

103^D CONGRESS
2^D SESSION

H. R. 200

To establish the framework for a health care system that will bring about universal access to affordable, quality health care by containing the growth in health care costs through a national health budget, managed competition, and other means, by improving access to and simplifying the administration of health insurance, by deterring and prosecuting health care fraud and abuse, by expanding benefits under the medicare program, by expanding eligibility and increasing payment levels under the medicaid program, and by making health insurance available to all children.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

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

JANUARY 26, 1994

Additional sponsors: Mr. BLACKWELL, and Mr. ROMERO-BARCELÓ

A BILL

To establish the framework for a health care system that will bring about universal access to affordable, quality health care by containing the growth in health care costs through a national health budget, managed competition, and other means, by improving access to and simplifying the administration of health insurance, by deterring and prosecuting health care fraud and abuse, by expanding benefits under the medicare program, by expanding eligibility and increasing payment levels under the medicaid

program, and by making health insurance available to all children.

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 “Health Care Cost Containment and Reform Act of
6 1993”.

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

Sec. 1. Short title; table of contents.
Sec. 2. General definitions.

TITLE I—COST CONTAINMENT

Subtitle A—National Health Budget

Sec. 101. National health expenditure budget.
Sec. 102. Classes of health care services.
Sec. 103. Allocation of health budget by class of service.
Sec. 104. Adjustments for changes in medicare benefits.
Sec. 105. National health expenditures reporting system.

Subtitle B—State Provider Payment Control Systems

Sec. 121. State provider payment rates.
Sec. 122. General conditions for State provider payment control systems.
Sec. 123. Control of aggregate expenditures requirement for State systems.
Sec. 124. Treatment of States failing to control aggregate expenditures.
Sec. 125. Termination of approval of State system.

Subtitle C—Maximum Payment Rates for Services Not Subject to State Pro-
vider Payment Control Systems or Provided by Staff or Group Model
Health Maintenance Organizations

Sec. 140. Exemption for services subject to approved State provider payment
control systems or provided by staff or group model health
maintenance organizations.

PART 1—ESTABLISHMENT AND APPLICATION OF MAXIMUM PAYMENT RATES
(OTHER THAN UNDER MEDICARE PROGRAM)

Sec. 141. Process.
Sec. 142. Payment methodology; relation to budget allocation.
Sec. 143. General application and enforcement of maximum payment rates.
Sec. 144. Limitation on payment rates under medicaid.

PART 2—METHODOLOGIES FOR DETERMINING MAXIMUM RATES (OTHER THAN UNDER MEDICARE PROGRAM)

- Sec. 151. Basis for maximum rates of payment for inpatient hospital services.
- Sec. 152. Basis for maximum payment rate for class of physicians' services and other professional medical services.
- Sec. 153. Basis for other maximum payment rates for services using certain medicare payment methodologies.
- Sec. 154. Other services.
- Sec. 155. Development of prospectively-determined payment methodologies.

PART 3—MEDICARE PAYMENT ADJUSTMENTS

- Sec. 161. Conforming medicare payment rates to medicare health expenditure allocations.
- Sec. 162. Adjustments to medicare payments for graduate medical education.

TITLE II—MANAGED CARE AND MANAGED COMPETITION

Subtitle A—Managed Care

- Sec. 201. Authorization for managed care systems to pay less than maximum payment rates.
- Sec. 202. Staff and group model health maintenance organizations exempt from maximum payment rates.
- Sec. 203. Repeal of sunset of dual choice requirement.
- Sec. 204. Multiple choice of health maintenance organizations.
- Sec. 205. Federal assistance for establishment and initial operation of staff and group model HMOs.
- Sec. 206. Preemption of "any willing provider" State laws.
- Sec. 207. Adjustment in medicare capitation payments to account for regional variations in application of secondary payor provisions.
- Sec. 208. GAO study of expansion of health maintenance organizations.

Subtitle B—Managed Competition

PART 1—ESTABLISHMENT OF NATIONAL HPPC PROGRAM

- Sec. 221. Establishment of program; grants to States.
- Sec. 222. Establishment of HPPCs; designation of HPPC areas.
- Sec. 223. Organization and operation of HPPCs.
- Sec. 224. Agreements with employers.
- Sec. 225. Agreements with qualified health plans (QHPs).
- Sec. 226. Enrolling individuals in qualified health plans through a HPPC.
- Sec. 227. Coordination among HPPCs.
- Sec. 228. Definitions.

PART 2—REQUIREMENTS FOR QUALIFIED HEALTH PLANS

- Sec. 251. Approval process; qualifications.
- Sec. 252. Benefit packages.

Subtitle C—National Patient Outcomes and Enrollee Satisfaction Data Reporting Program

- Sec. 271. National patient outcomes program.
- Sec. 272. Enrollee health plan satisfaction.
- Sec. 273. Research and demonstration.

Subtitle D—Study of Universal Health Insurance Coverage and Cost Containment

Sec. 291. Study.

TITLE III—HEALTH SYSTEMS REFORM

Subtitle A—Health Insurance Reform

Sec. 301. Excise tax on premiums received on health insurance policies which do not meet certain requirements.

Sec. 302. Health benefit plan standards.

“TITLE XXI—HEALTH BENEFIT PLAN STANDARDS

“Sec. 2101. Standards and requirements for health benefit plans.

“Sec. 2102. Establishment of standards.

“Sec. 2103. Requirements applicable to all health benefit plans.

“Sec. 2104. Standards applicable only to insured health benefit plans.

“Sec. 2105. Payment of commissions.

“Sec. 2106. Insurance requirement for multiple employer welfare arrangements.

“Sec. 2107. Nonapplication in Puerto Rico and the territories.

“Sec. 2108. Definitions.

Sec. 303. Assuring continuation of access to college and university health benefit plans by graduating students.

Subtitle B—Administrative Simplification

Sec. 321. Requirement for uniform health claims cards.

Sec. 322. Requirement for entitlement verification system.

Sec. 323. Requirements for uniform claims and electronic claims data set.

Sec. 324. Electronic medical records and reporting.

Sec. 325. Uniform hospital cost reporting.

Sec. 326. Definitions.

Subtitle C—Fraud and Abuse

PART 1—NATIONAL HEALTH CARE FRAUD CONTROL PROGRAM

Sec. 341. All-payer fraud and abuse control program.

Sec. 342. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health benefit plan.

Sec. 343. Prohibition against offering inducements to individuals enrolled under or employed by programs or plans.

Sec. 344. Intermediate sanctions for medicare health maintenance organizations.

PART 2—BAN ON IMPROPER PHYSICIAN REFERRALS

Sec. 351. Application of medicare ban on self-referrals to all payors.

Sec. 352. Extension of self-referral ban to additional specified services.

Sec. 353. Changes in exceptions and other provisions relating to compensation arrangements.

Sec. 354. Effective dates.

Subtitle D—Other Provisions

Sec. 361. Malpractice reform.

TITLE IV—EXPANSIONS OF HEALTH BENEFITS AND OTHER
HEALTH INITIATIVES

Subtitle A—Medicaid Benefit Improvements

- Sec. 401. Floor on medicaid payment levels for inpatient hospital services and physicians' services.
 Sec. 402. Medicaid eligibility expansion.
 Sec. 403. Full Federal payment for increased costs.

Subtitle B—Expansion of Medicare Benefits

PART 1—PREVENTIVE BENEFITS

- Sec. 411. Annual screening mammography.
 Sec. 412. Coverage of colorectal screening.
 Sec. 413. Coverage of certain immunizations.
 Sec. 414. Coverage of well-child care.
 Sec. 415. Demonstration projects for coverage of other preventive services.

PART 2—COVERAGE OF PRESCRIPTION DRUGS

- Sec. 421. Coverage of outpatient prescription drugs.
 Sec. 422. Establishment of Prescription Drug Payment Review Commission.
 Sec. 423. Coverage of prescription drugs for qualified medicare beneficiaries and qualified disabled and working individuals.

PART 3—QUALIFIED MEDICARE BENEFICIARY ENROLLMENT

- Sec. 431. Qualified medicare beneficiary enrollment.

Subtitle C—Health Insurance Deduction for the Self-Employed

- Sec. 441. Deduction for health insurance costs of self-employed individuals made permanent and increased.

Subtitle D—Health Insurance Program for Children

- Sec. 451. Health insurance for children.

“TITLE XXII—HEALTH INSURANCE FOR CHILDREN

- “Sec. 2200. Establishment of program of health insurance for children.

“PART A—ELIGIBILITY AND ENROLLMENT

- “Sec. 2201. Eligibility.
 “Sec. 2202. Enrollment periods.
 “Sec. 2203. Employment-based enrollment.
 “Sec. 2204. Coverage period.

“PART B—BENEFITS; PAYMENTS FOR BENEFITS

- “Sec. 2211. Scope of benefits.
 “Sec. 2212. Exclusions.
 “Sec. 2213. Payments for benefits.

“PART C—PREMIUMS; TRUST FUND

- “Sec. 2231. Amount of premiums.

“Sec. 2232. Payment of premiums.

“Sec. 2233. Children’s Health Insurance Trust Fund.

“PART D—GENERAL PROVISIONS

“Sec. 2251. Incorporation of certain medicare provisions.

“Sec. 2252. Incorporation of peer review provisions and fraud and abuse provisions.

1 **SEC. 2. GENERAL DEFINITIONS.**

2 (a) IN GENERAL.—In this Act (except as otherwise
3 provided):

4 (1) APPLICABLE COMMISSION.—The term “ap-
5 plicable Commission” means—

6 (A) with respect to services included in a
7 class of services furnished by a hospital, other
8 institutional provider, or home health provider,
9 the Prospective Payment Assessment Commis-
10 sion,

11 (B) with respect to prescription drugs on
12 or after January 1, 1995, the Prescription
13 Drug Payment Review Commission (established
14 under section 1847 of the Social Security Act,
15 as added by section 422 of this Act), and

16 (C) with respect to health care services not
17 described in subparagraphs (A) and (B), the
18 Physician Payment Review Commission.

19 (2) CLASS OF SERVICES.—The term “class”
20 means, with respect to health care services, a class
21 established under section 102.

1 (3) HEALTH CARE SERVICES.—The term
2 “health care services” means the items and services
3 described in section 102(a)(2) or included in health
4 care services under section 102(a)(3), but does not
5 include items and services described in section
6 102(a)(4).

7 (4) MEDICARE PROGRAM; MEDICARE BENE-
8 FICIARY.—(A) The term “medicare program” means
9 the programs established under parts A and B of
10 title XVIII of the Social Security Act.

11 (B) The term “medicare beneficiary” means an
12 individual entitled to benefits under part A or B, or
13 both, of the medicare program.

14 (5) MEDICAID PROGRAM.—The term “medicaid
15 program” means any State plan approved under title
16 XIX of the Social Security Act and includes a State
17 program operating under a waiver under section
18 1115 of such Act.

19 (6) NATIONAL HEALTH CARE EXPENDITURE
20 BUDGET.—The term “national health care expendi-
21 ture budget” means such a budget established under
22 section 101.

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

1 (8) STATE.—The term “State” means the 50
2 States and the District of Columbia.

3 (9) UNITED STATES.—The term “United
4 States” means the 50 States and the District of Co-
5 lumbia.

6 (b) TERM USED IN TITLES I AND II.—In titles I and
7 II:

8 (1) HEALTH MAINTENANCE ORGANIZATION.—
9 The term “health maintenance organization” means
10 an eligible organization with a contract under sec-
11 tion 1876 of the Social Security Act or a qualified
12 health maintenance organization (as defined in sec-
13 tion 1310(d) of the Public Health Service Act).

14 (2) STAFF OR GROUP MODEL HEALTH MAINTEN-
15 NANCE ORGANIZATION.—The term “staff or group
16 model health maintenance organization” means a
17 health maintenance organization (as defined in para-
18 graph (1)) for which 90 percent of the services of
19 physicians are provided through members of the
20 staff of the organization or through a medical group
21 (or groups).

22 **TITLE I—COST CONTAINMENT**
23 **Subtitle A—National Health Budget**

24 **SEC. 101. NATIONAL HEALTH EXPENDITURE BUDGET.**

25 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—For each calendar year (be-
2 ginning with 1995), there is established a national
3 health expenditure budget equal to the sum of—

4 (A) the medicare health expenditure budg-
5 et (under paragraph (2)), and

6 (B) the nonmedicare health expenditure
7 budget (under such paragraph).

