—

15           (1) APPLICATION.—A State may submit an ap-  
16 plication to the Secretary requesting the early imple-  
17 mentation of this subtitle with respect to claims or  
18 actions brought in the State.

19           (2) DECISION BY SECRETARY.—The Secretary  
20 shall issue a response to a State’s application under  
21 paragraph (1) not later than 90 days after receiving  
22 the application. If the Secretary determines that the  
23 State meets the requirements of this subtitle at the  
24 time of submitting its application, the Secretary  
25 shall approve the State’s application, and this sub-

1 title shall apply with respect to actions brought in  
2 the State on or after the expiration of the 90-day  
3 period that begins on the date the Secretary issues  
4 the response. If the Secretary denies the State's ap-  
5 plication, the Secretary shall provide the State with  
6 a written explanation of the grounds for the deci-  
7 sion.

8 **PART 2—UNIFORM STANDARDS FOR MEDICAL**  
9 **MALPRACTICE LIABILITY**

10 **SEC. 321. STATUTE OF LIMITATIONS.**

11 (a) IN GENERAL.—No medical malpractice liability  
12 claim may be brought after the expiration of the 2-year  
13 period that begins on the date the alleged injury that is  
14 the subject of the action should reasonably have been dis-  
15 covered, but in no event after the expiration of the 4-year  
16 period that begins on the date the alleged injury occurred.

17 (b) EXCEPTION FOR MINORS.—In the case of an al-  
18 leged injury suffered by a minor who has not attained 6  
19 years of age, no medical malpractice liability claim may  
20 be brought after the expiration of the 2-year period that  
21 begins on the date the alleged injury that is the subject  
22 of the action should reasonably have been discovered, but  
23 in no event after the date on which the minor attains 10  
24 years of age.

1 **SEC. 322. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**  
2 **TION THROUGH ALTERNATIVE DISPUTE RES-**  
3 **OLUTION.**

4 (a) IN GENERAL.—No medical malpractice liability  
5 action may be brought in any State court unless the medi-  
6 cal malpractice liability claim that is the subject of the  
7 action has been initially resolved under an alternative dis-  
8 pute resolution system certified by the Secretary under  
9 section 341(b).

10 (b) INITIAL RESOLUTION OF CLAIMS UNDER  
11 ADR.—For purposes of subsection (a), an action is “ini-  
12 tially resolved” under an alternative dispute resolution  
13 system if—

14 (1) the ADR reaches a decision on whether the  
15 defendant is liable to the plaintiff for damages; and

16 (2) if the ADR determines that the defendant  
17 is liable, the ADR determines the amount of dam-  
18 ages assessed against the defendant.

19 (c) PROCEDURES FOR FILING ACTIONS.—

20 (1) DEADLINE.—No medical malpractice liabil-  
21 ity action may be brought unless the action is filed  
22 in a court of competent jurisdiction not later than  
23 90 days after an opinion resolving the medical mal-  
24 practice liability claim that is the subject of the ac-  
25 tion is issued under the applicable alternative dis-  
26 pute resolution system.

1           (2) COURT OF COMPETENT JURISDICTION.—

2           For purposes of paragraph (1), the term “court of  
3           competent jurisdiction” means—

4                   (A) with respect to actions filed in a State  
5                   court, the appropriate State trial court; and

6                   (B) with respect to actions filed in a Fed-  
7                   eral court, the appropriate United States dis-  
8                   trict court.

9           (d) STATUS OF ADR DECISION.—The decision  
10           reached under an alternative dispute resolution system  
11           shall, for purposes of enforcement by a court of competent  
12           jurisdiction, have the same status in the court as the ver-  
13           dict of a medical malpractice liability action adjudicated  
14           in a State or Federal trial court.

15           (e) TREATMENT OF ADR DECISION.—

16                   (1) REQUIREMENTS FOR GOING FORWARD WITH  
17                   ACTION.—In order to bring a medical malpractice li-  
18                   ability action to contest the decision made under the  
19                   previous alternative dispute resolution system with  
20                   respect to a medical malpractice liability claim, the  
21                   party contesting the decision must—

22                           (A) show that—

23                                   (i) the decision was procured by cor-  
24                                   ruption, fraud, or undue means,

1 (ii) there was partiality or corruption  
2 under the system,

3 (iii) there was other misconduct under  
4 the system that materially prejudiced the  
5 party's rights, or

6 (iv) the decision was based on an  
7 error of law; or

8 (B) present new evidence before the trier  
9 of fact that was not available for presentation  
10 under the ADR system.

11 (2) BURDEN OF PROOF.—In any medical mal-  
12 practice liability action, the trier of fact shall uphold  
13 the decision made under the previous alternative dis-  
14 pute resolution system with respect to the claim that  
15 is the subject of the action unless the party contest-  
16 ing the decision proves by a preponderance of the  
17 evidence that the decision was incorrect.

18 **SEC. 323. RELATION TO ALTERNATIVE DISPUTE RESOLU-**  
19 **TION OF FEDERAL AGENCIES.**

20 (a) MANDATORY APPLICATION OF FEDERAL ADR IN  
21 MALPRACTICE CLAIMS AGAINST UNITED STATES.—Sec-  
22 tion 2672 of title 28, United States Code, is amended by  
23 striking the period at the end of the first paragraph and  
24 inserting the following: “, except that each Federal agency  
25 shall use arbitration or such alternative means of dispute

1 resolution to settle any tort claim against the United  
2 States consisting of a medical malpractice liability claim  
3 (as defined in section 312(8) of the Comprehensive Health  
4 and Rural Equality Act of 1993).”.

5 (b) TRANSMITTAL OF INFORMATION OF MAL-  
6 PRACTICE CLAIMS RESOLVED UNDER FEDERAL ADR.—  
7 Section 584 of title 5, United States Code, as added by  
8 section 4(b) of the Administrative Dispute Resolution Act  
9 (Public Law 101–552), is amended by adding at the end  
10 the following new subsection:

11 “(k) Each agency shall transmit on a regular basis  
12 to the Administrator for Health Care Policy and Research  
13 information on issues in controversy consisting of medical  
14 malpractice liability claims (as defined in section 312(8)  
15 of the Comprehensive Health and Rural Equality Act of  
16 1993) that are resolved under the agency’s dispute resolu-  
17 tion proceeding under this subchapter, in a manner that  
18 assures that the identity of the parties to such proceedings  
19 shall not be revealed.”.

20 **SEC. 324. MANDATORY PRETRIAL SETTLEMENT CON-**  
21 **FERENCE.**

22 (a) IN GENERAL.—Before the beginning of the trial  
23 phase of any medical malpractice liability action, the par-  
24 ties shall attend a conference called by the court for pur-

1 poses of determining whether grounds exist upon which  
2 the parties may negotiate a settlement for the action.

3 (b) REQUIRING PARTIES TO SUBMIT SETTLEMENT  
4 OFFERS.—At the conference called pursuant to subsection  
5 (a), each party to a medical malpractice liability action  
6 shall present an offer of settlement for the action.

7 **SEC. 325. CALCULATION AND PAYMENT OF DAMAGES.**

8 (a) LIMITATION ON NONECONOMIC DAMAGES.—The  
9 total amount of noneconomic damages that may be award-  
10 ed to a plaintiff and the members of the plaintiff's family  
11 for losses resulting from the injury which is the subject  
12 of a medical malpractice liability action may not exceed  
13 \$250,000, regardless of the number of parties against  
14 whom the action is brought or the number of actions  
15 brought with respect to the injury.

16 (b) TREATMENT OF PUNITIVE DAMAGES.—

17 (1) LIMITATION ON AMOUNT.—The total  
18 amount of punitive damages that may be imposed  
19 under a medical malpractice liability action may not  
20 exceed twice the total of the damages awarded to the  
21 plaintiff and the members of the plaintiff's family.

22 (2) PAYMENTS TO STATE FOR MEDICAL QUAL-  
23 ITY ASSURANCE ACTIVITIES.—

24 (A) IN GENERAL.—Any punitive damages  
25 imposed under a medical malpractice liability

1 action shall be paid to the State in which the  
2 action is brought.

3 (B) ACTIVITIES DESCRIBED.—A State  
4 shall use amount paid pursuant to subpara-  
5 graph (A) to carry out activities to assure the  
6 safety and quality of health care services pro-  
7 vided in the State, including (but not limited  
8 to)—

9 (i) licensing or certifying health care  
10 professionals and health care providers in  
11 the State;

12 (ii) operating alternative dispute reso-  
13 lution systems;

14 (iii) carrying out public education pro-  
15 grams relating to medical malpractice and  
16 the availability of alternative dispute reso-  
17 lution systems in the State; and

18 (iv) carrying out programs to reduce  
19 malpractice-related costs for retired provid-  
20 ers or other providers volunteering to pro-  
21 vide services in medically underserved  
22 areas.

23 (C) MAINTENANCE OF EFFORT.—A State  
24 shall use any amounts paid pursuant to sub-  
25 paragraph (A) to supplement and not to replace

1            amounts spent by the State for the activities  
2            described in subparagraph (B).

3            (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If  
4 more than \$100,000 in damages for expenses to be in-  
5 curred in the future is awarded to the plaintiff in a medi-  
6 cal malpractice liability action, the defendant shall provide  
7 for payment for such damages on a periodic basis deter-  
8 mined appropriate by the court (based upon projections  
9 of when such expenses are likely to be incurred), unless  
10 the court determines that it is not in the plaintiff's best  
11 interests to receive payments for such damages on such  
12 a periodic basis.

13            (d) MANDATORY OFFSETS FOR DAMAGES PAID BY  
14 A COLLATERAL SOURCE.—

15            (1) IN GENERAL.—The total amount of dam-  
16 ages received by a plaintiff in a medical malpractice  
17 liability action shall be reduced (in accordance with  
18 paragraph (2)) by any other payment that has been  
19 or will be made to the individual to compensate the  
20 plaintiff for the injury that was the subject of the  
21 action, including payment under—

22                    (A) Federal or State disability or sickness  
23                    programs;

24                    (B) Federal, State, or private health insur-  
25                    ance programs;

- 1 (C) private disability insurance programs;  
2 (D) employer wage continuation programs;  
3 and  
4 (E) any other source of payment intended  
5 to compensate the plaintiff for such injury.

6 (2) AMOUNT OF REDUCTION.—The amount by  
7 which an award of damages to a plaintiff shall be re-  
8 duced under paragraph (1) shall be—

9 (A) the total amount of any payments  
10 (other than such award) that have been made  
11 or that will be made to the plaintiff to com-  
12 pensate the plaintiff for the injury that was the  
13 subject of the action; minus

14 (B) the amount paid by the plaintiff (or by  
15 the spouse, parent, or legal guardian of the  
16 plaintiff) to secure the payments described in  
17 subparagraph (A).

18 **SEC. 326. TREATMENT OF ATTORNEY'S FEES AND OTHER**  
19 **COSTS.**

20 (a) LIMITATION ON ATTORNEY'S FEES.—If the  
21 plaintiff in a medical malpractice liability action has en-  
22 tered into an agreement with the plaintiff's attorney to  
23 pay the attorney's fees on a contingency basis, the attor-  
24 ney's fees for the action may not exceed—

1           (1) 25 percent of the first \$150,000 of any  
2           award or settlement paid to the plaintiff; or

3           (2) 15 percent of any additional amounts paid  
4           to the plaintiff.

5           (b) AWARDING ATTORNEY'S FEES AND OTHER  
6 COSTS TO WINNING PARTY.—

7           (1) IN GENERAL.—If the court in a medical  
8           malpractice liability action upholds a ruling of the  
9           alternative dispute resolution system with respect to  
10          whether or not a health care professional or health  
11          care provider committed malpractice or with respect  
12          to the amount of damages awarded, the court shall  
13          require the party that contested the ruling to pay to  
14          the opposing party the costs incurred by the oppos-  
15          ing party under the action, including attorney's fees,  
16          fees paid to expert witnesses, and other litigation ex-  
17          penses (but not including court costs, filing fees, or  
18          other expenses paid directly by the party to the  
19          court, or any fees or costs associated with the reso-  
20          lution of the claim that is the subject of the action  
21          under the alternative dispute resolution system).

22          (2) PERMITTING COURT TO WAIVE OR MODIFY  
23          IMPOSITION OF COSTS.—A court may issue a written  
24          order waiving or modifying the application of para-  
25          graph (1) to a party if the court finds that the appli-

1 cation of such paragraph to the party would con-  
2 stitute an undue hardship, or if the medical mal-  
3 practice liability action raised a novel issue of law.  
4 The order shall specify the grounds for the court's  
5 decision to waive or modify the application of such  
6 paragraph.

7 **SEC. 327. JOINT AND SEVERAL LIABILITY.**

8 The liability of each defendant in a medical mal-  
9 practice liability action shall be several only and shall not  
10 be joint, and each defendant shall be liable only for the  
11 amount of damages allocated to the defendant in direct  
12 proportion to the defendant's percentage of responsibility  
13 (as determined by the trier of fact).

14 **SEC. 328. UNIFORM STANDARD FOR DETERMINING NEG-**  
15 **LIGENCE.**

16 A defendant in a medical malpractice liability action  
17 may not be found to have acted negligently unless the de-  
18 fendant's conduct at the time of providing the health care  
19 services that are the subject of the action was not reason-  
20 able.

21 **SEC. 329. APPLICATION OF MEDICAL PRACTICE GUIDE-**  
22 **LINES IN MALPRACTICE LIABILITY ACTIONS.**

23 (a) USE OF GUIDELINES AS AFFIRMATIVE DE-  
24 FENSE.—In any medical malpractice liability action, it  
25 shall be a complete defense to any allegation that the de-

1 defendant was negligent that, in the provision of (or the fail-  
2 ure to provide) the services that are the subject of the  
3 action, the defendant followed the appropriate practice  
4 guideline.

5 (b) RESTRICTION ON GUIDELINES CONSIDERED AP-  
6 PROPRIATE.—

7 (1) GUIDELINES SANCTIONED BY SEC-  
8 RETARY.—For purposes of subsection (a), a practice  
9 guideline may not be considered appropriate with re-  
10 spect to actions brought during a year unless the  
11 Secretary has sanctioned the use of the guideline for  
12 purposes of an affirmative defense to medical mal-  
13 practice liability actions brought during the year in  
14 accordance with paragraph (2) or (3).

15 (2) ANNUAL PROCESS FOR SANCTIONING  
16 GUIDELINES.—By not later than October 1 of each  
17 year (beginning with 1994), the Secretary shall re-  
18 view the practice guidelines and standards developed  
19 by the Administrator for Health Care Policy and Re-  
20 search pursuant to section 1142 of the Social Secu-  
21 rity Act, and shall sanction those guidelines which  
22 the Secretary considers appropriate for purposes of  
23 an affirmative defense to medical malpractice liabil-  
24 ity actions brought during the next year as appro-

1        appropriate practice guidelines for purposes of subsection  
2        (a).

3            (3) USE OF STATE GUIDELINES.—Upon the ap-  
4        plication of a State, the Secretary may sanction  
5        practice guidelines selected by the State for purposes  
6        of an affirmative defense to medical malpractice li-  
7        ability actions brought in the State as appropriate  
8        practice guidelines for purposes of subsection (a) if  
9        the guidelines meet such requirements as the Sec-  
10       retary may impose.

11        (c) PROHIBITING APPLICATION OF FAILURE TO FOL-  
12       LOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEG-  
13       LIGENCE.—No plaintiff in a medical malpractice liability  
14       action may be deemed to have presented prima facie evi-  
15       dence that a defendant was negligent solely by showing  
16       that the defendant failed to follow the appropriate practice  
17       guideline.

18        (d) PROMOTION OF MEDICAL PRACTICE GUIDE-  
19       LINES.—

20            (1) CONSIDERATION OF MALPRACTICE LIABIL-  
21        ITY DATA IN DEVELOPING AND UPDATING GUIDE-  
22        LINES.—Section 1142(c)(5) of the Social Security  
23        Act (42 U.S.C. 1320b-12(c)(5)) is amended by  
24        striking “claims data” and all that follows through  
25        “patients” and inserting the following: “claims data,

1 data on clinical and functional status of patients,  
2 and data on medical malpractice liability actions”.

3 (2) DEVELOPMENT OF REPORTING FORMS FOR  
4 STATE ADR SYSTEMS.—The Secretary, in consulta-  
5 tion with the Administrator for the Health Care Pol-  
6 icy and Research, shall develop a standard reporting  
7 form to be used by State alternative dispute resolu-  
8 tion systems in transmitting information to the Ad-  
9 ministrator pursuant to section 341(a)(7) of this Act  
10 on disputes resolved under such systems.

11 (e) FUNDING ESTABLISHMENT OF PRACTICE GUIDE-  
12 LINES.—

13 (1) IN GENERAL.—Each insurer or other entity  
14 that provides individual or group health coverage (as  
15 defined by the Secretary), including health insurance  
16 and coverage under an employer group health plan,  
17 shall pay to the Secretary, at a time and in a man-  
18 ner specified by the Secretary,  $\frac{1}{4}$  of 1 percent of the  
19 gross premiums or other amounts paid for the provi-  
20 sion of such coverage.

21 (2) PLACEMENT IN A SEPARATE ACCOUNT.—  
22 Amounts paid to the Secretary under paragraph (1)  
23 shall be placed in a separate account in the Treas-  
24 ury.

1           (3) USE OF FUNDS FOR PRACTICE GUIDE-  
2           LINES.—Amounts in such account shall only be  
3           available, pursuant to appropriations Act, for pur-  
4           poses of establishing and sanctioning practice guide-  
5           lines to carry out this section.

6           (4) SUPPLEMENTATION.—The funds in such  
7           account are intended to supplement, and not to dis-  
8           place, amounts otherwise appropriated for the estab-  
9           lishment of such practice guidelines.

10 **SEC. 330. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
11 **SERVICES.**

12           (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

13           (1) IN GENERAL.—In the case of a medical  
14           malpractice liability action relating to services pro-  
15           vided during labor or the delivery of a baby, if the  
16           defendant health care professional did not previously  
17           treat the plaintiff for the pregnancy, the trier of fact  
18           may not find that the defendant committed mal-  
19           practice and may not assess damages against the de-  
20           fendant unless the malpractice is proven by clear  
21           and convincing evidence.

22           (2) APPLICABILITY TO GROUP PRACTICES OR  
23           AGREEMENTS AMONG PROVIDERS.—For purposes of  
24           paragraph (1), a health care professional shall be  
25           considered to have previously treated an individual

1 for a pregnancy if the professional is a member of  
2 a group practice whose members previously treated  
3 the individual for the pregnancy or is providing serv-  
4 ices to the individual during labor or the delivery of  
5 a baby pursuant to an agreement with another pro-  
6 fessional.