8 (2) AMOUNT.—Subject to section 104—

9 (A) 1995.—The total amount of the medi-
10 care and nonmedicare health expenditure budg-
11 ets for 1995 is equal to the respective medicare
12 and nonmedicare budget baselines (determined
13 under paragraphs (1) and (2), respectively, of
14 subsection (b) for 1994) multiplied by the appli-
15 cable adjustment factor (specified under sub-
16 section (c)) for 1995.

17 (B) SUBSEQUENT YEARS.—The total
18 amount of each such budget for each year after
19 1995 is equal to the respective budget deter-
20 mined under this paragraph for the previous
21 year multiplied by the applicable adjustment
22 factor (specified under subsection (c)) for the
23 year involved.

24 (3) PUBLICATION.—The Secretary of Health
25 and Human Services shall publish in the Federal

1 Register and report to the Congress, by not later
2 than April 1 before each year, the amounts of the
3 national health expenditure budget, of the medicare
4 health expenditure budget, and of the nonmedicare
5 health expenditure budget for the year.

6 (b) BUDGET BASELINES.—

7 (1) MEDICARE BUDGET BASELINE.—The Sec-
8 retary shall compute a medicare budget baseline
9 under this paragraph for 1994 as follows:

10 (A) 1993 ACTUAL EXPENDITURES.—The
11 Secretary shall determine (on the basis of the
12 best data available) the amount of the aggre-
13 gate medicare expenditures (as defined in sub-
14 section (d)(1)) during 1993.

15 (B) PROJECTION FOR 1994.—The Sec-
16 retary shall increase such amount by the Sec-
17 retary's estimate of the percentage increase in
18 the aggregate medicare expenditures between
19 the midpoint of 1993 and the midpoint of 1994.

20 (2) NONMEDICARE BUDGET BASELINE.—The
21 Secretary shall compute a nonmedicare budget base-
22 line under this paragraph for 1994 as follows:

23 (A) 1993 ACTUAL EXPENDITURES.—The
24 Secretary shall determine (on the basis of the
25 best data available) the amount of the aggre-

1 gate nonmedicare expenditures (as defined in
2 subsection (d)(2)) for health care services dur-
3 ing 1993.

4 (B) PROJECTION FOR 1994.—The Sec-
5 retary shall increase such amount by the Sec-
6 retary's estimate of the percentage increase in
7 the aggregate nonmedicare expenditures for
8 such services between the midpoint of 1993 and
9 the midpoint of 1994.

10 (c) APPLICABLE ADJUSTMENT FACTOR.—The appli-
11 cable adjustment factor under this subsection for each
12 year is 1 plus the sum (expressed as a fraction) of—

13 (1) the average annual percentage increase in
14 the gross domestic product (in current dollars, as
15 published by the Secretary of Commerce) during the
16 5-year period ending with the second previous year;
17 plus

18 (2)(A) for 1995, 3.5 percentage points,

19 (B) for 1996, 2.5 percentage points,

20 (C) for 1997, 1.5 percentage points,

21 (D) for 1998, 0.5 percentage point, and

22 (E) for each year thereafter, 0 percentage
23 points.

24 (d) AGGREGATE MEDICARE AND NONMEDICARE EX-
25 PENDITURES DEFINED.—

1 (1) AGGREGATE MEDICARE EXPENDITURES.—

2 In this Act, the term “aggregate medicare expendi-
3 tures” means, with respect to health care services or
4 a class of services, expenditures made under the
5 medicare program with respect to the provision of
6 such services or class of services, and also includes
7 receipts of providers with respect to amounts pay-
8 able as deductibles, coinsurance, or other amounts
9 for which the beneficiary is liable with respect to
10 items and services covered under such program pro-
11 vided to a medicare beneficiary, and including pay-
12 ments made under a contract under section
13 1833(a)(1) or section 1876 of the Social Security
14 Act (other than the portion of such payments that
15 is attributable to administrative costs).

16 (2) AGGREGATE NONMEDICARE EXPENDI-
17 TURES.—

18 (A) IN GENERAL.—Subject to the succeed-
19 ing provisions of this paragraph, in this Act,
20 the term “aggregate nonmedicare expenditures”
21 means, with respect to health care services or a
22 class of services, receipts of providers in the
23 United States with respect to the provision of
24 such services or class of services, excluding ag-

1 aggregate medicare expenditures with respect to
2 such services or class of services.

3 (B) INCLUSION OF ALL PAYORS.—Except
4 as provided in paragraph (3), the amount of ag-
5 gregate nonmedicare expenditures shall be de-
6 termined without regard to the source of pay-
7 ment and shall include (as specified by the Sec-
8 retary) direct patient expenditures as well as
9 payments made by third party payors (includ-
10 ing Government health programs).

11 (3) EXCLUSIONS.—In computing aggregate
12 nonmedicare expenditures, there shall be excluded,
13 as specified by the Secretary—

14 (A) nonoperating revenues (such as inter-
15 est);

16 (B) receipts attributable to personal com-
17 fort and convenience items described in section
18 102(a)(5);

19 (C) direct payments from the Federal Gov-
20 ernment, from State government, from units of
21 local government for research to the extent un-
22 related (and not attributable) to the provision
23 of health care services;

24 (D) receipts attributable to the program
25 for the provision of hospital care and medical

1 services by the Department of Veterans' Affairs
2 under chapter 17 of title 38, United States
3 Code;

4 (E) payments made to health care facilities
5 and providers of the Department of Defense
6 and of the Indian Health Service; and

7 (F) such other receipts unrelated to the
8 provision of health care services as the Sec-
9 retary specifies.

10 **SEC. 102. CLASSES OF HEALTH CARE SERVICES.**

11 (a) ESTABLISHMENT OF CLASSES.—

12 (1) IN GENERAL.—

13 (A) SPECIFIED SERVICES.—

14 (i) IN GENERAL.—Subject to subpara-
15 graph (B)(ii), in the case of items and
16 services specified in a subparagraph under
17 paragraph (2), all of the items and services
18 described in that subparagraph shall be
19 considered to be a “separate” class of
20 health care services.

21 (ii) OVERLAPPING SERVICES.—Except
22 as the Secretary may provide, items and
23 services specified in a subparagraph of
24 paragraph (2) shall be considered to be ex-

1 cluded from the subsequent subparagraphs
2 of that paragraph.

3 (B) OTHER ITEMS AND SERVICES.—

4 (i) IN GENERAL.—In the case of items
5 and services included as health care serv-
6 ices under paragraph (3), the Secretary
7 shall group such items and services into
8 such class or classes of health care services
9 as may be appropriate.

10 (ii) INCLUSION IN CLASSES OF SPECI-
11 FIED HEALTH CARE SERVICES.—In carry-
12 ing out clause (i), the Secretary may in-
13 clude an item or service described in para-
14 graph (3) within a class of services estab-
15 lished under subparagraph (A).

16 (2) SPECIFIED HEALTH CARE SERVICES.—Sub-
17 ject to paragraph (4), the items and services speci-
18 fied in this paragraph are as follows:

19 (A) Inpatient hospital services, other than
20 mental health services.

21 (B) Outpatient hospital services and ambu-
22 latory facility services (including renal dialysis
23 facility services), other than mental health serv-
24 ices.

1 (C) Diagnostic testing services (including
2 clinical laboratory services and x-ray services).

3 (D) Physicians' services and other profes-
4 sional medical services, other than mental
5 health services.

6 (E) Home health services and hospice care.

7 (F) Rehabilitation services, such as phys-
8 ical therapy, occupational and speech therapy.

9 (G) Durable medical equipment and sup-
10 plies.

11 (H) Prescription drugs and biologicals and
12 insulin.

13 (I) Nursing facility services, including
14 skilled nursing facility services and intermediate
15 care facility services, other than mental health
16 services.

17 (J) Mental health services.

18 (3) ADDITIONAL ITEMS AND SERVICES.—Sub-
19 ject to paragraph (4), the Secretary shall specify ad-
20 ditional items and services (not described in para-
21 graph (2)) for which payment is generally made
22 under a private or public health plan.

23 (4) EXCLUSIONS.—The following items and
24 services shall not be considered to be health care

1 services and shall not be included in a class of serv-
2 ices under paragraph (1):

3 (A) Over-the-counter medications and med-
4 ical equipment and devices, not provided pursu-
5 ant to a prescription.

6 (B) Homemaker and home health aide
7 services and personal care services, and other
8 services described in section 1915(c)(4)(B), sec-
9 tion 1929(a), or section 1930(a) of the Social
10 Security Act.

11 (C) Intermediate care facility and other
12 custodial services for the mentally retarded.

13 (D) Inpatient mental health services of a
14 custodial nature.

15 (5) EXCLUSION OF INSTITUTIONAL CHARGES
16 FOR PERSONAL COMFORT AND CONVENIENCE
17 ITEMS.—Payments received (and amounts charged)
18 by a facility which are attributable to items (such as
19 private rooms, telephones, and television rentals)
20 provided for the personal comfort and convenience of
21 patients shall not be counted as receipts (nor subject
22 to limitations on amounts that may be charged) for
23 purposes of this title.

24 (b) PUBLICATION.—

1 (1) IN GENERAL.—The Secretary shall pub-
2 lish—

3 (A) by not later than April 1, 1994, pro-
4 posed regulations defining the health care serv-
5 ices and establishing the classes of services
6 under this section, and

7 (B) by not later than June 1, 1994, final
8 regulations defining the health care services and
9 establishing such classes.

10 (2) ITEMS INCLUDED IN REGULATIONS.—In
11 such regulations, the Secretary shall define—

12 (A) the class or classes to be established
13 under subsection (a)(1),

14 (B) the services to be included within each
15 class, and

16 (C) the methods and sources of data for
17 computing, for purposes of this title, aggregate
18 medicare and nonmedicare expenditures for
19 services within the class.

20 (3) CHANGES.—

21 (A) NO CHANGES AUTHORIZED.—After the
22 Secretary has established classes of services
23 under paragraph (1)(B), the Secretary may not
24 change such classes (or the services included in
25 such classes), except in the case of services not

1 previously classified. Any such services not pre-
2 viously classified shall be classified within one
3 of the classes previously established.

4 (B) RECOMMENDED CHANGES.—If the
5 Secretary determines that a change in the clas-
6 sification established under this section may be
7 appropriate, the Secretary shall submit to the
8 Congress a report proposing such change. The
9 Secretary shall include in the report an expla-
10 nation of—

11 (i) the rationale for such change, and

12 (ii) the impact of such change on the
13 total aggregate medicare and non-medicare
14 expenditures permitted for classes of serv-
15 ices that would be affected by the change.

16 (4) COMMISSION REPORTS.—

17 (A) INITIAL REPORTS.—With respect to
18 the establishment of classes of services under
19 this section, each applicable Commission (as de-
20 fined in section 2(a)(1))—

21 (i) by not later than March 1, 1994,
22 shall report its recommendations to the
23 Secretary and Congress concerning such
24 classes, and

1 (ii) by not later than May 1, 1994,
2 shall report to the Secretary and the Con-
3 gress its comments concerning the classi-
4 fication proposed by the Secretary under
5 paragraph (1)(A).

6 (B) PERIODIC REPORTS.—Each applicable
7 Commission shall periodically report to Con-
8 gress on changes in the system of classification
9 under this section that should be made to pro-
10 mote the more efficient provision of medically
11 appropriate health care services.

12 **SEC. 103. ALLOCATION OF HEALTH BUDGET BY CLASS OF**
13 **SERVICE.**

14 (a) ALLOCATION.—

15 (1) IN GENERAL.—The Secretary shall allocate
16 the medicare and nonmedicare health expenditure
17 budgets under section 101 for a year among classes
18 of services specified under section 102.

19 (2) PROPORTIONAL ALLOCATION BASED ON
20 HISTORICAL PROJECTED EXPENDITURES.—Subject
21 to section 104—

22 (A) MEDICARE HEALTH EXPENDITURE
23 BUDGET.—The percent of the medicare health
24 expenditure budget allocated to each class for a

1 year shall be equal to the quotient (expressed as
2 a percentage) of—

3 (i) the historical projected medicare
4 expenditures for the class for the year (as
5 determined under subsection (b)(1)), di-
6 vided by

7 (ii) the sum of such historical pro-
8 jected medicare expenditures for all the
9 classes for the year.