7 (b) CLEAR AND CONVINCING EVIDENCE DEFINED.—  
8 In subsection (a), the term “clear and convincing evi-  
9 dence” is that measure or degree of proof that will  
10 produce in the mind of the trier of fact a firm belief or  
11 conviction as to the truth of the allegations sought to be  
12 established, except that such measure or degree of proof  
13 is more than that required under preponderance of the evi-  
14 dence, but less than that required for proof beyond a rea-  
15 sonable doubt.

16 (c) EFFECTIVE DATE.—This section shall apply to  
17 claims accruing or actions brought on or after the expira-  
18 tion of the 2-year period that begins on the date of the  
19 enactment of this Act.

20 **SEC. 331. PREEMPTION.**

21 (a) IN GENERAL.—This part supersedes any State  
22 law only to the extent that State law—

23 (1) permits the recovery of a greater amount of  
24 damages by a plaintiff;

1           (2) permits the collection of a greater amount  
2 of attorneys' fees by a plaintiff's attorney;

3           (3) establishes a longer period during which a  
4 medical malpractice liability claim may be initiated;  
5 or

6           (4) establishes a stricter standard for determin-  
7 ing whether a defendant was negligent or for deter-  
8 mining the liability of defendants described in sec-  
9 tion 330(a) in actions described in such section.

10       (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
11 OF LAW OR VENUE.—Nothing in subsection (a) shall be  
12 construed to—

13           (1) waive or affect any defense of sovereign im-  
14 munity asserted by any State under any provision of  
15 law;

16           (2) waive or affect any defense of sovereign im-  
17 munity asserted by the United States;

18           (3) affect the applicability of any provision of  
19 the Foreign Sovereign Immunities Act of 1976;

20           (4) preempt State choice-of-law rules with re-  
21 spect to claims brought by a foreign nation or a citi-  
22 zen of a foreign nation; or

23           (5) affect the right of any court to transfer  
24 venue or to apply the law of a foreign nation or to  
25 dismiss a claim of a foreign nation or of a citizen

1 of a foreign nation on the ground of inconvenient  
2 forum.

3 **PART 3—REQUIREMENTS FOR STATE**

4 **ALTERNATIVE DISPUTE RESOLUTION SYSTEMS**

5 **SEC. 341. BASIC REQUIREMENTS FOR ADR.**

6 (a) IN GENERAL.—A State’s alternative dispute reso-  
7 lution system meets the requirements of this section if the  
8 system—

9 (1) applies to all medical malpractice liability  
10 claims under the jurisdiction of the State courts;

11 (2) requires that a written opinion resolving the  
12 dispute be issued that contains findings of fact relat-  
13 ing to the dispute;

14 (3) requires individuals who hear and resolve  
15 claims under the system to meet such qualifications  
16 as the State may require (in accordance with regula-  
17 tions of the Secretary);

18 (4) is approved by the State or by local govern-  
19 ments in the State;

20 (5) with respect to a State system that consists  
21 of multiple dispute resolution procedures—

22 (A) permits the parties to a dispute to se-  
23 lect the procedure to be used for the resolution  
24 of the dispute under the system, and

1 (B) if the parties do not agree on the pro-  
2 cedure to be used for the resolution of the dis-  
3 pute, assigns a particular procedure to the par-  
4 ties;

5 (6) provides for the transmittal to the State  
6 agency responsible for monitoring or disciplining  
7 health care professionals and health care providers  
8 of any findings made under the system that such a  
9 professional or provider committed malpractice, un-  
10 less, during the 90-day period beginning on the date  
11 the system resolves the claim against the profes-  
12 sional or provider, the professional or provider  
13 brings a medical malpractice liability action contest-  
14 ing the decision made under the system; and

15 (7) provides for the regular transmittal to the  
16 Administrator for Health Care Policy and Research  
17 of information on disputes resolved under the sys-  
18 tem, in a manner that assures that the identity of  
19 the parties to a dispute shall not be revealed.

20 (b) APPLICATION OF MALPRACTICE LIABILITY  
21 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—  
22 The provisions of part 2 shall apply with respect to claims  
23 brought under a State's alternative dispute resolution sys-  
24 tem in the same manner as such provisions apply with

1 respect to medical malpractice liability actions brought in  
2 the State.

3 **SEC. 342. CERTIFICATION OF STATE SYSTEMS.**

4 (a) IN GENERAL.—Not later than October 1 of each  
5 year (beginning with 1994), the Secretary, in consultation  
6 with the Attorney General, shall determine whether a  
7 State’s alternative dispute resolution system meets the re-  
8 quirements of this part for the following calendar year.

9 (b) BASIS FOR CERTIFICATION.—The Secretary shall  
10 certify a State’s alternative dispute resolution system  
11 under this subsection if the Secretary determines under  
12 subsection (a) that the system meets the requirements of  
13 section 341.

14 **SEC. 343. REPORTS ON IMPLEMENTATION AND EFFECTIVE-**  
15 **NESS OF ALTERNATIVE DISPUTE RESOLU-**  
16 **TION SYSTEMS.**

17 (a) IN GENERAL.—Not later than 5 years after the  
18 date of the enactment of this Act, the Secretary shall pre-  
19 pare and submit to Congress a report describing and eval-  
20 uating State alternative dispute resolution systems oper-  
21 ated pursuant to this part.

22 (b) CONTENTS OF REPORT.—The Secretary shall in-  
23 clude in the report prepared and submitted under sub-  
24 section (a)—

25 (1) information on—

1 (A) the effect of such systems on the cost  
2 of health care within the State,

3 (B) the impact of such systems on the ac-  
4 cess of individuals to health care within the  
5 State, and

6 (C) the effect of such systems on the qual-  
7 ity of health care provided within such State;  
8 and

9 (2) to the extent that such report does not pro-  
10 vide information on no-fault systems operated by  
11 States as alternative dispute resolution systems pur-  
12 suant to this part, an analysis of the feasibility and  
13 desirability of establishing a system under which  
14 medical malpractice liability claims shall be resolved  
15 on a no-fault basis.

16 **PART 4—OTHER REQUIREMENTS AND**  
17 **PROGRAMS**

18 **SEC. 351. PERMITTING STATE PROFESSIONAL SOCIETIES**  
19 **TO PARTICIPATE IN DISCIPLINARY ACTIVI-**  
20 **TIES.**

21 (a) **ROLE OF PROFESSIONAL SOCIETIES.**—Notwith-  
22 standing any other provision of State or Federal law, a  
23 State agency responsible for the conduct of disciplinary  
24 actions for a type of health care practitioner may enter  
25 into agreements with State or county professional societies

1 of such type of health care practitioner to permit such so-  
2 cieties to participate in the licensing of such health care  
3 practitioner, and to review any health care malpractice ac-  
4 tion, health care malpractice claim or allegation, or other  
5 information concerning the practice patterns of any such  
6 health care practitioner. Any such agreement shall comply  
7 with subsection (b).

8 (b) REQUIREMENTS OF AGREEMENTS.—Any agree-  
9 ment entered into under subsection (a) for licensing activi-  
10 ties or the review of any health care malpractice action,  
11 health care malpractice claim or allegation, or other infor-  
12 mation concerning the practice patterns of a health care  
13 practitioner shall provide that—

14 (1) the health care professional society conducts  
15 such activities or review as expeditiously as possible;

16 (2) after the completion of such review, such so-  
17 ciety shall report its findings to the State agency  
18 with which it entered into such agreement;

19 (3) the conduct of such activities or review and  
20 the reporting of such findings be conducted in a  
21 manner which assures the preservation of confiden-  
22 tiality of health care information and of the review  
23 process; and

24 (4) no individual affiliated with such society is  
25 liable for any damages or injury directly caused by

1 the individual's actions in conducting such activities  
2 or review.

3 (c) AGREEMENTS NOT MANDATORY.—Nothing in  
4 this section may be construed to require a State to enter  
5 into agreements with societies described in subsection (a)  
6 to conduct the activities described in such subsection.

7 (d) EFFECTIVE DATE.—This section shall take effect  
8 2 years after the date of the enactment of this Act.

## 9 **Subtitle C—Administrative Cost** 10 **Savings**

### 11 **PART 1—STANDARDIZED CLAIMS PROCESSING**

#### 12 **SEC. 361. ADOPTION OF DATA ELEMENTS, UNIFORM** 13 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-** 14 **MISSION STANDARDS.**

15 (a) IN GENERAL.—The Secretary of Health and  
16 Human Services (in this subtitle referred to as the “Sec-  
17 retary”) shall adopt standards relating to each of the fol-  
18 lowing:

19 (1) Data elements for use in paper and elec-  
20 tronic claims processing under health benefit plans,  
21 as well as for use in utilization review and manage-  
22 ment of care (including data fields, formats, and  
23 medical nomenclature, and including plan benefit  
24 and insurance information).

1           (2) Uniform claims forms (including uniform  
2           procedure and billing codes for uses with such forms  
3           and including information on other health benefit  
4           plans that may be liable for benefits).

5           (3) Uniform electronic transmission of the data  
6           elements (for purposes of billing and utilization re-  
7           view).

8 Standards under paragraph (3) relating to electronic  
9 transmission of data elements for claims for services shall  
10 supersede (to the extent specified in such standards) the  
11 standards adopted under paragraph (2) relating to the  
12 submission of paper claims for such services. Standards  
13 under paragraph (3) shall include protections to assure  
14 the confidentiality of patient-specific information and to  
15 protect against the unauthorized use and disclosure of in-  
16 formation.

17       (b) USE OF TASK FORCES.—In adopting standards  
18 under this section—

19           (1) the Secretary shall take into account the  
20           recommendations of current task forces, including at  
21           least the Workgroup on Electronic Data Inter-  
22           change, National Uniform Billing Committee, the  
23           Uniform Claim Task Force, and the Computer-based  
24           Patient Record Institute;

1           (2) the Secretary shall consult with the Na-  
2           tional Association of Insurance Commissioners (and,  
3           with respect to standards under subsection (a)(3),  
4           the American National Standards Institute); and

5           (3) the Secretary shall, to the maximum extent  
6           practicable, seek to make the standards consistent  
7           with any uniform clinical data sets which have been  
8           adopted and are widely recognized.

9           (c) DEADLINES FOR PROMULGATION.—The Sec-  
10          retary shall promulgate the standards under—

11           (1) subsection (a)(1) relating to claims process-  
12          ing data, by not later than 12 months after the date  
13          of the enactment of this Act;

14           (2) subsection (a)(2) (relating to uniform  
15          claims forms) by not later than 12 months after the  
16          date of the enactment of this Act; and

17           (3)(A) subsection (a)(3) relating to trans-  
18          mission of information concerning hospital and phy-  
19          sicians services, by not later than 24 months after  
20          the date of the enactment of this Act, and

21           (B) subsection (a)(3) relating to transmission  
22          of information on other services, by such later date  
23          as the Secretary may determine it to be feasible.

24           (d) REPORT TO CONGRESS.—Not later than 3 years  
25          after the date of the enactment of this Act, the Secretary

1 shall report to Congress recommendations regarding re-  
2 structuring the medicare peer review quality assurance  
3 program given the availability of hospital data in elec-  
4 tronic form.

5 **SEC. 362. APPLICATION OF STANDARDS.**

6 (a) IN GENERAL.—If the Secretary determines, at  
7 the end of the 2-year period beginning on the date that  
8 standards are adopted under section 361 with respect to  
9 classes of services, that a significant number of claims for  
10 benefits for such services under health benefit plans are  
11 not being submitted in accordance with such standards,  
12 the Secretary may require, after notice in the Federal  
13 Register of not less than 6 months, that all providers of  
14 such services must submit claims to health benefit plans  
15 in accordance with such standards. The Secretary may  
16 waive the application of such a requirement in such cases  
17 as the Secretary finds that the imposition of the require-  
18 ment would not be economically practicable.

19 (b) SIGNIFICANT NUMBER.—The Secretary shall  
20 make an affirmative determination described in subsection  
21 (a) for a class of services only if the Secretary finds that  
22 there would be a significant, measurable additional gain  
23 in efficiencies in the health care system that would be ob-  
24 tained by imposing the requirement described in such  
25 paragraph with respect to such services.

1 (c) APPLICATION OF REQUIREMENT.—

2 (1) IN GENERAL.—If the Secretary imposes the  
3 requirement under subsection (a)—

4 (A) in the case of a requirement that im-  
5 poses the standards relating to electronic trans-  
6 mission of claims for a class of services, each  
7 health care provider that furnishes such services  
8 for which benefits are payable under a health  
9 benefit plan shall transmit electronically and di-  
10 rectly to the plan on behalf of the beneficiary  
11 involved a claim for such services in accordance  
12 with such standards;

13 (B) any health benefit plan may reject any  
14 claim subject to the standards adopted under  
15 section 361 but which is not submitted in ac-  
16 cordance with such standards;

17 (C) it is unlawful for a health benefit plan  
18 (i) to reject any such claim on the basis of the  
19 form in which it is submitted if it is submitted  
20 in accordance with such standards or (ii) to re-  
21 quire, for the purpose of utilization review or as  
22 a condition of providing benefits under the plan,  
23 a provider to transmit medical data elements  
24 that are inconsistent with the standards estab-  
25 lished under section 361(a)(1); and

1 (D) the Secretary may impose a civil  
2 money penalty on any provider that knowingly  
3 and repeatedly submits claims in violation of  
4 such standards or on any health benefit plan  
5 (other than a health benefit plan described in  
6 paragraph (2)) that knowingly and repeatedly  
7 rejects claims in violation of subparagraph (B),  
8 in an amount not to exceed \$100 for each such  
9 claim.

10 The provisions of section 1128A of the Social Secu-  
11 rity Act (other than the first sentence of subsection  
12 (a) and other than subsection (b)) shall apply to a  
13 civil money penalty under subparagraph (D) in the  
14 same manner as such provisions apply to a penalty  
15 or proceeding under section 1128A(a) of such Act.

16 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-  
17 ULATION.—A plan described in this paragraph is a  
18 health benefit plan—

19 (A) that is subject to regulation by a  
20 State, and

21 (B) with respect to which the Secretary  
22 finds that—

23 (i) the State provides for application  
24 of the standards established under section  
25 361, and

1                   (ii) the State regulatory program pro-  
2                   vides for the appropriate and effective en-  
3                   forcement of such standards.

4           (d) TREATMENT OF REJECTIONS.—If a plan rejects  
5 a claim pursuant to subsection (c)(1), the plan shall per-  
6 mit the person submitting the claim a reasonable oppor-  
7 tunity to resubmit the claim on a form or in an electronic  
8 manner that meets the requirements for acceptance of the  
9 claim under such subsection.

10 **SEC. 363. PERIODIC REVIEW AND REVISION OF**  
11 **STANDARDS.**

12           (a) IN GENERAL.—The Secretary shall—

13                   (1) provide for the ongoing receipt and review  
14 of comments and suggestions for changes in the  
15 standards adopted and promulgated under section  
16 361;

17                   (2) establish a schedule for the periodic review  
18 of such standards; and

19                   (3) based upon such comments, suggestions,  
20 and review, revise such standards and promulgate  
21 such revisions.

22           (b) APPLICATION OF REVISED STANDARDS.—If the  
23 Secretary under subsection (a) revises the standards de-  
24 scribed in 501, then, in the case of any claim for benefits  
25 submitted under a health benefit plan more than the mini-

1 mum period (of not less than 6 months specified by the  
2 Secretary) after the date the revision is promulgated  
3 under subsection (a)(3), such standards shall apply under  
4 section 362 instead of the standards previously promul-  
5 gated.

6 **SEC. 364. HEALTH BENEFIT PLAN DEFINED.**

7 In this subtitle, the term “health benefit plan” has  
8 the meaning given such term in section 208(2) and in-  
9 cludes—

10 (1) the medicare program (under title XVIII of  
11 the Social Security Act) and medicare supplemental  
12 health insurance, and

13 (2) a State medicaid plan (approved under title  
14 XIX of such Act).

15 **PART 2—ELECTRONIC MEDICAL DATA**

16 **STANDARDS**

17 **SEC. 371. MEDICAL DATA STANDARDS FOR HOSPITALS AND**  
18 **OTHER PROVIDERS.**

19 (a) PROMULGATION OF HOSPITAL DATA STAND-  
20 ARDS.—

21 (1) IN GENERAL.—Between July 1, 1995, and  
22 January 1, 1996, the Secretary shall promulgate  
23 standards described in subsection (b) for hospitals  
24 concerning electronic medical data.

1           (2) REVISION.—The Secretary may from time  
2           to time revise the standards promulgated under this  
3           subsection.

4           (b) CONTENTS OF DATA STANDARDS.—The stand-  
5           ards promulgated under subsection (a) shall include at  
6           least the following:

7           (1) A definition of a standard set of data ele-  
8           ments for use by utilization and quality control peer  
9           review organizations.

10          (2) A definition of the set of comprehensive  
11          data elements, which set shall include for hospitals  
12          the standard set of data elements defined under  
13          paragraph (1).

14          (3) Standards for an electronic patient care in-  
15          formation system with data obtained at the point of  
16          care, including standards to protect against the un-  
17          authorized use and disclosure of information.

18          (4) A specification of, and manner of presen-  
19          tation of, the individual data elements of the sets  
20          and system under this subsection.

21          (5) Standards concerning the transmission of  
22          electronic medical data.

23          (6) Standards relating to confidentiality of pa-  
24          tient-specific information.

1 The standards under this section shall be consistent with  
2 standards for data elements established under section 361.

3 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-  
4 VIDERS.—

5 (1) IN GENERAL.—The Secretary may promul-  
6 gate standards described in paragraph (2) concern-  
7 ing electronic medical data for providers that are not  
8 hospitals. The Secretary may from time to time re-  
9 vise the standards promulgated under this sub-  
10 section.

11 (2) CONTENTS OF DATA STANDARDS.—The  
12 standards promulgated under paragraph (1) for non-  
13 hospital providers may include standards comparable  
14 to the standards described in paragraphs (2), (4),  
15 and (5) of subsection (b) for hospitals.

16 (d) CONSULTATION.—In promulgating and revising  
17 standards under this section, the Secretary shall—

18 (1) consult with the American National Stand-  
19 ards Institute, hospitals, with the advisory commis-  
20 sion established under section 375, and with other  
21 affected providers, health benefit plans, and other  
22 interested parties, and

23 (2) take into consideration, in developing stand-  
24 ards under subsection (b)(1), the data set used by  
25 the utilization and quality control peer review pro-

1       gram under part B of title XI of the Social Security  
2       Act.