10 (B) NONMEDICARE HEALTH EXPENDITURE
11 BUDGET.—The percent of the nonmedicare
12 health expenditure budget allocated to each
13 class for a year shall be equal to the quotient
14 (expressed as a percentage) of—

15 (i) the historical projected
16 nonmedicare expenditures for the class for
17 the year (as determined under subsection
18 (b)(2)), divided by

19 (ii) the sum of such historical pro-
20 jected nonmedicare expenditures for all the
21 classes for the year.

22 (3) PUBLICATION.—

23 (A) IN GENERAL.—The Secretary shall, in
24 conjunction with the publication of budgets
25 under section 101(a)(3) for a year and by not

1 later than April 1 before the year, publish in
2 the Federal Register and report to the Congress
3 the allocation of the budgets among the classes
4 of services under this subsection.

5 (B) EXCEPTION FOR 1995.—For 1995,
6 the Secretary shall publish and report the allo-
7 cation of the budgets among the classes of
8 services under this subsection not later than
9 August 1, 1994.

10 (b) HISTORICAL PROJECTED EXPENDITURES.—

11 (1) MEDICARE.—

12 (A) DETERMINATION.—For purposes of
13 subsection (a)—

14 (i) FOR 1994.—The historical pro-
15 jected medicare expenditures for a class of
16 services for 1994 is equal to the portion of
17 the amount of aggregate medicare expendi-
18 tures during 1993 (as determined under
19 section 101(b)(1)(A)) which is attributable
20 to the class of services, multiplied by the
21 medicare trend factor (described in sub-
22 paragraph (B)) for the class for 1994.

23 (ii) SUBSEQUENT YEARS.—The histor-
24 ical projected medicare expenditures for a
25 class of services for a year after 1994 is

1 equal to the amount of the allocation for
2 the class under subsection (a)(2)(A) (tak-
3 ing into account any adjustment under sec-
4 tion 104) for the preceding year multiplied
5 by the medicare trend factor (described in
6 subparagraph (B)) for the class for the
7 year involved.

8 (B) MEDICARE TREND FACTOR.—In sub-
9 paragraph (A), subject to section 104(b)(2), the
10 “medicare trend factor”, for a class of services,
11 is 1 plus the average annual rate of increase in
12 aggregate medicare expenditures for the class of
13 services during the 5-year period ending with
14 1993.

15 (2) NONMEDICARE.—

16 (A) DETERMINATION.—For purposes of
17 subsection (a)—

18 (i) FOR 1994.—The historical pro-
19 jected nonmedicare expenditures for a class
20 of services for 1994 is equal to the portion
21 of the amount of aggregate nonmedicare
22 expenditures during 1993 (as determined
23 under section 101(b)(2)(A)) which is at-
24 tributable to the class of services, multi-
25 plied by the nonmedicare trend factor (de-

1 scribed in subparagraph (B)) for the class
2 for 1994.

3 (ii) SUBSEQUENT YEARS.—The histor-
4 ical projected nonmedicare expenditures for
5 a class of services for a year after 1994 is
6 equal to the amount of the allocation for
7 the class under subsection (a)(2)(B) (tak-
8 ing into account any adjustment under sec-
9 tion 104) for the preceding year multiplied
10 by the medicare trend factor (described in
11 subparagraph (B)) for the class for the
12 year involved.

13 (B) NONMEDICARE TREND FACTOR.—In
14 subparagraph (A), subject to section 104(b)(2),
15 the “nonmedicare trend factor”, for a class of
16 services, is 1 plus the average annual rate of in-
17 crease in aggregate nonmedicare expenditures
18 for the class of services during the 5-year pe-
19 riod ending with 1993.

20 (3) PUBLICATION OF TREND FACTORS.—The
21 Secretary shall publish, by not later than August 1,
22 1994, the medicare and nonmedicare trend factors
23 for the different classes of services.

24 (c) REVIEW AND CHANGES IN ALLOCATION.—

25 (1) IN GENERAL.—

1 (A) NO ADMINISTRATIVE AUTHORITY TO
2 CHANGE.—Except as specifically provided in
3 section 104 or by law enacted after the enact-
4 ment of this Act, the Secretary has no authority
5 to change the allocation or trend factors from
6 the allocation and trend factors provided under
7 this section.

8 (B) RECOMMENDED CHANGES.—If the
9 Secretary determines that a change in the allo-
10 cation of a budget among classes is appropriate,
11 the Secretary shall submit to the Congress a re-
12 port proposing such change. The Secretary shall
13 include in the report an explanation of—

- 14 (i) the rationale for such change, and
15 (ii) the impact of such change on the
16 total aggregate medicare and nonmedicare
17 expenditures permitted for classes of serv-
18 ices that would be affected by the change.

19 (2) COMMISSION REVIEW.—Each applicable
20 Commission shall annually review and report to Con-
21 gress, in its report submitted under section
22 102(b)(4), on the effect of the trend factors used in
23 the allocation of the budgets among classes of serv-
24 ices. Such report shall include such recommenda-
25 tions for appropriate adjustments in the trend fac-

1 tors as the applicable Commission considers appro-
2 priate to properly take into account at least—

3 (A) changes in health care technology,

4 (B) changes in the patterns and practices
5 relating to health care delivery found to be ap-
6 propriate,

7 (C) changes in the distribution of health
8 care services, and

9 (D) the special health care needs of under-
10 served rural and inner city populations.

11 **SEC. 104. ADJUSTMENTS FOR CHANGES IN MEDICARE BEN-**
12 **EFITS.**

13 (a) IN GENERAL.—With respect to a change in cov-
14 erage under the medicare program provided in title IV of
15 this Act that is effective in a year and results in an in-
16 crease in expenditures for a class of services under the
17 medicare program—

18 (1) the Secretary shall—

19 (A) increase the medicare health expendi-
20 ture budget under section 101 in the year by
21 the amount (estimated by the Secretary) of
22 such increase in expenditures, and

23 (B) decrease the nonmedicare health ex-
24 penditure budget under section 101 in the year
25 by such amount; and

1 (2) the Secretary shall—

2 (A) increase the amount allocated under
3 section 103(a) to the class of services under the
4 medicare health expenditure budget for that
5 year by such amount, and

6 (B) decrease the amount allocated under
7 section 103(a) to the class of services under the
8 nonmedicare health expenditure budget for that
9 year by such amount.

10 (b) SUBSEQUENT YEARS.—If the Secretary makes a
11 change in a budget or allocation in a particular year under
12 subsection (a) with respect to a class of services—

13 (1) the budgets and allocations for subsequent
14 years shall be computed based upon the changes
15 made in the budget or allocations for the particular
16 year, and

17 (2) the Secretary may adjust the medicare
18 trend factor (under section 103(b)(1)(B)) and
19 nonmedicare trends factor (under section
20 103(b)(2)(B)) applied to such class of services in
21 subsequent years to the extent appropriate to reflect
22 any difference between the trend factor otherwise
23 applicable for the class and the annual rate of in-
24 crease in aggregate medicare and nonmedicare ex-
25 penditures for the services affected by the change.

1 **SEC. 105. NATIONAL HEALTH EXPENDITURES REPORTING**
2 **SYSTEM.**

3 (a) IN GENERAL.—The Secretary shall establish a
4 national health expenditures reporting system (in this sec-
5 tion referred to as the “system”) for purposes of—

6 (1) establishing the national health expendi-
7 tures budget,

8 (2) allocating the health budgets among classes
9 of services,

10 (3) determining maximum payment rates,

11 (4) monitoring of State provider payment con-
12 trol systems, and

13 (5) otherwise carrying out this title.

14 (b) INFORMATION REPORTING.—

15 (1) BY PROVIDER.—Under the system, provid-
16 ers of health care services shall report (beginning
17 not later than January 1, 1995) such information
18 relating to the provision of health care services (in-
19 cluding the volume and receipts for such services) in
20 such form and manner (including the use of elec-
21 tronic transmission), by such classification, and at
22 such periodic intervals, as the Secretary shall specify
23 in regulation.

24 (2) USE OF REPORTING MECHANISMS.—To the
25 maximum extent practicable and appropriate, report-
26 ing under such system shall be done through report-

1 ing mechanisms (such as uniform hospital reports
2 provided under section 325) and using data bases
3 otherwise in use.

4 (3) USE OF SURVEYS.—The Secretary may,
5 where appropriate, provide for the collection of infor-
6 mation under the system through surveys of a sam-
7 ple of health care providers or with respect to a sam-
8 ple of information with respect to such providers.

9 (4) CONFIDENTIALITY.—Information gathered
10 pursuant to the authority provided under this sec-
11 tion shall not be disclosed in a manner that identi-
12 fies individual providers of services.

13 (5) TRANSITION.—Before January 1, 1995, for
14 purposes of this title, the Secretary may use such
15 other data collection and estimation techniques as
16 may be appropriate for purposes described in sub-
17 section (a).

18 (c) ENFORCEMENT.—If a provider of health services
19 is required, under the system under this section, to report
20 information and refuses, after being requested by the Sec-
21 retary, to provide the information required, or deliberately
22 provides information that is false, the Secretary may im-
23 pose a civil money penalty of not to exceed \$10,000 for
24 each such refusal or provision of false information. The
25 provisions of section 1128A of the Social Security Act

1 (other than subsections (a) and (b)) shall apply to civil
2 money penalties under the previous sentence in the same
3 manner as such provisions apply to a penalty or proceed-
4 ing under section 1128A(a) of such Act.

5 (d) INCLUSION OF HEALTH MAINTENANCE ORGANI-
6 ZATIONS.—In this section, the term “provider of health
7 care services” includes health maintenance organizations.

8 **Subtitle B—State Provider** 9 **Payment Control Systems**

10 **SEC. 121. STATE PROVIDER PAYMENT RATES.**

11 (a) IN GENERAL.—In the case of a State with a State
12 provider payment control system (in this subtitle referred
13 to as a “State system”) approved under this section—

14 (1) the payment rates provided under such sys-
15 tem shall apply to services covered under the system
16 and furnished in the State, and

17 (2) pursuant to section 140(a), maximum pay-
18 ment rates shall not be established or applied to
19 such services under subtitle C.

20 (b) PROCESS.—

21 (1) APPLICATION.—The Secretary may not ap-
22 prove a State system under this section unless the
23 State submits to the Secretary an application in
24 such form and manner as the Secretary may require
25 and containing the information and assurance re-

1 quired under this subtitle, together with any other
2 information and assurance as the Secretary may re-
3 quire.

4 (2) RESPONSE.—The Secretary shall be deemed
5 to have approved the application of a State under
6 paragraph (1) for a State system unless the Sec-
7 retary, within 90 days after the date the State sub-
8 mits the application to the Secretary, either denies
9 such application in writing or informs the State in
10 writing with respect to any additional information or
11 assurances needed to make a final determination
12 with respect to the application. After the date the
13 Secretary receives such additional information and
14 assurances, the application shall be deemed to be ap-
15 proved unless the Secretary, within 90 days of such
16 date, denies the application.

17 (3) DEEMED APPROVAL OF CERTAIN SYS-
18 TEMS.—

19 (A) IN GENERAL.—In the case of a hos-
20 pital reimbursement control system approved
21 under section 1886(c)(4) of the Social Security
22 Act or described in section 1814(b)(3) of such
23 Act and used for payment of hospital services
24 in the State under the medicare program, the
25 system is deemed to be a State system approved

1 under this section with respect to payment for
2 hospital services.

3 (B) TERMINATION.—Insofar as subpara-
4 graph (A) applies to a State system, the con-
5 tinuation of the approval of the system is condi-
6 tioned upon the system’s compliance with the
7 requirements of section 123(a).

8 (4) EFFECT OF APPROVAL.—The approval of a
9 State system under this section shall be deemed to
10 constitute the approval by the Secretary of a waiver
11 of such requirements relating to the determination
12 of payment amounts under the medicare and medic-
13 aid programs as may be necessary to implement
14 such system.

15 (c) CONDITIONS FOR APPROVAL.—

16 (1) IN GENERAL.—The Secretary shall approve
17 the application of a State with respect to a State
18 system only if the Secretary determines that the
19 conditions for approval described in sections 122 and
20 123 are met.

21 (2) LIMITATION ON DISAPPROVAL.—The Sec-
22 retary cannot deny the application of a State for a
23 State system on the ground that the methodology
24 used under the system to control payments for inpa-
25 tient hospital services is based on a payment meth-

1 odology other than on the basis of a diagnosis-
2 related group.

3 (d) TERMINATION OF APPROVAL.—The Secretary
4 shall terminate approval of a State system in accordance
5 with section 125 if—

6 (1) the Secretary determines that the system no
7 longer meets the requirements of section 122(b)(1)
8 (relating to all payors), section 122(b)(3)(B) (relat-
9 ing to limitation on differentials for medicaid serv-
10 ices), or section 122(e) (relating to certain require-
11 ments for hospitals); or

12 (2) the Secretary has reason to believe that the
13 assurances described in any of the following sections
14 are not being (or will not be) met:

15 (A) Section 122(b)(2) (relating to equi-
16 table treatment of all payors).

17 (B) Section 122(f) (relating to special re-
18 quirements for hospital admissions and exclu-
19 sions).

20 (C) Section 123 (relating to limiting aggre-
21 gate expenditures).

22 **SEC. 122. GENERAL CONDITIONS FOR STATE PROVIDER**
23 **PAYMENT CONTROL SYSTEMS.**

24 (a) APPLICATION TO CLASSES OF SERVICES.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 the system applies to—

3 (A) inpatient hospital services (including
4 services of exempt hospitals (as defined in sec-
5 tion 151(f)(2)) statewide;

6 (B) inpatient and outpatient hospital serv-
7 ices (including services of exempt hospitals (as
8 so defined) statewide;

9 (C) physicians services statewide; or

10 (D) such inpatient and outpatient hospital
11 services and physicians services statewide.

12 (2) ADDITIONAL CLASSES.—The system may
13 apply to services in a class of services in addition to
14 services described in paragraph (1) only if the sys-
15 tem applies to all services within such class of serv-
16 ices.

17 (b) APPLICATION TO ALL PAYORS; EQUITABLE
18 TREATMENT.—

19 (1) APPLICATION TO ALL PAYORS.—The system
20 applies to substantially all payors (including the
21 medicare program and the medicaid program in the
22 State) for services to which the system applies.

23 (2) EQUITABLE TREATMENT.—The Secretary
24 has been provided satisfactory assurances as to the
25 equitable treatment of all payors (including the med-

1 icare and medicaid programs and other Federal and
2 State programs) under the system.

3 (3) PAYMENT RATE DIFFERENTIALS PER-
4 MITTED.—

5 (A) IN GENERAL.—Subject to subpara-
6 graph (B), a State may provide for payment
7 rates for services furnished under the medicaid
8 program that are different from the payment
9 rates for services for which payment is made by
10 other payors.

11 (B) LIMITATION ON DIFFERENTIALS FOR
12 SERVICES UNDER MEDICAID.—The ratio of the
13 average rate of payment for services under the
14 medicaid program to such average rate of pay-
15 ment for the same services by health benefit
16 plans (other than the medicare and medicaid
17 programs) may not be less than the ratio of the
18 average of the rates of payment within the class
19 of services for which payment is provided under
20 the medicaid program to such average rate of
21 payment under other health benefit plans (other
22 than the medicare and medicaid programs) dur-
23 ing the most recent year before the implementa-
24 tion of the State system, as determined by the
25 Secretary.

1 (4) SEPARATE RATE NEGOTIATIONS PERMITTED
2 FOR HEALTH MAINTENANCE ORGANIZATIONS.—A
3 State may provide that a health maintenance organi-
4 zation (as defined in section 2(b)) may negotiate di-
5 rectly with providers of services covered under the
6 system with respect to the organization's rate of
7 payment for such services.

8 (5) MINIMUM PAYMENT RATES.—Under the
9 State system, the State may provide that the
10 amount of payment for any service within a class of
11 services under the system may not be less than a
12 minimum payment rate established by the State for
13 the services.

14 (c) OPERATION.—The system is operated directly by
15 the State or by a State agency or other public authority.

16 (d) REPORTS REQUIRED.—Providers of services cov-
17 ered under the system must make such reports as the Sec-
18 retary may require in order to monitor assurances pro-
19 vided under section 123 and make determinations under
20 section 124.

21 (e) ASSURANCES OF CONTINUED ACCESS.—The
22 State must provide the Secretary with satisfactory assur-
23 ances that operation of the system will not result in any
24 change in hospital admission practices or the provision of
25 other services which result in—

1 (1) a significant reduction in the proportion of
2 patients (receiving services covered under the sys-
3 tem) who have no third-party coverage and who are
4 unable to pay for such services,

5 (2) a significant reduction in the proportion of
6 individuals provided services for which payment is
7 (or is likely to be) less than the anticipated charges
8 or costs of such services, or

9 (3) the refusal to provide services to individuals
10 who would be expected to require unusually costly or
11 prolonged treatment for reasons other than those re-
12 lated to the appropriateness of the care available
13 from the provider.

14 (f) SPECIAL REQUIREMENTS FOR HOSPITAL ADMIS-
15 SIONS AND EXCLUSIONS.—If the system applies to pay-
16 ment for hospital services, the system requires hospitals
17 to which the system applies to meet the requirement of
18 section 1866(a)(1)(G) of the Social Security Act with re-
19 spect to the medicare program and the system provides
20 for the exclusion of certain costs in accordance with sec-
21 tion 1862(a)(14) of such Act (except for such waivers
22 thereof as the Secretary provides by regulation).

23 **SEC. 123. CONTROL OF AGGREGATE EXPENDITURES RE-**
24 **QUIREMENT FOR STATE SYSTEMS.**

25 (a) ASSURANCES REQUIRED.—

1 (1) IN GENERAL.—A State system may not be
2 approved until the Secretary has been provided sat-
3 isfactory assurances that under the system, during a
4 3-year period (the first such period beginning with
5 the first month in which this section applies to that
6 system in the State)—

7 (A) the sum of the aggregate medicare and
8 nonmedicare expenditures (as defined in section
9 101(d)) for the class (or classes) of services
10 covered under the system will not exceed the
11 applicable total limit specified in paragraph (2);
12 and

13 (B) the aggregate medicare expenditures
14 for such class (or classes) under the system will
15 not exceed the applicable medicare limit speci-
16 fied in paragraph (3).

17 (2) APPLICABLE TOTAL LIMIT.—The applicable
18 total limit specified in this paragraph is the total of
19 the maximum amount of payments that would be
20 payable in the State for the covered class (or class-
21 es) of services if the State system were not in effect.

22 (3) APPLICABLE MEDICARE LIMIT.—The appli-
23 cable medicare limit specified in this paragraph is
24 the total of the maximum amount of payments that
25 would be payable in the State for the covered class

1 (or classes) of services under the medicare program
2 if the State system were not in effect.

3 (4) SPECIAL RULE FOR EXPENDITURES FOR
4 HMOS.—In determining aggregate expenditures for
5 purposes of subparagraphs (A) and (B) of para-
6 graph (1), the Secretary shall exclude expenditures
7 for services of staff or group model health mainte-
8 nance organizations if the State system provides
9 that such organizations may negotiate directly with
10 providers of services covered under the system with
11 respect to the organization's rate of payment for
12 such services and, in determining the applicable lim-
13 its under paragraphs (2) and (3), the Secretary shall
14 exclude payments for services of such organizations.

15 (b) ANNUAL DETERMINATION BY SECRETARY.—

16 (1) IN GENERAL.—The Secretary shall annually
17 determine whether a State system met the assur-
18 ances required under subsection (a) for the most re-
19 cent 3-year period for which the State system was
20 in effect.

21 (2) AGGREGATION.—The Secretary may not de-
22 termine under paragraph (1) that—

23 (A) aggregate medicare and nonmedicare
24 expenditures under a State system exceeded the
25 applicable total limit for a 3-year period unless

1 the Secretary determines that, for all classes of
2 services covered under the system, aggregate
3 medicare and nonmedicare expenditures in the
4 State exceeded such limit for all such classes,
5 and

6 (B) aggregate medicare expenditures under
7 a State system exceeded the applicable medicare
8 limit for a 3-year period unless the Secretary
9 determines that, for all classes of services cov-
10 ered under the system, aggregate medicare ex-
11 penditures in the State exceeded the applicable
12 medicare limit for all such classes.

13 (c) USE OF MEDICARE SAVINGS.—

14 (1) IN GENERAL.—If the Secretary determines
15 that a State system under this subtitle has resulted
16 in medicare savings over a period of 3 consecutive
17 years, in the 4th year there shall be paid to the
18 State an amount equal to the medicare savings in
19 the first year of such 3-year period. Such payments
20 shall be made from the Federal Hospital Insurance
21 Trust Fund or the Federal Supplementary Medical
22 Insurance Trust Fund in such amounts as reflects
23 the medicare savings attributable to the respective
24 Trust Fund in such first year.

25 (2) DEFINITIONS.—In this subsection:

1 (A) The term “medicare spending” means,
2 with respect to a State in a year, aggregate
3 medicare expenditures incurred under the medi-
4 care program in the State in the year.

5 (B) The term “baseline medicare spend-
6 ing” means, with respect to a State in a year,
7 the amount of aggregate medicare expenditures
8 that the Secretary estimates would have been
9 incurred under the medicare program in the
10 State in the year if this subtitle did not apply
11 in the State.

12 (C) The term “medicare savings” means,
13 with respect to a State in a year, the amount
14 by which the baseline medicare spending for the
15 State in the year exceeds the medicare spending
16 for the State in the year.

17 **SEC. 124. TREATMENT OF STATES FAILING TO CONTROL**
18 **AGGREGATE EXPENDITURES**

19 (a) IN GENERAL.—The Secretary shall terminate the
20 State system (in accordance with section 125) or impose
21 a sanction described in subsection (b) on a State if the
22 Secretary determines that, with respect to a State system
23 under this subtitle for a 3-year period—

24 (1) the aggregate medicare and nonmedicare
25 expenditures (as defined in section 101(d)) for the

1 class (or classes) of services covered under the sys-
2 tem exceeded the applicable total limit specified in
3 section 123(a)(2); or

4 (2) the aggregate medicare expenditures for the
5 class (or classes) of services covered under the sys-
6 tem exceeded the applicable medicare limit specified
7 in section 123(a)(3).

8 (b) SANCTIONS.—The sanctions described in this
9 subsection are as follows:

10 (1) In the case of a determination under sub-
11 section (a)(1), a reduction in the aggregate
12 nonmedicare expenditures otherwise applicable for
13 the class (or classes) of services covered under the
14 system for the following year (or for the following 3-
15 year period, if the Secretary determines that a re-
16 duction for such period is appropriate in the case of
17 a State) in an amount equal to—

18 (A) the amount by which the aggregate
19 medicare and nonmedicare expenditures for the
20 class (or classes) for the preceding 3-year pe-
21 riod exceeded the applicable total limit, less

22 (B) the amount of any reduction under
23 paragraph (2).

24 (2) In the case of a determination under sub-
25 section (a)(2), a reduction in the aggregate medicare

1 expenditures otherwise applicable for the class (or
2 classes) of services covered under the system for the
3 following year (or for the following 3-year period, if
4 the Secretary determines that a reduction for such
5 period is appropriate in the case of a State) in an
6 amount equal to the amount by which the aggregate
7 medicare expenditures for the class (or classes) for
8 the preceding 3-year period exceeded the applicable
9 medicare limit.

10 (c) NOTICE.—The Secretary may not impose any
11 sanction against a State under subsection (b) unless the
12 Secretary has provided the State with notice of the Sec-
13 retary’s determination under subsection (a) and intent to
14 impose the sanction under subsection (b).

15 **SEC. 125. TERMINATION OF APPROVAL OF STATE SYSTEM.**

16 (a) PROCESS REQUIREMENTS.—

17 (1) NOTICE.—The Secretary may terminate the
18 approval of a State system under this subtitle only
19 after the expiration of a 90-day period beginning on
20 the date the Secretary informs the State of the Sec-
21 retary’s intention to terminate such approval, unless,
22 during such 90-day period, the State requests a
23 hearing with the Secretary.

24 (2) HEARING.—If the State requests a hearing
25 during the 90-day period described in paragraph (1),

1 the Secretary shall conduct a hearing during which
2 the State may present evidence showing that the
3 Secretary should not terminate the approval of its
4 system. If the Secretary decides to reject such evi-
5 dence, the Secretary shall terminate the approval of
6 the State's system beginning with the first day of
7 the first month that begins after the Secretary's de-
8 cision.