3       **SEC. 372. APPLICATION OF ELECTRONIC DATA STANDARDS**  
4               **TO CERTAIN HOSPITALS.**

5       (a) **MEDICARE REQUIREMENT FOR SHARING OF**  
6 **HOSPITAL INFORMATION.**—As of January 1, 1997, sub-  
7 ject to paragraph (2), each hospital, as a requirement of  
8 each participation agreement under section 1866 of the  
9 Social Security Act, shall—

10           (1) maintain clinical data included in the set of  
11 comprehensive data elements under section  
12 371(b)(2) in electronic form on all inpatients,

13           (2) upon request of the Secretary or of a utili-  
14 zation and quality control peer review organization  
15 (with which the Secretary has entered into a con-  
16 tract under part B of title XI of such Act), transmit  
17 electronically the data set, and

18           (3) upon request of the Secretary, or of a fiscal  
19 intermediary or carrier, transmit electronically any  
20 data (with respect to a claim) from such data set,  
21 in accordance with the standards promulgated under sec-  
22 tion 371(a).

23       (b) **WAIVER AUTHORITY.**—Until January 1, 2000:

24           (1) The Secretary may waive the application of  
25 the requirements of subsection (a) for a hospital

1 that is a small rural hospital, for such period as the  
2 hospital demonstrates compliance with such require-  
3 ments would constitute an undue financial hardship.

4 (2) The Secretary may waive the application of  
5 the requirements of subsection (a) for a hospital  
6 that is in the process of developing a system to pro-  
7 vide the required data set and executes agreements  
8 with its fiscal intermediary and its utilization and  
9 quality control peer review organization that the hos-  
10 pital will meet the requirements of subsection (a) by  
11 a specified date (not later than January 1, 2000).

12 (3) The Secretary may waive the application of  
13 the requirement of subsection (a)(1) for a hospital  
14 that agrees to obtain from its records the data ele-  
15 ments that are needed to meet the requirements of  
16 paragraphs (2) and (3) of subsection (a) and agrees  
17 to subject its data transfer process to a quality as-  
18 surance program specified by the Secretary.

19 (c) APPLICATION TO HOSPITALS OF THE DEPART-  
20 MENT OF VETERANS AFFAIRS.—

21 (1) IN GENERAL.—The Secretary of Veterans  
22 Affairs shall provide that each hospital of the De-  
23 partment of Veterans Affairs shall comply with the  
24 requirements of subsection (a) in the same manner

1 as such requirements would apply to the hospital if  
2 it were participating in the medicare program.

3 (2) WAIVER.—Such Secretary may waive the  
4 application of such requirements to a hospital in the  
5 same manner as the Secretary of Health and  
6 Human Services may waive under subsection (b) the  
7 application of the requirements of subsection (a).

8 **SEC. 373. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**  
9 **CIES.**

10 (a) IN GENERAL.—Effective January 1, 2000, if a  
11 provider is required under a Federal program to transmit  
12 a data element that is subject to a presentation or trans-  
13 mission standard (as defined in subsection (b)), the head  
14 of the Federal agency responsible for such program (if not  
15 otherwise authorized) is authorized to require the provider  
16 to present and transmit the data element electronically in  
17 accordance with such a standard.

18 (b) PRESENTATION OR TRANSMISSION STANDARD  
19 DEFINED.—In subsection (a), the term “presentation or  
20 transmission standard” means a standard, promulgated  
21 under subsection (b) or (c) of section 371, described in  
22 paragraph (4) or (5) of section 371(b).

1 **SEC. 374. LIMITATION ON DATA REQUIREMENTS WHERE**  
2 **STANDARDS ARE IN EFFECT.**

3 (a) IN GENERAL.—If standards with respect to data  
4 elements are promulgated under section 371 with respect  
5 to a class of provider, a health benefit plan may not re-  
6 quire, for the purpose of utilization review or as a condi-  
7 tion of providing benefits under the plan, that a provider  
8 in the class—

9 (1) provide any data element not in the set of  
10 comprehensive data elements specified under such  
11 standards, or

12 (2) transmit or present any such data element  
13 in a manner inconsistent with the applicable stand-  
14 ards for such transmission or presentation.

15 (b) COMPLIANCE.—

16 (1) IN GENERAL.—The Secretary may impose a  
17 civil money penalty on any health benefit plan (other  
18 than a health benefit plan described in paragraph  
19 (2)) that fails to comply with subsection (a) in an  
20 amount not to exceed \$100 for each such failure.  
21 The provisions of section 1128A of the Social Secu-  
22 rity Act (other than the first sentence of subsection  
23 (a) and other than subsection (b)) shall apply to a  
24 civil money penalty under this paragraph in the  
25 same manner as such provisions apply to a penalty  
26 or proceeding under section 1128A(a) of such Act.

1           (2) PLANS SUBJECT TO EFFECTIVE STATE REG-  
2           ULATION.—A plan described in this paragraph is a  
3           health benefit plan that is subject to regulation by  
4           a State, if the Secretary finds that—

5                   (A) the State provides for application of  
6                   the requirement of subsection (a), and

7                   (B) the State regulatory program provides  
8                   for the appropriate and effective enforcement of  
9                   such requirement with respect to such plans.

10 **SEC. 375. ADVISORY COMMISSION.**

11           (a) IN GENERAL.—The Secretary shall establish an  
12           advisory commission including hospital executives, hospital  
13           data base managers, physicians, health services research-  
14           ers, and technical experts in collection and use of data  
15           and operation of data systems. Such commission shall in-  
16           clude, as ex officio members, a representative of the Direc-  
17           tor of the National Institutes of Health, the Administrator  
18           for Health Care Policy and Research, the Secretary of  
19           Veterans Affairs, and the Director of the Centers for Dis-  
20           ease Control.

21           (b) FUNCTIONS.—The advisory commission shall  
22           monitor and advise the Secretary concerning—

23                   (1) the standards established under this part,  
24                   and

1           (2) operational concerns about the implementa-  
2           tion of such standards under this part.

3           (c) STAFF.—From the amounts appropriated under  
4           subsection (d), the Secretary shall provide sufficient staff  
5           to assist the advisory commission in its activities under  
6           this section.

7           (d) AUTHORIZATION OF APPROPRIATIONS.—There  
8           are authorized to be appropriated such sums as are nec-  
9           essary to carry out this section.

10           **PART 3—ADDITIONAL STANDARDS AND**  
11           **REQUIREMENTS**

12           **SEC. 381. STANDARDS RELATING TO USE OF MEDICARE**  
13           **AND MEDICAID MAGNETIZED HEALTH BENE-**  
14           **FIT CARDS; SECONDARY PAYOR DATA BANK.**

15           (a) MAGNETIZED IDENTIFICATION CARDS UNDER  
16           MEDICARE PROGRAM.—The Secretary shall adopt stand-  
17           ards relating to the design and use of magnetized medi-  
18           care identification cards in order to assist health care pro-  
19           viders providing medicare covered services to individuals—

20           (1) in determining whether individuals are eligi-  
21           ble for benefits under the medicare program, and

22           (2) in billing the medicare program for such  
23           services provided to eligible individuals.

24           Such cards shall be designed to be compatible with ma-  
25           chines currently employed to transmit information on

1 credit cards. Such cards also shall be designed to be able  
2 to be used with respect to the provision of benefits under  
3 medicare supplemental policies.

4 (b) ADOPTION UNDER MEDICAID PLANS.—

5 (1) IN GENERAL.—The Secretary shall take  
6 such steps as may be necessary to encourage and as-  
7 sist States to design and use magnetized medicaid  
8 identification cards that meet such standards, for  
9 use under their medicaid plans.

10 (2) LIMITATION ON MMIS FUNDS.—In applying  
11 section 1903(a)(3) of the Social Security Act, the  
12 Secretary may determine that Federal financial par-  
13 ticipation is not available under that section to a  
14 State which has provided for a magnetized card sys-  
15 tem that is inconsistent with the standards adopted  
16 under subsection (a).

17 (c) MEDICARE AND MEDICAID SECONDARY PAYOR  
18 DATA BANK.—The Secretary shall establish a medicare  
19 and medicaid information system which is designed to pro-  
20 vide information on those group health plans and other  
21 health benefit plans that are primary payors to the medi-  
22 care program and medicaid program under section  
23 1862(b) or section 1905(a)(25) of the Social Security Act.

24 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
25 are authorized to be appropriated, in equal proportions

1 from the Federal Hospital Insurance Trust Fund and  
2 from the Federal Supplementary Medical Insurance Trust  
3 Fund, a total of \$25,000,000 to carry out subsections (a)  
4 and (c), including the issuance of magnetized cards to  
5 medicare beneficiaries.

6 **SEC. 382. PREEMPTION OF STATE QUILL PEN LAWS.**

7 (a) IN GENERAL.—Effective January 1, 1995, no ef-  
8 fect shall be given to any provision of State law that re-  
9 quires medical or health insurance records (including bill-  
10 ing information) to be maintained in written, rather than  
11 electronic, form.

12 (b) SECRETARIAL AUTHORITY.—The Secretary of  
13 Health and Human Services may issue regulations to  
14 carry out subsection (a). Such regulations may provide for  
15 such exceptions to subsection (a) as the Secretary deter-  
16 mines to be necessary to prevent fraud and abuse, with  
17 respect to controlled substances, and in such other cases  
18 as the Secretary deems appropriate.

19 **SEC. 383. USE OF STANDARD IDENTIFICATION NUMBERS.**

20 (a) IN GENERAL.—Effective January 1, 1995, each  
21 health benefit plan shall—

22 (1) for each of its beneficiaries that has a social  
23 security account number, use that number as the  
24 personal identifier for claims processing and related  
25 purposes, and

1           (2) for each provider that has a unique identi-  
2           fier for purposes of title XVIII of the Social Security  
3           Act and that furnishes health care items or services  
4           to a beneficiary under the plan, use that identifier  
5           as the identifier of that provider for claims process-  
6           ing and related purposes.