9 (3) JUDICIAL REVIEW PROHIBITED.—There
10 shall be no administrative or judicial review of a de-
11 cision by the Secretary to terminate the approval of
12 a State system under this subsection.

13 (b) EFFECT OF TERMINATION ON PAYMENT RATES
14 APPLICABLE TO SERVICES IN STATE.—

15 (1) IN GENERAL.—If the Secretary terminates
16 the approval of a State system under this section,
17 the maximum payment rates applicable to services
18 within the class (or classes) of services covered
19 under the State system shall be the maximum pay-
20 ment rates otherwise applicable to services within
21 the class (or classes) under subtitle C, subject to the
22 adjustment described in paragraph (2).

23 (2) RECAPTURE OF EXCESS SPENDING.—

24 (A) MEDICARE.—The Secretary shall mod-
25 ify the percentage payment adjustment applied

1 under section 161 to services within the class
2 (or classes) of services that were covered under
3 a State system for which approval was termi-
4 nated under this section by such factor as the
5 Secretary determines necessary to decrease the
6 amount of aggregate medicare expenditures
7 that would otherwise be made for services pro-
8 vided in the State by the amount by which ag-
9 gregate medicare expenditures for such class
10 (or classes) of services exceeded the applicable
11 medicare limit specified in section 123(a)(3) for
12 the preceding year.

13 (B) NONMEDICARE.—The Secretary shall
14 reduce the maximum payment rates applicable
15 under part 1 of subtitle C to services within the
16 class (or classes) of services that were covered
17 under a State system for which approval was
18 terminated under this section by such factor as
19 the Secretary determines necessary to decrease
20 the amount of aggregate nonmedicare expendi-
21 tures that would otherwise be made for services
22 provided in the State by—

23 (i) the amount by which aggregate
24 medicare and nonmedicare expenditures
25 for such class (or classes) of services ex-

1 ceeded the applicable total limit specified
2 in section 123(a)(2) for the preceding year,
3 less

4 (ii) the amount of any decrease in ag-
5 gregate medicare expenditures in the State
6 provided under subparagraph (A).

7 **Subtitle C—Maximum Payment**
8 **Rates for Services Not Subject**
9 **to State Provider Payment Con-**
10 **trol Systems or Provided by**
11 **Staff or Group Model Health**
12 **Maintenance Organizations**

13 **SEC. 140. EXEMPTION FOR SERVICES SUBJECT TO AP-**
14 **PROVED STATE PROVIDER PAYMENT CON-**
15 **TROL SYSTEMS OR PROVIDED BY STAFF OR**
16 **GROUP MODEL HEALTH MAINTENANCE OR-**
17 **GANIZATIONS.**

18 (a) APPROVED STATE PROVIDER PAYMENT CON-
19 TROL SYSTEMS.—In the case of services furnished in a
20 State and to which the State provider payment control
21 system (approved by the Secretary under section 121) ap-
22 plies—

23 (1) the Secretary shall not propose, establish,
24 or apply maximum payment rates to such services
25 under part 1 of this subtitle, and

1 (2) the adjustments on payments rates for such
2 services made under the medicare program under
3 section 161 shall not apply.

4 (b) SERVICES PROVIDED BY STAFF OR GROUP
5 MODEL HEALTH MAINTENANCE ORGANIZATIONS.—

6 (1) IN GENERAL.—Subject to paragraph (2),
7 the maximum payment rates established under part
8 1 shall not apply to charges or payments for services
9 furnished to individuals who are enrolled in a staff
10 or group model health maintenance organization (as
11 defined in section 2(b)(2)) with respect to health
12 care services covered under the subscriber agree-
13 ment.

14 (2) CONTINUED APPLICATION TO OUT-OF-AREA
15 COVERAGE AND EMERGENCY SERVICES.—Paragraph
16 (1) shall not apply to services described in section
17 1876(c)(4)(B) of the Social Security Act.

18 (3) INDIRECT APPLICATION UNDER MEDICARE
19 PROGRAM.—Nothing in this subsection shall be con-
20 strued as affecting the payment of amounts to
21 health maintenance organizations under the medi-
22 care program under a risk-sharing contract under
23 section 1876 of the Social Security Act. However,
24 adjustments in payment rates under section 161

1 may affect the computation of the average adjusted
2 per capita cost under such section.

3 PART 1—ESTABLISHMENT AND APPLICATION OF MAXI-
4 MUM PAYMENT RATES (OTHER THAN UNDER MEDI-
5 CARE PROGRAM)

6 **SEC. 141. PROCESS.**

7 (a) PUBLICATION OF RATES.—Subject to section
8 140, the Secretary shall cause to have published in the
9 Federal Register—

10 (1) not later than April 1 of each year (or not
11 later than September 1, 1994, in the case of rates
12 for 1995), proposed maximum payment rates under
13 this subtitle for the following year for public com-
14 ment, and

15 (2) during the last 15 days of October of each
16 year (or not later than December 1, 1994, in the
17 case of rates for 1995), after such consideration of
18 public comment on the proposed rates, the maximum
19 payment rates under this subtitle for the following
20 year.

21 (b) ITEMS INCLUDED IN PUBLICATIONS.—The Sec-
22 retary shall include in the publications referred to in sub-
23 section (a)—

1 (1) a description of the payment methodology
2 used in the establishment of maximum payment
3 rates; and

4 (2) in the case of a publication under sub-
5 section (a)(2), the extent that the rates differ from
6 the applicable Commission's recommendations under
7 subsection (c), an explanation of the Secretary's
8 grounds for not following such recommendations.

9 (c) REPORTS OF COMMISSIONS.—With respect to the
10 establishment of maximum payment rates for services
11 under this subtitle, the applicable Commission, not later
12 than June 1 of each year, shall report its recommenda-
13 tions to the Secretary and Congress concerning such rates
14 for the following year. Each such report may include such
15 other recommendations relating to the operation of this
16 subtitle as the Commission considers appropriate.

17 (d) PAYMENT RATE DEFINED.—In this subtitle, the
18 term “payment rate” means, with respect to health care
19 services for which amounts are payable under a plan or
20 program, the rate of payment provided for under the plan
21 or program and including cost-sharing (including
22 deductibles, coinsurance, and extra billing amounts) appli-
23 cable under the plan or program with respect to the serv-
24 ices.

1 **SEC. 142. PAYMENT METHODOLOGY; RELATION TO BUDGET**

2 **ALLOCATION.**

3 (a) PAYMENT METHODOLOGY.—

4 (1) IN GENERAL.—The Secretary shall establish
5 maximum payment rates under this subtitle consist-
6 ent with the payment rate methodology specified
7 under part 2.

8 (2) TREATMENT OF SERVICES WITHIN A
9 CLASS.—Nothing in this title shall be construed as
10 requiring that maximum payment rates established
11 under this subtitle for different health care services
12 within a class of services be the same or determined
13 under the same methodology.

14 (b) RELATION TO OVERALL LIMIT ON EXPENDI-
15 TURES FOR CLASSES OF SERVICES.—

16 (1) IN GENERAL.—The maximum payment
17 rates for a year shall be established under this sub-
18 title in a manner so that, as applied under section
19 143—

20 (A) the aggregate nonmedicare expendi-
21 tures for all the services within each class sub-
22 ject to such rates, is equal to

23 (B) the allocation to the class for the year
24 under section 102 with respect to the
25 nonmedicare health expenditure budget (less

1 the amount of the reduction in the allocation
2 provided under paragraph (2)).

3 (2) REMOVAL OF PORTION OF ALLOCATION AT-
4 TRIBUTABLE TO STATE PROVIDER PAYMENT CON-
5 TROL SYSTEMS OR STAFF OR GROUP MODEL
6 HEALTH MAINTENANCE ORGANIZATIONS.—For pur-
7 poses of paragraph (1)(B), the allocation to a class
8 of services for a year shall be reduced by the product
9 of—

10 (A) such allocation, and

11 (B) the proportion of such allocation that
12 the Secretary estimates is attributable to serv-
13 ices exempt under section 140 from the estab-
14 lishment or application of maximum payment
15 rates under this part.

16 **SEC. 143. GENERAL APPLICATION AND ENFORCEMENT OF**
17 **MAXIMUM PAYMENT RATES.**

18 (a) LIMITS ON CHARGES.—Subject to section 140—

19 (1) IN GENERAL.—In the case of a provider
20 that provides health care services to an individual
21 for which a maximum payment rate is established
22 under this subtitle—

23 (A) the provider may not charge (i) an
24 amount in excess of such rate or (ii) on a pay-

1 ment basis other than the payment basis estab-
2 lished for such services under part 2;

3 (B) the provider may not collect for such
4 services an amount in excess of such rate; and

5 (C) the individual and other entities, in-
6 cluding a health benefit plan, are not liable col-
7 lectively for payment of any amount that ex-
8 ceeds such rate.

9 (2) RELATION TO MEDICARE PROGRAM.—This
10 subsection shall not apply to services furnished to an
11 individual who is entitled to benefits with respect to
12 such services under the medicare program.

13 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
14 ALTIES.—

15 (1) IMPROPER CHARGES.—If a provider im-
16 poses a charge in violation of subsection (a)(1)(A),
17 the provider is subject to civil money penalty in an
18 amount not to exceed \$100 for each such charge.

19 (2) IMPROPER COLLECTION.—If a provider col-
20 lects excess amounts in violation of subsection
21 (a)(1)(B) and does not refund such excess amounts
22 within 30 days of date on which the provider is noti-
23 fied that the provider collected excess amount, the
24 provider is subject to a civil money penalty in an
25 amount equal to three times the amount of such ex-

1 cess which has not been so refunded or, if greater,
2 \$500.

3 (3) PROCESS.—The provisions of section 1128A
4 of the Social Security Act (other subsections (a) and
5 (b)) shall apply to a civil money penalty under this
6 subsection in the same manner as such provisions
7 apply to a penalty or proceeding under section
8 1128A(a) of such Act.

9 (4) DEPOSIT OF PENALTIES IN ANTI-FRAUD
10 AND ABUSE TRUST FUND.—Any civil money pen-
11 alties collected under this subsection shall be paid
12 into the Anti-Fraud and Abuse Trust Fund estab-
13 lished under section 341(b).

14 **SEC. 144. LIMITATION ON PAYMENT RATES UNDER MEDIC-**
15 **AID.**

16 (a) IN GENERAL.—Subject to subsection (b), not-
17 withstanding any other provision of law, payment may not
18 be made under section 1903(a)(1) of the Social Security
19 Act to a State for amounts expended as medical assistance
20 for health care services for which maximum payment rates
21 are established under this part, to the extent that the rate
22 of payment for such services exceeds the maximum pay-
23 ment rate so established.

24 (b) APPLICATION OF MEDICAID PAYMENT
25 FLOORS.—Subsection (a) shall not apply to the extent

1 payment rates do not exceed the applicable minimum pay-
2 ment rates required to be provided under section 401 or
3 under section 1902(a)(13)(G) of the Social Security Act.

4 **PART 2—METHODOLOGIES FOR DETERMINING MAXI-**
5 **MUM RATES (OTHER THAN UNDER MEDICARE PRO-**
6 **GRAM)**

7 **SEC. 151. BASIS FOR MAXIMUM RATES OF PAYMENT FOR**
8 **INPATIENT HOSPITAL SERVICES.**

9 (a) IN GENERAL.—

10 (1) IN GENERAL.—Subject to additions under
11 subsection (d) and to other adjustments under sub-
12 section (e), the maximum payment rate established
13 under this subtitle for a service within the class of
14 services consisting of inpatient hospital services that
15 is provided by a hospital (as defined in paragraph
16 (2)) during a year shall be equal to the product of—

17 (A) the standardized amount applicable to
18 the hospital, as established in accordance with
19 subsection (b); and

20 (B) the weighting factor assigned to the
21 service (as determined in accordance with sub-
22 section (c)).

23 (2) HOSPITAL DEFINED.—In this section, the
24 term “hospital” does not include an exempt hospital
25 (as defined in subsection (f)).

1 (b) ESTABLISHMENT OF STANDARDIZED
2 AMOUNTS.—

3 (1) IN GENERAL.—The Secretary shall establish
4 a standardized amount under subsection (a) for hos-
5 pitals located in a large urban area and for other
6 hospitals for a year by standardizing the hospital’s
7 average cost per discharge (based on the hospital’s
8 allowed operating receipts, as determined under
9 paragraph (2)) in accordance with paragraph (3).
10 For purposes of the preceding sentence, a hospital is
11 located in a “large urban area” if the hospital is
12 treated as being located in a large urban area under
13 section 1886(d) of the Social Security Act for pur-
14 poses of the medicare program.

15 (2) ALLOWED OPERATING RECEIPTS DE-
16 FINED.—

17 (A) IN GENERAL.—For purposes of para-
18 graph (1) and except as provided in subpara-
19 graph (B), a hospital’s “allowed operating re-
20 cepts” means the total of all receipts of the
21 hospital (without regard to the source) attrib-
22 utable to routine operating costs, ancillary serv-
23 ice operating costs, and special care unit oper-
24 ating costs with respect to inpatient hospital
25 services, as determined on an average per ad-

1 mission or per discharge basis (as determined
2 by the Secretary), during 1993, increased by
3 the Secretary's estimate of the percentage in-
4 crease in such receipts between the midpoint of
5 1993 and the midpoint of 1994.

6 (B) EXCLUSIONS.—In determining a hos-
7 pital's allowed operating receipts under sub-
8 paragraph (A), the Secretary shall exclude the
9 following:

10 (i) Receipts attributable to services
11 for which payment was made to the hos-
12 pital under the medicare program.

13 (ii) The value of the costs of services
14 which are treated as bad debt or charity
15 care (as defined by the Secretary) for pur-
16 poses of the hospital's cost reports.

17 (iii) The value of the costs of services
18 furnished under the medicaid program
19 which are in excess of the payment re-
20 ceived from such program by the hospital.

21 (C) CERTAIN OUTPATIENT RECEIPTS IN-
22 CLUDED.—In determining a hospital's allowed
23 operating receipts under subparagraph (A), the
24 Secretary shall include all receipts attributable
25 to services that are provided by the hospital (or

1 by an entity wholly owned or operated by the
2 hospital) to a patient during the 3 days imme-
3 diately preceding the date of the patient's ad-
4 mission if such services are diagnostic services
5 (including clinical diagnostic laboratory tests)
6 or are other services related to the admission
7 (as defined by the Secretary).

8 (3) PROCESS FOR STANDARDIZING AMOUNTS.—
9 The Secretary shall standardize the average per dis-
10 charge amount for each hospital for a year by—

11 (A) adjusting for variations among hos-
12 pitals by area in the average hospital wage
13 level, using the area wage level applied for hos-
14 pitals under the medicare program under sec-
15 tion 1886(d)(3)(E) of the Social Security Act;

16 (B) adjusting for variations in case mix
17 among hospitals;

18 (C) excluding an estimate of the additional
19 payments to be made for outliers, using the
20 amounts paid to hospitals for outliers under the
21 medicare program under section 1886(d)(5)(A)
22 of such Act (except that the Secretary may
23 apply different amounts if the Secretary finds
24 that such different amounts more accurately re-

1 flect outliers for services furnished to individ-
2 uals who are not medicare beneficiaries);

3 (D) adjusting for variations among hos-
4 pitals by area in input prices other than wages
5 and wage-related costs;

6 (E) excluding an estimate of indirect medi-
7 cal education costs, using the indirect medical
8 education adjustment applied for hospitals
9 under the medicare program under section
10 1886(d)(5)(B) of such Act;

11 (F) excluding an estimate of direct grad-
12 uate medical education costs; and

13 (G) excluding an estimate of capital-related
14 costs.

15 (c) ESTABLISHMENT OF DIAGNOSIS-RELATED
16 GROUPS AND WEIGHTING FACTORS.—

17 (1) IN GENERAL.—

18 (A) DIAGNOSIS-RELATED GROUPS.—For
19 purposes of this section, the Secretary shall es-
20 tablish a classification of inpatient hospital dis-
21 charges by diagnosis-related groups and a
22 methodology for classifying specific hospital dis-
23 charges within these groups.

24 (B) WEIGHTING FACTORS.—For each di-
25 agnosis-related group established under sub-

1 paragraph (A), the Secretary shall assign an
2 appropriate weighting factor which reflects the
3 relative hospital resources used with respect to
4 discharges classified within that group com-
5 pared to discharges classified within other
6 groups.

7 (C) USE OF MEDICARE GROUPS AND FAC-
8 TORS.—In establishing diagnosis-related groups
9 and assigning weighting factors for such groups
10 under this paragraph, the Secretary shall use
11 the diagnosis-related groups and weighting fac-
12 tors used under the medicare program under
13 section 1886(d)(4) of the Social Security Act,
14 except to the extent that the Secretary must es-
15 tablish diagnosis-related groups in addition to
16 the groups under such program, or adjust such
17 weighting factors, to take into account the ap-
18 plication of payment rates under this section to
19 inpatient hospital services furnished to individ-
20 uals who are not medicare beneficiaries.

21 (2) STANDARD BENEFIT PACKAGE.—The diag-
22 nosis-related groups and the weighting factors as-
23 signed to such groups shall be based upon a stand-
24 ard benefit package consisting of the standard inpa-
25 tient hospital services provided under health benefit

1 plans (other than the medicare program and the
2 medicaid program), as determined by the Secretary
3 on the basis of a survey of such plans.

4 (3) ADJUSTMENT FOR VARIATIONS FROM
5 STANDARD BENEFIT PACKAGE.—The Secretary shall
6 establish a table of adjustment factors to adjust the
7 weighting factors to reflect the actuarial differences
8 between the value of the coverage under the stand-
9 ard benefit package described in paragraph (2) and
10 the value of the services provided under health bene-
11 fit plans that vary from the services provided under
12 the standard benefit package.

13 (d) INCREASES TO MAXIMUM PAYMENT RATES.—

14 (1) COSTS OF DIRECT GRADUATE MEDICAL
15 EDUCATION.—In the case of a hospital that has in-
16 curred costs for direct graduate medical education
17 during a year, the Secretary shall increase the maxi-
18 mum payment rate otherwise applicable under this
19 section to inpatient services furnished by the hos-
20 pital, consistent with the methodology used to make
21 payments to hospitals under the medicare program
22 for such costs under section 1886(h) of the Social
23 Security Act.

24 (2) ADJUSTMENT FOR INDIRECT MEDICAL EDU-
25 CATION.—The Secretary shall increase the maximum

1 payment rate otherwise applicable under this section
2 for a hospital for to take into account indirect costs
3 of medical education incurred by a hospital, in ac-
4 cordance with the methodology used to adjust pay-
5 ments to hospitals under the medicare program for
6 such costs under section 1886(d)(5)(B) of the Social
7 Security Act.

8 (3) ADJUSTMENT FOR OUTLIERS.—The Sec-
9 retary shall increase the maximum payment rate
10 otherwise applicable under this section for a hos-
11 pital—

12 (A) for length of stay outliers for dis-
13 charges in a diagnosis-related group (as deter-
14 mined by the Secretary in accordance with the
15 criteria used to adjust payments to hospitals
16 under the medicare program for such outliers
17 under section 1886(d)(5)(A)(i) of the Social Se-
18 curity Act); and

19 (B) for cost outliers for any discharges in
20 a diagnosis-related group (as determined by the
21 Secretary in accordance with the criteria used
22 to adjust payments to hospitals under the medi-
23 care program for such outliers under section
24 1886(d)(5)(A)(ii) of the Social Security Act).

1 (4) UNCOMPENSATED CARE ADJUSTMENT.—

2 The Secretary shall increase the maximum payment
3 rate otherwise applicable under this section for a
4 hospital to take into account the costs incurred by
5 a hospital in providing services described in clause
6 (ii) or (iii) of subsection (b)(2)(B).

7 (e) OTHER ADJUSTMENTS.—

8 (1) NEEDS OF CERTAIN FACILITIES.—The Sec-
9 retary may adjust the maximum payment rates oth-
10 erwise determined under this section in such manner
11 and to such extent as the Secretary considers appro-
12 priate to take into account the needs of—

13 (A) regional and national referral centers
14 described in section 1886(d)(5)(C) of the Social
15 Security Act;

16 (B) sole community hospitals described in
17 section 1886(d)(5)(D) of such Act; and

18 (C) essential access hospitals designated by
19 the Secretary under section 1820(i)(1) of such
20 Act.

21 (2) PAYMENTS FOR TRANSFERRED PA-
22 TIENTS.—The Secretary shall provide for an adjust-
23 ment to the maximum payment rates under this sec-
24 tion to take into account inpatient hospital services
25 provided to patients transferred to (or from) the

1 hospital, in accordance with the standards used to
2 determine such adjustments under the medicare pro-
3 gram.

4 (3) PAYMENTS FOR CAPITAL.—Payments to
5 hospitals for capital and capital-related costs shall
6 be determined in the same manner as payments for
7 capital and capital-related costs are made under sec-
8 tion 1886(g) of the Social Security Act, adjusted to
9 take into account the portion of such costs for which
10 the hospital receives payment from health benefit
11 plans (other than the medicare and medicaid pro-
12 grams).

13 (f) MAXIMUM PAYMENT RATES FOR EXEMPT HOS-
14 PITALS.—

15 (1) HOSPITAL-SPECIFIC, PER ADMISSION
16 AMOUNT.—In the case of an exempt hospital (as de-
17 fined in paragraph (2)), the maximum payment rate
18 for inpatient hospital services provided by the hos-
19 pital shall be determined on a per admission basis,
20 based on the allowable operating receipts of the hos-
21 pital (determined in the same manner as such re-
22 cepts are determined for other hospitals under sub-
23 section (b)).

24 (2) EXEMPT HOSPITAL.—The term “exempt
25 hospital” means—

1 (A) a psychiatric hospital (as defined in
2 section 1861(f) of the Social Security Act), in-
3 cluding a psychiatric unit of a hospital which is
4 a distinct part of the hospital (as defined by the
5 Secretary);

6 (B) a rehabilitation hospital (as defined by
7 the Secretary), including a rehabilitation unit of
8 a hospital which is a distinct part of the hos-
9 pital (as defined by the Secretary);

10 (C) a hospital whose inpatients are pre-
11 dominantly individuals under 18 years of age;

12 (D) a hospital which has an average inpa-
13 tient length of stay (as determined by the Sec-
14 retary) of greater than 25 days; or

15 (E) a hospital that the Secretary has clas-
16 sified, at any time on or before December 31,
17 1992, for purposes of applying exceptions and
18 adjustments to payment amounts under section
19 1886(d) of such Act, as a hospital involved ex-
20 tensively in treatment for or research on cancer.

21 **SEC. 152. BASIS FOR MAXIMUM PAYMENT RATE FOR CLASS**
22 **OF PHYSICIANS' SERVICES AND OTHER PRO-**
23 **FESSIONAL MEDICAL SERVICES.**

24 (a) USE OF RELATIVE VALUE FEE SCHEDULE.—

1 (1) IN GENERAL.—Subject to subsection (b),
2 the maximum payment rates established under this
3 subtitle for a service within the class of services con-
4 sisting of physicians' services and other professional
5 medical services during a year shall be equal to the
6 product of—

7 (A) the relative value for the service ap-
8 plied under section 1848(b) of the Social Secu-
9 rity Act;

10 (B) an applicable conversion factor (deter-
11 mined by the Secretary in an amount consistent
12 with the requirements of section 142(b)); and

13 (C) the geographic adjustment factor ap-
14 plied under section 1848(b) of the Social Secu-
15 rity Act.

16 (b) NEW PROCEDURE CODES AND RELATIVE VALUE
17 UNITS.—In applying subsection (a) in the case of services
18 for which relative value units have not been established
19 under section 1848 of the Social Security Act, the Sec-
20 retary shall establish relative value units in the same man-
21 ner as if payment for such services were made under the
22 medicare program.

23 (c) PUBLICATION OF DEFINITIONS, RELATIVE
24 VALUE UNITS, AND PAYMENT POLICIES.—The Secretary
25 shall provide for publication of such definitions, relative

1 value units (established under subsection (b)), and pay-
2 ment policies as may be necessary for payors to apply the
3 maximum payment rates established under this section.