7           (b) COMPLIANCE.—

8           (1) IN GENERAL.—The Secretary may impose a  
9           civil money penalty on any health benefit plan (other  
10          than a health benefit plan described in paragraph  
11          (2)) that fails to comply with standards established  
12          under subsection (a) in an amount not to exceed  
13          \$100 for each such failure. The provisions of section  
14          1128A of the Social Security Act (other than the  
15          first sentence of subsection (a) and other than sub-  
16          section (b)) shall apply to a civil money penalty  
17          under this paragraph in the same manner as such  
18          provisions apply to a penalty or proceeding under  
19          section 1128A(a) of such Act.

20          (2) PLANS SUBJECT TO EFFECTIVE STATE REG-  
21          ULATION.—A plan described in this paragraph is a  
22          health benefit plan that is subject to regulation by  
23          a State, if the Secretary finds that—

24                  (A) the State provides for application of  
25                  the requirement of subsection (a), and

1 (B) the State regulatory program provides  
2 for the appropriate and effective enforcement of  
3 such requirement with respect to such plans.

4 **SEC. 384. COORDINATION OF BENEFIT STANDARDS.**

5 (a) REVIEW OF COORDINATION OF BENEFIT PROB-  
6 LEMS.—Between July 1, 1995, and January 1, 1996, the  
7 Secretary shall determine whether problems relating to—

8 (1) the rules for determining the liability of  
9 health benefit plans when benefits are payable under  
10 two or more such plans, or

11 (2) the availability of information among such  
12 health benefit plans when benefits are so payable,  
13 cause significant administrative costs.

14 (b) CONTINGENT PROMULGATION OF STANDARDS.—

15 (1) IN GENERAL.—If the Secretary determines  
16 that such problems do cause significant administra-  
17 tive costs that could be significantly reduced through  
18 the implementation of standards, the Secretary shall  
19 promulgate standards concerning—

20 (A) the liability of health benefit plans  
21 when benefits are payable under two or more  
22 such plans, and

23 (B) the transfer among health benefit  
24 plans of appropriate information (which may in-  
25 clude standards for the use of unique identifi-

1           ers, and for the listing of all individuals covered  
2           under a health benefit plan) in determining li-  
3           ability in cases when benefits are payable under  
4           two or more such plans.

5           (2) EFFECTIVE DATE.—The standards promul-  
6           gated under paragraph (1) shall become effective on  
7           a date specified by the Secretary, which date shall  
8           be not earlier than one year after the date of pro-  
9           mulgation of the standards.

10          (c) COMPLIANCE.—

11           (1) IN GENERAL.—The Secretary may impose a  
12           civil money penalty on any health benefit plan (other  
13           than a health benefit plan described in paragraph  
14           (2)) that fails to comply with standards promulgated  
15           under subsection (b) in an amount not to exceed  
16           \$100 for each such failure. The provisions of section  
17           1128A of the Social Security Act (other than the  
18           first sentence of subsection (a) and other than sub-  
19           section (b)) shall apply to a civil money penalty  
20           under this paragraph in the same manner as such  
21           provisions apply to a penalty or proceeding under  
22           section 1128A(a) of such Act.

23           (2) PLANS SUBJECT TO EFFECTIVE STATE REG-  
24           ULATION.—A plan described in this paragraph is a

1 health benefit plan that is subject to regulation by  
2 a State, if the Secretary finds that—

3 (A) the State provides for application of  
4 the standards established under subsection (b),  
5 and

6 (B) the State regulatory program provides  
7 for the appropriate and effective enforcement of  
8 such standards with respect to such plans.

9 (d) REVISION OF STANDARDS.—If the Secretary es-  
10 tablishes standards under subsection (b), the Secretary  
11 may revise such standards from time to time and such  
12 revised standards shall be applied under subsection (c) on  
13 or after such date (not earlier than 6 months after the  
14 date the revision is promulgated) as the Secretary shall  
15 specify.

## 16 **Subtitle C—Estimates of Expenses** 17 **Prior to Treatment**

### 18 **SEC. 391. REQUIREMENT.**

19 (a) IN GENERAL.—If requested, except as provided  
20 in subsection (b), each hospital, physician, or other pro-  
21 vider of a health care item or service, before providing any  
22 health care item or services to any individual in the United  
23 States shall disclose to the individual (in form and manner  
24 specified by the Secretary of Health and Human Services)  
25 a range of prices to be charged for the item or service.

1 In the case of provision of items and services for which  
2 the particular services to be provided are not readily deter-  
3 minable in advance, the Secretary shall permit the use of  
4 such estimates as may be appropriate.

5 (b) EXCEPTION FOR EMERGENCIES.—Subsection (a)  
6 shall not apply in the case of emergency treatment and  
7 such other extenuating circumstances as the Secretary  
8 may provide by regulation.

9 (c) ENFORCEMENT.—No individual shall be liable for  
10 payment for a health care item or service for which a dis-  
11 closure is required under subsection (a), if the disclosure  
12 has not been substantially made in accordance with such  
13 subsection.

14 (d) EFFECTIVE DATE.—This section shall apply to  
15 items and services furnished on or after 1 year after the  
16 date of the enactment of this Act.

## 17 **Subtitle D—Antitrust Exemptions**

### 18 **SEC. 395. PERMITTING COOPERATIVE ARRANGEMENTS BE-**

#### 19 **TWEEN HOSPITALS.**

20 (a) EXEMPTION.—Upon issuance of a certificate  
21 under subsection (c) with respect to an arrangement, the  
22 antitrust laws shall not apply with respect to—

23 (1) an arrangement among hospitals providing  
24 for (or attempting to provide for) the combination of  
25 two or more hospitals, or

1           (2) a cooperative arrangement entered into sole-  
2 ly by two or more hospitals with respect to sharing  
3 expensive capital-intensive medical technology or  
4 other highly resource-intensive services.

5           (b) APPLICATION.—In order to obtain the benefits of  
6 subsection (a) with respect to an arrangement, one or  
7 more licensed hospitals may submit to the Secretary of  
8 Health and Human Services an application, containing  
9 such information as the Secretary may require with re-  
10 spect to the arrangement, including—

11           (1) a statement that such hospital desires to  
12 negotiate and enter into a voluntary cooperative ar-  
13 rangement under which the hospital is operating in  
14 one State or region for the sharing of medical tech-  
15 nology or services with another hospital;

16           (2) a description of the nature and scope of the  
17 activities contemplated under the arrangement that  
18 demonstrates that consumer costs would not in-  
19 crease under the arrangement;

20           (3) a description of the financial arrangement  
21 between the hospital and other hospitals that are  
22 parties to the arrangement; and

23           (4) any other information determined appro-  
24 priate by the Secretary.

1           (c) EVALUATIONS OF APPLICATIONS.—Not later  
2 than 120 days after the date an application under sub-  
3 section (b) is received, the Secretary, in consultation with  
4 the Administrator for the Health Care Financing Admin-  
5 istration, shall issue a certificate approving the arrange-  
6 ment if the Secretary determines that under the arrange-  
7 ment—

8                   (1) Federal expenditures will be reduced;

9                   (2) hospital services in geographical proximity  
10 to the communities traditionally served will be pre-  
11 served; and

12                   (3) consumer costs would not increase.

13           (d) ANTITRUST LAWS DEFINED.—For purposes of  
14 this section, the term “antitrust laws” has the meaning  
15 given such term in subsection (a) of the first section of  
16 the Clayton Act (15 U.S.C. 12), except that such term  
17 includes section 5 of the Federal Trade Commission Act  
18 (15 U.S.C. 45) to the extent that such section 5 applies  
19 with respect to unfair methods of competition.

1       **TITLE IV—LONG-TERM CARE**  
2       **Subtitle A—Treatment of Long-**  
3       **Term Care Insurance Plans**

4       **SEC. 401. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**  
5                   **ED AS ACCIDENT AND HEALTH INSURANCE**  
6                   **FOR PURPOSES OF TAXATION OF LIFE INSUR-**  
7                   **ANCE COMPANIES.**

8       (a) IN GENERAL.—Section 818 of the Internal Reve-  
9 nue Code of 1986 (relating to other definitions and special  
10 rules) is amended by adding at the end the following new  
11 subsection:

12       “(g) QUALIFIED LONG-TERM CARE INSURANCE  
13 TREATED AS ACCIDENT OR HEALTH INSURANCE.—For  
14 purposes of this part—

15               “(1) IN GENERAL.—Any reference to accident  
16 or health insurance shall be treated as including a  
17 reference to qualified long-term care insurance.

18               “(2) QUALIFIED LONG-TERM CARE INSUR-  
19 ANCE.—For purposes of this subsection—

20                   “(A) IN GENERAL.—Subject to subpara-  
21 graphs (B) and (C), the term ‘qualified long-  
22 term care insurance’ means insurance under a  
23 policy or rider, which is issued by a qualified is-  
24 suer, which meets standards at least as strin-  
25 gent as those set forth in the January 1990

1 Long-Term Care Insurance Model Regulation  
2 of the National Association of Insurance Com-  
3 missioners, and which is certified by the Sec-  
4 retary of Health and Human Services (in ac-  
5 cordance with procedures similar to the proce-  
6 dures prescribed in section 1882 of the Social  
7 Security Act (42 U.S.C. 1385ss) used in the  
8 certification of medicare supplemental policies  
9 (as defined in subsection (g)(1) of such sec-  
10 tion)) to be advertised, marketed, offered, or  
11 designed to provide coverage—

12 “(i) for not less than 12 consecutive  
13 months for each covered person who has  
14 attained age 50,

15 “(ii) on an expense incurred, indem-  
16 nity, or prepaid basis,

17 “(iii) for 1 or more medically nec-  
18 essary, diagnostic services, preventive serv-  
19 ices, therapeutic services, rehabilitation  
20 services, maintenance services, or personal  
21 care services, and

22 “(iv) provided in a setting other than  
23 an acute care unit of a hospital.

1 The requirement of clause (iv) shall be met only  
2 if at least 1 of the settings in which such cov-  
3 erage is provided is the patient's home.

4 “(B) COVERAGE SPECIFICALLY EX-  
5 CLUDED.—Such term does not include any in-  
6 surance under any policy or rider which is of-  
7 fered primarily to provide any combination of  
8 the following kinds of coverage:

9 “(i) Basic Medicare supplement cov-  
10 erage.

11 “(ii) Basic hospital-based acute care  
12 expense coverage.

13 “(iii) Basic medical-surgical expense  
14 coverage.

15 “(iv) Hospital confinement indemnity  
16 coverage.

17 “(v) Major medical expense coverage.

18 “(vi) Disability income protection cov-  
19 erage.

20 “(vii) Accident only coverage.

21 “(viii) Specified disease coverage.

22 “(ix) Specified accident coverage.

23 “(x) Limited benefit health coverage.

1           “(C) QUALIFIED ISSUER.—For purposes of  
2           subparagraph (A), the term ‘qualified issuer’  
3           means any of the following:

4                   “(i) Private insurance company.

5                   “(ii) Fraternal benefit society.

6                   “(iii) Nonprofit health corporation.

7                   “(iv) Nonprofit hospital corporation.

8                   “(v) Nonprofit medical service cor-  
9                   poration.

10                   “(vi) Prepaid health plan.”

11           (b) EFFECTIVE DATE.—The amendment made by  
12           subsection (a) shall apply to taxable years beginning after  
13           December 31, 1993.

14   **SEC. 402. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**  
15                   **ED AS ACCIDENT AND HEALTH INSURANCE**  
16                   **FOR PURPOSES OF EXCLUSION FOR BENE-**  
17                   **FITS RECEIVED UNDER SUCH INSURANCE**  
18                   **AND FOR EMPLOYER CONTRIBUTIONS FOR**  
19                   **SUCH INSURANCE.**

20           (a) IN GENERAL.—Section 105 of the Internal Reve-  
21           nue Code of 1986 (relating to amounts received under ac-  
22           cident and health plans) is amended by adding at the end  
23           the following new subsection:

1       “(j) SPECIAL RULES RELATING TO QUALIFIED  
2 LONG-TERM CARE INSURANCE.—For purposes of section  
3 104, this section, and section 106—

4           “(1) BENEFITS TREATED AS PAYABLE FOR  
5 SICKNESS, ETC.—Any benefit received through quali-  
6 fied long-term care insurance (as defined in section  
7 818(g)) shall be treated as received for personal in-  
8 juries or sickness.

9           “(2) EXPENSES FOR WHICH REIMBURSEMENT  
10 PROVIDED UNDER QUALIFIED LONG-TERM CARE IN-  
11 SURANCE TREATED AS INCURRED FOR MEDICAL  
12 CARE.—Expenses incurred by a taxpayer for which  
13 reimbursement is paid through qualified long-term  
14 care insurance (as so defined) shall be treated for  
15 purposes of subsection (b) as incurred for medical  
16 care (as defined in section 213(d)).

17           “(3) REFERENCES TO ACCIDENT AND HEALTH  
18 PLANS.—Any reference to an accident or health plan  
19 shall be treated as including a reference to a plan  
20 providing qualified long-term care insurance.”

21       (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall apply to taxable years beginning after  
23 December 31, 1993.

1 **SEC. 403. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**  
2 **WITHDRAWN FROM INDIVIDUAL RETIRE-**  
3 **MENT PLANS OR 401(k) PLANS FOR QUALI-**  
4 **FIED LONG-TERM CARE INSURANCE.**

5 (a) IN GENERAL.—Part III of subchapter B of chap-  
6 ter 1 of the Internal Revenue Code of 1986 (relating to  
7 items specifically excluded from gross income) is amended  
8 by redesignating section 136 as section 137 and by insert-  
9 ing after section 135 the following new section:

10 **“SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT**  
11 **ACCOUNTS AND SECTION 401(k) PLANS FOR**  
12 **QUALIFIED LONG-TERM CARE INSURANCE.**

13 “(a) GENERAL RULE.—The amount includible in the  
14 gross income of an individual for the taxable year by rea-  
15 son of qualified distributions during such taxable year  
16 shall not exceed the excess of—

17 “(1) the amount which would (but for this sec-  
18 tion) be so includible by reason of such distributions,  
19 over

20 “(2) the aggregate premiums paid by such indi-  
21 vidual during such taxable year for any policy of  
22 qualified long-term care insurance (as defined in sec-  
23 tion 818(g)) for the benefit of such individual or the  
24 spouse of such individual.

25 “(b) QUALIFIED DISTRIBUTION.—For purposes of  
26 this section, the term ‘qualified distribution’ means any

1 distribution to an individual from an individual retirement  
2 account or a section 401(k) plan if such individual has  
3 attained age 59½ on or before the date of the distribution  
4 (and, in the case of a distribution used to pay premiums  
5 for the benefit of the spouse of such individual, such  
6 spouse has attained age 59½ on or before the date of the  
7 distribution).

8 “(c) DEFINITIONS.—For purposes of this section—

9 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The  
10 term ‘individual retirement account’ has the mean-  
11 ing given such term by section 408(a).

12 “(2) SECTION 401(k) PLAN.—The term ‘section  
13 401(k) plan’ means any employer plan which meets  
14 the requirements of section 401(a) and which in-  
15 cludes a qualified cash or deferred arrangement (as  
16 defined in section 401(k)).

17 “(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

18 “(1) WITHDRAWALS CANNOT EXCEED ELEC-  
19 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR  
20 DEFERRED ARRANGEMENT.—This section shall not  
21 apply to any distribution from a section 401(k) plan  
22 to the extent the aggregate amount of such distribu-  
23 tions for the use described in subsection (a) exceeds  
24 the aggregate employer contributions made pursuant  
25 to the employee’s election under section 401(k)(2).

1           “(2) WITHDRAWALS NOT TO CAUSE DISQUALI-  
2           FICATION.—A plan shall not be treated as failing to  
3           satisfy the requirements of section 401, and an ar-  
4           rangement shall not be treated as failing to be a  
5           qualified cash or deferred arrangement (as defined  
6           in section 401(k)(2)), merely because under the plan  
7           or arrangement distributions are permitted which  
8           are excludable from gross income by reason of this  
9           section.”.

10          (b) CONFORMING AMENDMENTS.—

11           (1) Section 401(k) of such Code is amended by  
12           adding at the end the following new paragraph:

13           “(11) CROSS REFERENCE.—

**“For provision permitting tax-free withdrawals  
                  for payment of long-term care premiums, see section  
                  136.”**

14           (2) Section 408(d) of such Code is amended by  
15           adding at the end the following new paragraph:

16           “(8) CROSS REFERENCE.—

**For provision permitting tax-free withdrawals  
                  from individual retirement accounts for payment of  
                  long-term care premiums, see section 136.”**

17           (3) The table of sections for such part III is  
18           amended by striking the last item and inserting the  
19           following new items:

                  “Sec. 136. Distributions from individual retirement accounts and  
                  section 401(k) plans for qualified long-term care in-  
                  surance.

                  “Sec. 137. Cross references to other Acts.”

1 (c) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall apply to taxable years beginning after  
3 December 31, 1993.

4 **SEC. 404. EXCHANGE OF LIFE INSURANCE POLICY FOR**  
5 **QUALIFIED LONG-TERM CARE POLICY NOT**  
6 **TAXABLE.**

7 (a) IN GENERAL.—Subsection (a) of section 1035 of  
8 the Internal Revenue Code of 1986 (relating to certain  
9 exchanges of insurance policies) is amended by striking  
10 the period at the end of paragraph (3) and inserting “;  
11 or” and by adding at the end the following new paragraph:

12 “(4) in the case of an individual who has at-  
13 tained age 59½, a contract of life insurance or a  
14 contract of endowment insurance or an annuity con-  
15 tract for a contract of qualified long-term care insur-  
16 ance (as defined in section 818(g)) for the benefit of  
17 such individual or the spouse of such individual if  
18 such spouse has attained age 59½ on or before the  
19 date of the exchange.”

20 (b) EFFECTIVE DATE.—The amendment made by  
21 this section shall apply to taxable years beginning after  
22 December 31, 1993.

1                   **Subtitle B—Treatment of**  
2                   **Accelerated Death Benefits**

3   **SEC. 411. TAX TREATMENT OF ACCELERATED DEATH BENE-**  
4                   **FITS UNDER LIFE INSURANCE CONTRACTS.**

5           (a) GENERAL RULE.—Section 101 of the Internal  
6 Revenue Code of 1986 (relating to certain death benefits)  
7 is amended by adding at the end thereof the following new  
8 subsection:

9           “(g) TREATMENT OF CERTAIN ACCELERATED  
10 DEATH BENEFITS.—

11           “(1) IN GENERAL.—For purposes of this sec-  
12 tion, any amount paid to an individual under a life  
13 insurance contract on the life of an insured who is  
14 a terminally ill individual or who is permanently con-  
15 fined to a nursing home shall be treated as an  
16 amount paid by reason of the death of such insured.