4 **SEC. 153. BASIS FOR OTHER MAXIMUM PAYMENT RATES**
5 **FOR SERVICES USING CERTAIN MEDICARE**
6 **PAYMENT METHODOLOGIES.**

7 The maximum payment rates established under this
8 subtitle for services for any of the following classes of serv-
9 ices shall be determined using the applicable payment
10 methodologies under the medicare program as follows:

11 (1) In the case of facility services described in
12 section 1832(a)(2)(F) of the Social Security Act fur-
13 nished in connection with a surgical procedure speci-
14 fied pursuant to section 1833(i)(1)(A) of such Act
15 and furnished to an individual in an ambulatory sur-
16 gical center described in such section, the methodol-
17 ogy described in section 1833(i)(2) of such Act.

18 (2) For the class of diagnostic testing services
19 described in section 102(a)(2)(C)—

20 (A) in the case of clinical laboratory serv-
21 ices, the methodology described in sections
22 1833(a)(2)(D) and 1833(h) of such Act, and

23 (B) in the case of other diagnostic services,
24 the applicable methodology under part B of title
25 XVIII of such Act.

1 (3) In the case of an item of durable medical
2 equipment (described in section 1834(a)(13) of such
3 Act), the methodology described in section
4 1834(a)(1) of such Act.

5 (4) In the case of prosthetic devices and
6 orthotics and prosthetics, the methodology described
7 in section 1834(h)(1)(A) of such Act.

8 (5) In the case of psychologists and clinical so-
9 cial workers, the methodologies described in section
10 1833(a)(1)(L) and 1833(a)(1)(F), respectively.

11 (6) For prescription drugs, the methodology de-
12 scribed in section 1834(e) of such Act.

13 (7) For renal dialysis services, home dialysis
14 supplies and equipment (as defined in section
15 1881(b)(8) of such Act), and self-care home dialysis
16 support services (as defined in section 1881(b)(9) of
17 such Act), the methodology described in section
18 1881(b) of such Act.

19 (8) For any other service within a class of serv-
20 ices for which the amount of payment made under
21 part B of the medicare program is determined on
22 the basis of reasonable or prevailing charge, the
23 methodology used for payment for such service
24 under such part.

1 **SEC. 154. OTHER SERVICES.**

2 In the case of services within a class of services for
3 which a methodology for establishing maximum payment
4 rates is not otherwise provided pursuant to the preceding
5 provisions of this subtitle, the Secretary shall establish an
6 appropriate methodology for establishing such rates, tak-
7 ing into account the payment methodology or methodolo-
8 gies in use under the medicare program or other health
9 benefit plans.

10 **SEC. 155. DEVELOPMENT OF PROSPECTIVELY-DETER-**
11 **MINED PAYMENT METHODOLOGIES.**

12 (a) DEVELOPMENT OF PROSPECTIVE PAYMENT
13 METHODOLOGIES FOR ALL CLASSES OF SERVICES.—

14 (1) PROPOSAL.—The Secretary shall develop
15 proposals to establish a methodology for each class
16 of services (or services within such a class) for which
17 payment rates are not specified in sections 151
18 through 153 and are not determined on a prospec-
19 tive basis pursuant to this subtitle under which pay-
20 ment rates for such services shall be determined on
21 a prospectively-determined basis.

22 (2) REPORT.—Not later than 3 years after the
23 date of the enactment of this Act, the Secretary
24 shall submit the proposals developed under para-
25 graph (1) to the Committee on Ways and Means and
26 the Committee on Energy and Commerce of the

1 House of Representatives, the Committee on Fi-
2 nance of the Senate.

3 (b) ADJUSTMENT TO PROSPECTIVE METHODOLOGY
4 FOR CHILDREN'S HOSPITALS.—If any methodology is im-
5 plemented to determine the amount of payments for the
6 operating costs of inpatient hospital services under the
7 medicare program on the basis of prospectively-determined
8 rates for hospitals whose inpatients are predominantly in-
9 dividuals under 18 years of age, the Secretary shall assure
10 that payments under such methodology shall—

11 (1) be made on a hospital-specific basis;

12 (2) be based on the resource requirements of
13 the population receiving services from such hospitals;
14 and

15 (3) be determined by using pediatric-specific in-
16 patient data.

17 PART 3—MEDICARE PAYMENT ADJUSTMENTS

18 **SEC. 161. CONFORMING MEDICARE PAYMENT RATES TO**
19 **MEDICARE HEALTH EXPENDITURE ALLOCA-**
20 **TIONS.**

21 (a) IN GENERAL.—Notwithstanding any other provi-
22 sion of law (including the amendments made by title IV
23 of this Act), but subject to section 140(a)(2), the Sec-
24 retary shall adjust the payment rate or allowance (or, in
25 the absence of such a rate, payment amount) otherwise

1 applied under the medicare program (and any maximum
2 charge limits or payment limits imposed under such pro-
3 gram) for any health care service in a class of services
4 by the percentage payment adjustment specified by the
5 Secretary under subsection (b) for the class for the year
6 involved.

7 (b) PERCENTAGE PAYMENT ADJUSTMENT COM-
8 PUTED.—Subject to section 125(b)(2)(A), at the same
9 time as the Secretary establishes maximum payment rates
10 under part 1, the Secretary shall compute and publish,
11 for each class of services for each year, such percentage
12 payment adjustment as the Secretary determines to be
13 necessary to assure that—

14 (1) aggregate medicare expenditures for such
15 class of services for the year subject to such adjust-
16 ment, does not exceed

17 (2) the allocation (under section 103(a)(2)(A))
18 of aggregate medicare expenditures attributable to
19 such class for the year less the product of such allo-
20 cation and the proportion of such allocation that the
21 Secretary estimates is attributable to services ex-
22 empt under section 140 from the establishment or
23 application of maximum payment rates under part
24 1.

1 (c) PUBLICATIONS.—In publishing payment rates
2 under the medicare program, the Secretary shall take into
3 account any percentage payment adjustment applied
4 under this section.

5 **SEC. 162. ADJUSTMENTS TO MEDICARE PAYMENTS FOR**
6 **GRADUATE MEDICAL EDUCATION.**

7 (a) DETERMINATION OF FULL-TIME-EQUIVALENT
8 RESIDENTS DURING INITIAL RESIDENCY PERIOD.—

9 (1) EMPHASIS ON PRIMARY CARE.—Paragraph
10 (4)(C)(ii) of section 1886(h) of the Social Security
11 Act (42 U.S.C. 1395ww(h)) is amended by striking
12 “is 1.00,” and inserting the following: “is—

13 “(I) 1.1, in the case of a resident
14 who is a primary care resident (as de-
15 fined in paragraph (5)(H)),

16 “(II) 1.0, in the case of a resi-
17 dent who is not a primary care resi-
18 dent and who specializes in internal
19 medicine or pediatrics,

20 “(III) .9, in the case of a resi-
21 dent who is not described in subclause
22 (I) or (II) and who is in the initial 3
23 years of the residency period, or

1 “(IV) .8, in the case of a resident
2 not described in subclause (I), (II), or
3 (III),”.

4 (2) PRIMARY CARE RESIDENT DEFINED.—Para-
5 graph (5) of such section is amended—

6 (A) by redesignating subparagraph (H) as
7 subparagraph (I), and

8 (B) by inserting after subparagraph (G)
9 the following new subparagraph:

10 “(H) PRIMARY CARE RESIDENT.—The
11 term ‘primary care resident’ means (in accord-
12 ance with criteria established by the Secretary)
13 a resident being trained in a distinct program
14 of family practice medicine, general practice,
15 general internal medicine, or general pediat-
16 rics.”.

17 (b) EFFECTIVE DATE.—The amendments made by
18 subsection (a) shall apply to cost reporting periods begin-
19 ning on or after October 1, 1993.

1 **TITLE II—MANAGED CARE AND**
2 **MANAGED COMPETITION**
3 **Subtitle A—Managed Care**

4 **SEC. 201. AUTHORIZATION FOR MANAGED CARE SYSTEMS**
5 **TO PAY LESS THAN MAXIMUM PAYMENT**
6 **RATES.**

7 Nothing in this Act shall be construed as preventing
8 managed care systems from negotiating with providers
9 payment rates that are less than the maximum payment
10 rates established under title I.

11 **SEC. 202. STAFF AND GROUP MODEL HEALTH MAINTENANCE**
12 **ORGANIZATIONS EXEMPT FROM MAXIMUM PAYMENT RATES.**

14 Pursuant to section 140(b), the maximum payment
15 rates established under part 1 of subtitle C of title I shall
16 not apply to charges or payments for services furnished
17 to individuals who are enrolled in a staff or group model
18 health maintenance organization (as defined in section
19 2(b)(2)) with respect to health care services covered under
20 the subscriber agreement.

21 **SEC. 203. REPEAL OF SUNSET OF DUAL CHOICE REQUIRE-**
22 **MENT.**

23 Effective upon the enactment of this Act, section 7(b)
24 of the Health Maintenance Organization Amendments of
25 1988 (Public Law 100–517) is repealed and the provisions

1 of section 1310 of the Public Health Service Act shall be
2 effective as if such section 7(b) had not been enacted.

3 **SEC. 204. MULTIPLE CHOICE OF HEALTH MAINTENANCE**
4 **ORGANIZATIONS.**

5 (a) IN GENERAL.—Section 1310(a) of the Public
6 Health Service Act (42 U.S.C. 300e–9(a)) is amended by
7 adding at the end the following new paragraph:

8 “(3) Nothing in this subsection shall be construed as
9 limiting the option of membership to a limited number of
10 organizations.”.

11 (b) DISTRIBUTION OF MATERIALS.—Paragraph (1)
12 of such section is amended by adding at the end the follow-
13 ing new sentence: “Each such health benefit plan shall
14 make available, to each individual eligible to enroll with
15 a qualified health maintenance organization under such an
16 option, such marketing materials as the organization pro-
17 vides to the plan.”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall take effect 6 months after the date of
20 the enactment of this Act.

1 **SEC. 205. FEDERAL ASSISTANCE FOR ESTABLISHMENT AND**
2 **INITIAL OPERATION OF STAFF AND GROUP**
3 **MODEL HMOS.**

4 (a) IN GENERAL.—The Secretary shall provide for
5 grants for the establishment and initial operation of staff
6 or group model health maintenance organizations.

7 (b) PURPOSES.—Funds provided under this section
8 may be used for purposes specified by the Secretary, which
9 shall include—

10 (1) surveys of the prospective market for such
11 organizations to determine the feasibility of operat-
12 ing such an organization in the service area,

13 (2) activities relating to initial enrollment of in-
14 dividuals,

15 (3) working capital during the startup period,

16 (4) recruitment of physicians and other health
17 personnel, and

18 (5) acquisition of building and equipment.

19 (c) APPLICATION PROCESS.—No grant may be pro-
20 vided under this section unless—

21 (1) an application therefore has been submitted
22 (in such form and manner and containing such in-
23 formation, as the Secretary specifies) to and ap-
24 proved by the Secretary, and

25 (2) the Secretary determines that sufficient
26 planning for the organization's establishment has

1 been conducted by the applicant and the feasibility
2 of establishing and operating the organization has
3 been established by the applicant.

4 (d) PERIOD OF GRANT.—Grants under this section
5 shall be for a period of 1 year but may be renewed for
6 2 additional periods of 1 year each.

7 (e) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated \$25,000,000 for each
9 of fiscal years 1994 through 1998 to carry out this
10 section.

11 **SEC. 206. PREEMPTION OF STATE LAWS RESTRICTING**
12 **HEALTH MAINTENANCE ORGANIZATIONS.**

13 (a) IN GENERAL.—

14 (1) PREEMPTION.—Except as provided in para-
15 graph (2), any provision of State law that restricts
16 the ability of a health maintenance organization to
17 negotiate reimbursement rates with providers or to
18 contract selectively with one provider or a limited
19 number of providers is hereby preempted and may
20 not be enforced.

21 (2) EXCEPTION FOR STATES WITH PROVIDER
22 PAYMENT CONTROL SYSTEMS.—Paragraph (1) shall
23 not apply to a provision of State law that restricts
24 the ability of a health maintenance organization to
25 negotiate reimbursement rates with providers if the

1 State has a State provider payment control system
2 approved under section 121.

3 (b) EFFECTIVE DATE.—Subsection (a) shall take ef-
4 fect on January 1, 1994.