17           “(2) TERMINALLY ILL INDIVIDUAL.—For pur-  
18 poses of this subsection, the term ‘terminally ill indi-  
19 vidual’ means an individual who has been certified  
20 by a physician, licensed under State law, as having  
21 an illness or physical condition which can reasonably  
22 be expected to result in death in 12 months or less.

23           “(3) PERMANENTLY CONFINED TO A NURSING  
24 HOME.—For purposes of this subsection, an individ-  
25 ual has been permanently confined to a nursing

1 home if the individual is presently confined to a  
2 nursing home and has been certified by a physician,  
3 licensed under State law, as having an illness or  
4 physical condition which can reasonably be expected  
5 to result in the individual remaining in a nursing  
6 home for the rest of his life.”

7 (b) EFFECTIVE DATE.—The amendment made by  
8 this section shall apply to taxable years beginning after  
9 December 31, 1993.

10 **SEC. 412. TAX TREATMENT OF COMPANIES ISSUING QUALI-**  
11 **FIED ACCELERATED DEATH BENEFIT RID-**  
12 **ERS.**

13 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-  
14 ERS TREATED AS LIFE INSURANCE.—Section 818 of the  
15 Internal Revenue Code of 1986 (relating to other defini-  
16 tions and special rules) is amended by adding at the end  
17 thereof the following new subsection:

18 “(g) QUALIFIED ACCELERATED DEATH BENEFIT  
19 RIDERS TREATED AS LIFE INSURANCE.—For purposes of  
20 this part—

21 “(1) IN GENERAL.—Any reference to a life in-  
22 surance contract shall be treated as including a ref-  
23 erence to a qualified accelerated death benefit rider  
24 on such contract.

1           “(2) QUALIFIED ACCELERATED DEATH BENE-  
2           FIT RIDERS.—For purposes of this subsection, the  
3           term ‘qualified accelerated death benefit rider’  
4           means any rider or addendum on, or other provision  
5           of, a life insurance contract which provides for pay-  
6           ments to an individual on the life of an insured upon  
7           such insured becoming a terminally ill individual (as  
8           defined in section 101(g)(2)) or being permanently  
9           confined to a nursing home (as defined in section  
10          101(g)(3)).”

11          (b) DEFINITIONS OF LIFE INSURANCE AND MODI-  
12          FIED ENDOWMENT CONTRACTS.—

13           (1) RIDER TREATED AS QUALIFIED ADDI-  
14           TIONAL BENEFIT.—Paragraph (5)(A) of section  
15           7702(f) of such Code is amended by striking “or”  
16           at the end of clause (iv), by redesignating clause (v)  
17           as clause (vi), and by inserting after clause (iv) the  
18           following new clause:

19                   “(v) any qualified accelerated death  
20                   benefit rider (as defined in section  
21                   818(g)(2)) or any qualified long-term care  
22                   insurance rider which reduces the death  
23                   benefit, or”.

24           (2) TRANSITIONAL RULE.—For purposes of ap-  
25           plying section 7702 or 7702A of the Internal Reve-

1 nue Code of 1986 to any contract (or determining  
2 whether either such section applies to such con-  
3 tract), the issuance of a rider or addendum on, or  
4 other provision of, a life insurance contract permit-  
5 ting the acceleration of death benefits (as described  
6 in section 101(g) of such Code) or for qualified long-  
7 term care insurance (as defined in section 849(b) of  
8 such Code) shall not be treated as a modification or  
9 material change of such contract.

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

13 **TITLE V—INCENTIVES FOR PRO-**  
14 **VISION OF SERVICES IN**  
15 **RURAL AREAS**

16 **SEC. 501. DEDUCTION FOR MEDICAL SCHOOL EDUCATION**  
17 **LOAN INTEREST INCURRED BY DOCTORS**  
18 **SERVING IN MEDICALLY UNDERSERVED**  
19 **RURAL AREAS.**

20 (a) IN GENERAL.—Paragraph (2) of section 163(h)  
21 of the Internal Revenue Code of 1986 (relating to dis-  
22 allowance of deduction for personal interest) is amended  
23 by striking “and” at the end of subparagraph (D), by re-  
24 designating subparagraph (E) as subparagraph (F), and

1 by inserting after subparagraph (D) the following new  
2 subparagraph:

3           “(E) any qualified medical education loan  
4           interest (within the meaning of paragraph (5)),  
5           and”.

6           (b) QUALIFIED MEDICAL EDUCATION LOAN INTER-  
7           EST DEFINED.—Paragraph (5) of section 163(h) of such  
8           Code is amended to read as follows:

9           “(5) QUALIFIED MEDICAL EDUCATION LOAN IN-  
10          TEREST.—

11           “(A) IN GENERAL.—The term ‘qualified  
12           medical education loan interest’ means inter-  
13           est—

14           “(i) which is on a medical education  
15           loan of a physician,

16           “(ii) which is paid or accrued by such  
17           physician, and

18           “(iii) which accrues during the pe-  
19           riod—

20           “(I) such physician is providing  
21           primary care (including internal medi-  
22           cine, pediatrics, obstetrics/gynecology,  
23           family medicine, and osteopathy) to  
24           residents of a medically underserved  
25           rural area, and

1                   “(II) such physician’s principal  
2                   place of abode is in such area.

3                   “(B) MEDICAL EDUCATION LOAN.—The  
4                   term ‘medical education loan’ means indebted-  
5                   ness incurred to pay the individual’s—

6                   “(i) qualified tuition and related ex-  
7                   penses (as defined in section 117(b)) in-  
8                   curred for the medical education of such  
9                   individual, or

10                   “(ii) reasonable living expenses while  
11                   away from home in order to attend an edu-  
12                   cational institution described in section  
13                   170(b)(1)(A)(ii) for the medical education  
14                   of such individual.

15                   “(C) PHYSICIAN.—For purposes of sub-  
16                   paragraph (A), the term ‘physician’ has the  
17                   meaning given such term by section 1861(r)(1)  
18                   of the Social Security Act.

19                   “(D) MEDICALLY UNDERSERVED RURAL  
20                   AREA.—The term ‘medically underserved rural  
21                   area’ means any rural area which is a medically  
22                   underserved area (as defined in section 330(b)  
23                   or 1302(7) of the Public Health Service Act).”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years ending after the  
3 date of the enactment of this Act.

4 **SEC. 502. REQUIRING DEVELOPMENT OF COMPREHENSIVE**  
5 **PLANS FOR MEDICALLY UNDERSERVED**  
6 **RURAL POPULATIONS.**

7 (a) STATE COMPREHENSIVE PLANS FOR MEDICALLY  
8 UNDERSERVED RURAL AREAS.—As a requirement of an  
9 agreement between the Secretary of Health and Human  
10 Services and a State under section 103(d)(2) in the case  
11 of a State that has one or more rural areas that are medi-  
12 cally underserved areas (as defined in section 330(b) or  
13 1302(7) of the Public Health Service Act), the State shall  
14 develop and submit to the Secretary a comprehensive plan  
15 that addresses the health care needs of the populations  
16 in all such areas. The comprehensive plan shall utilize, in  
17 the most efficient manner possible and to the maximum  
18 extent possible, the current resources of Federal, State,  
19 and local governments, including public health clinics.

20 (b) RESPONSE TO MANAGED COMPETITION.—

21 (1) IN GENERAL.—If a State is required to es-  
22 tablish a comprehensive plan under subsection (a),  
23 the State may not operate a managed competition  
24 system (described in paragraph (2)) unless, with re-

1 spect to each medically underserved rural area in the  
2 State, either—

3 (A) the system provides assurances with  
4 respect to the timely and cost-effective delivery  
5 of appropriate health care in that area, or

6 (B) the application of the system is waived  
7 with respect to residents of such area and there  
8 is established, in accordance with the plan, an  
9 alternative method of assuring the timely and  
10 cost-effective delivery of appropriate health care  
11 in that area.

12 (2) MANAGED COMPETITION SYSTEM DE-  
13 SCRIBED.—A managed competition system described  
14 in this paragraph is a system under which a State  
15 assures access to basic health care services for all  
16 residents through the enrollment of such residents  
17 under a certified health plan offered by a health in-  
18 surance purchasing cooperative or similar entity.

19 **SEC. 503. INCLUSION OF TRANSPORTATION COSTS FOR**  
20 **PHYSICIANS IN UNDERSERVED RURAL AREAS**  
21 **IN THE PRACTICE INDEX UNDER THE MEDI-**  
22 **CARE PHYSICIAN PAYMENT SCHEDULE.**

23 (a) IN GENERAL.—Section 1848(e) of the Social Se-  
24 curity Act (42 U.S.C. 1395w-4(e)) is amended—

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

3 “(D) INCLUSION OF TRANSPORTATION  
 4 COSTS.—In establishing the index under sub-  
 5 paragraph (A)(i), the Secretary shall take into  
 6 account transportation costs associated with  
 7 providing health care services to patients in  
 8 rural health professional shortage areas (as des-  
 9 ignated under section 332 of the Public Health  
 10 Service Act).”.

11 (b) EFFECTIVE DATE.—The amendment made by  
 12 subsection (a) shall apply to services furnished on or after  
 13 January 1, 1994.

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