5 **SEC. 207. ADJUSTMENT IN MEDICARE CAPITATION PAY-**
6 **MENTS TO ACCOUNT FOR REGIONAL VARI-**
7 **ATIONS IN APPLICATION OF SECONDARY**
8 **PAYOR PROVISIONS.**

9 (a) IN GENERAL.—Section 1876(a)(4) of the Social
10 Security Act (42 U.S.C. 1395mm(a)(4)) is amended by
11 adding at the end the following new sentence: “In estab-
12 lishing the adjusted average per capita cost for a geo-
13 graphic area, the Secretary shall take into account the dif-
14 ferences between the proportion of individuals in the area
15 with respect to whom there is a group health plan that
16 is a primary payor (within the meaning of section
17 1862(b)(2)(A)) compared to the proportion of all such in-
18 dividuals with respect to whom there is such a group
19 health plan.”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall apply to contracts entered into for
22 years beginning with 1995.

1 **SEC. 208. GAO STUDY OF EXPANSION OF HEALTH MAINTENANCE ORGANIZATIONS.**
2

3 (a) STUDY.—The Comptroller General shall conduct
4 a study of additional measures that may be taken to en-
5 courage the development and expansion of health mainte-
6 nance organizations.

7 (b) REPORT.—By not later than 18 months after the
8 date of the enactment of this Act, the Comptroller General
9 shall submit a report to Congress on the study conducted
10 under subsection (a) and shall include in the report such
11 recommendations as may be appropriate.

12 **Subtitle B—Managed Competition**

13 PART 1—ESTABLISHMENT OF NATIONAL HEALTH PLAN
14 PURCHASING COOPERATIVE PROGRAM

15 **SEC. 221. ESTABLISHMENT OF PROGRAM; GRANTS TO STATES.**
16

17 (a) IN GENERAL.—The Secretary shall establish a
18 program for the establishment and operation of health
19 plan purchasing cooperatives (each in this subtitle referred
20 to as a “HPPC”) in each State in accordance with this
21 subtitle.

22 (b) GRANT PROGRAM FOR HPPCS.—

23 (1) IN GENERAL.—The Secretary may provide
24 assistance, through grants, contracts, and coopera-
25 tive agreements, with States and with HPPCs for

1 the planning, development, and initial operation of
2 HPPCs under this subtitle.

3 (2) TERMS.—Assistance under this subsection
4 shall be provided under such terms and conditions as
5 the Secretary may specify consistent with the follow-
6 ing:

7 (A) The period of such assistance may not
8 extend for longer than 5 years with respect to
9 any HPPC.

10 (B) The total amount of assistance with
11 respect to any HPPC may not exceed
12 \$5,000,000.

13 (3) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated, for the pro-
15 vision of assistance under this subsection, a total of
16 \$150,000,000 for the 5-fiscal-year period beginning
17 with fiscal year 1994.

18 **SEC. 222. ESTABLISHMENT OF HPPCS; DESIGNATION OF**
19 **HPPC AREAS.**

20 (a) STATE REQUIREMENT.—

21 (1) IN GENERAL.—Each State—

22 (A) shall provide by law for the organiza-
23 tion and operation, by not later than January
24 1, 1996, of 1 or more health plan purchasing

1 cooperatives in accordance with section 223,
2 and

3 (B) may provide (in accordance with sub-
4 sections (b) and (c)) for the designation of more
5 than 1 HPPC areas in the State.

6 (2) COVERAGE OF ALL GEOGRAPHIC AREAS IN
7 A STATE.—In carrying out this subsection, HPPCs
8 shall be established, and HPPC areas designated, in
9 a State so as to provide for the offering of qualified
10 health plans in every geographic area of the State.

11 (3) SINGLE ORGANIZATION SERVING MULTIPLE
12 HPPC AREAS.—Nothing in this subsection shall be
13 construed as preventing—

14 (A) a single corporation from being the
15 HPPC for more than one HPPC area, or

16 (B) a State from coordinating, through a
17 single entity, the activities of one or more
18 HPPCs in the State.

19 (4) FEDERAL DEFAULT.—If a State fails to
20 provide for the organization and continued operation
21 of 1 or more HPPCs or designation of HPPC areas
22 in accordance with this section, the Secretary shall
23 provide for such organization and operation or des-
24 ignation, and, in such case with respect to such a
25 HPPC, any subsequent reference to State law or a

1 Governor in this subtitle shall be deemed a reference
2 to Federal law or the Secretary, respectively.

3 (b) HPPC AREAS.—

4 (1) IN GENERAL.—Except as may be otherwise
5 provided under this subsection and subsection (c),
6 each State shall be considered a separate HPPC
7 area.

8 (2) ALTERNATIVE, INTRASTATE AREAS.—
9 HPPC areas within a State may cover less than the
10 entire State so long as—

11 (A) all portions of each metropolitan sta-
12 tistical area in the State are within the same
13 HPPC area, and

14 (B) the number of individuals residing
15 within a HPPC area is not less than 1,000,000.

16 (c) INTERSTATE HPPCs.—

17 (1) AUTHORIZATION.—One or more contiguous
18 States may provide—

19 (A) for the designation consistent with
20 paragraph (2) of a HPPC area that includes
21 adjoining portions of the States, and

22 (B) for the organization and operation, in
23 accordance with rules of the Secretary, of a
24 HPPC with respect to such a designated HPPC
25 area.

1 (2) INTERSTATE HPPC AREAS.—Any HPPC
2 area designated under paragraph (1)(A)—

3 (A) that includes any part of a metropoli-
4 tan statistical area shall include all of such
5 area, and

6 (B) shall have a population of not less
7 than 1,000,000.

8 **SEC. 223. ORGANIZATION AND OPERATION OF HPPCS.**

9 (a) IN GENERAL.—Each HPPC shall be organized
10 and operated consistent with the requirements of this sub-
11 title.

12 (b) ORGANIZATION.—Each HPPC shall be a not-for-
13 profit public benefit corporation established under State
14 law and governed by a Board of Directors appointed by
15 the Governor or other chief executive officer of the State.

16 (c) GENERAL DUTIES OF HPPCS.—

17 (1) MAKING HEALTH CARE PLANS AVAILABLE
18 TO EMPLOYERS.—

19 (A) IN GENERAL.—Each HPPC shall enter
20 into agreements with qualified health plans
21 under section 225 under which coverage under
22 such a QHP is made available with respect to
23 employers which—

24 (i) have employees who reside in the
25 HPPC area served by the HPPC, and

1 (ii) have entered into an agreement
2 with the HPPC under section 224.

3 (B) HPPC OUTREACH TO SMALL EMPLOY-
4 ERS.—Beginning not later than 1 year after the
5 date a HPPC is organized, a HPPC shall in-
6 ventory and inform all small employers (as de-
7 fined in section 228(c)(2)) in the HPPC area
8 (including employers in rural areas of the
9 HPPC area) of the health benefits available,
10 through enrollment with qualified health plans,
11 through the HPPC for their employees (and
12 family members) who reside in a HPPC area
13 served by the HPPC.

14 (2) OPTION OF ENROLLMENT FOR ELIGIBLE
15 RESIDENTS.—A HPPC may provide, under such an
16 agreement with a qualified health plan, for coverage
17 under such a plan with respect to individuals who
18 are eligible residents (as defined in section
19 228(a)(4)).

20 (3) CONSTRUCTION.—Nothing in this sub-
21 section shall be construed as requiring—

22 (A) an employer to enter into an agree-
23 ment under section 224 with a HPPC, or

24 (B) an employee or other individual to en-
25 roll in a QHP offered by a HPPC.

1 (d) SCOPE OF PLANS OFFERED.—To the maximum
2 extent practicable, each HPPC—

3 (1) shall enter into agreements with each QHP
4 which is a qualified health maintenance organization
5 (as defined in section 228(b)(2));

6 (2) shall enter into agreements with at least
7 one qualified health plan that is a service benefit
8 plan and at least one qualified health plan that is an
9 indemnity plan for each HPPC area served by the
10 HPPC; and

11 (3) may enter into agreements with other quali-
12 fied health plans (such as preferred provider organi-
13 zations).

14 **SEC. 224. AGREEMENTS WITH EMPLOYERS.**

15 (a) IN GENERAL.—Each agreement under this sec-
16 tion, between a HPPC and an employer, shall include (as
17 specified by the Secretary) provisions consistent with the
18 requirements specified in the succeeding subsections of
19 this section.

20 (b) FORWARDING INFORMATION ON ELIGIBLE EM-
21 PLOYEES.—

22 (1) IN GENERAL.—Under an agreement under
23 this section between an employer and a HPPC, the
24 employer must forward to the appropriate HPPC
25 the name and address (and other identifying infor-

1 mation required by the HPPC) of each employee (in-
2 cluding part-time and seasonal employees).

3 (2) INFORMATION ON PLANS.—Under the
4 agreement and consistent with section 226, the
5 HPPC—

6 (A) shall provide to each employee identi-
7 fied under paragraph (1) information on bene-
8 fits available through QHPs, and

9 (B) upon the request of such an employee,
10 shall enroll the employee (and, at the option of
11 the employee, eligible family members) in such
12 plans.

13 (3) APPROPRIATE HPPC.—In this subsection,
14 the term “appropriate HPPC” means the HPPC for
15 the principal place of business of the employer or (at
16 the option of an employee) the HPPC serving the
17 place of residence of the employee.

18 (c) PAYROLL DEDUCTION OPTION.—

19 (1) IN GENERAL.—Under an agreement under
20 this section between an employer and a HPPC, if
21 the HPPC indicates to the employer that an eligible
22 employee is enrolled in a QHP through the HPPC—

23 (A) the employer shall pay to the HPPC
24 the amount of any employer contribution to-

1 wards the premium for enrollment of the em-
2 ployee under the QHP, and

3 (B) if the employee elects to have any em-
4 ployee share of premiums deducted from wages
5 or other compensation paid by the employer,
6 the employer shall provide for the deduction,
7 from the employee's wages or other compensa-
8 tion, of the employee's share of the amount of
9 the premium due and the payment of such de-
10 duction to the HPPC.

11 (2) SPECIAL RULES FOR PAYMENT OF EM-
12 PLOYEE SHARE.—In the case of an employee who is
13 paid wages or other compensation on a monthly or
14 more frequent basis, an employer shall not be re-
15 quired to provide for payment of amounts of the em-
16 ployee's share to a HPPC other than at the same
17 time at which the amounts are deducted from wages
18 or other compensation. In the case of an employee
19 who is paid wages or other compensation less fre-
20 quently than monthly, an employer may be required
21 to provide for payment of amounts under paragraph
22 (1)(B) to a HPPC on a monthly basis.

23 (d) LIMITED EMPLOYER OBLIGATIONS.—Nothing in
24 this section shall be construed as—

1 (1) requiring an employer to provide directly for
2 enrollment of eligible employees under a QHP or
3 other health plan,

4 (2) requiring the employer to make, or prevent-
5 ing the employer from making, information about
6 such plans available to such employees, or

7 (3) requiring the employer to make, or prevent-
8 ing the employer from making, an employer con-
9 tribution for coverage of such individuals under such
10 a plan.

11 (e) REFUSAL TO ENTER INTO AGREEMENT.—A
12 HPPC may refuse to enter into an agreement under this
13 section with a small employer if less than a percentage
14 (specified by the HPPC, consistent with rules of the Sec-
15 retary) of the otherwise eligible employees of the employer
16 are enrolled with a QHP pursuant to such agreement.

17 **SEC. 225. AGREEMENTS WITH QUALIFIED HEALTH PLANS**
18 **(QHPs).**

19 (a) AGREEMENTS.—

20 (1) IN GENERAL.—Each HPPC for a HPPC
21 area shall enter into an agreement under this section
22 with each qualified health plan that serves residents
23 of the area. Each such agreement under this section
24 between a QHP and a HPPC shall include (as speci-
25 fied by the Secretary) provisions consistent with the

1 requirements of the succeeding subsections of this
2 section. Except as provided in paragraph (2)(A), a
3 HPPC may not refuse to enter into such an agree-
4 ment with a QHP.

5 (2) TERMINATION OF AGREEMENT.—In accord-
6 ance with regulations of the Secretary—

7 (A) the HPPC may terminate an agree-
8 ment under paragraph (1) if the QHP’s ap-
9 proval under this subtitle is terminated, and

10 (B) the QHP may terminate such an
11 agreement only upon sufficient notice in order
12 to provide for the orderly enrollment of enroll-
13 ees under other QHPs.

14 The Secretary shall establish a process for the ter-
15 mination of agreements under this paragraph.

16 (b) OFFER OF ENROLLMENT UNDER PLAN.—

17 (1) IN GENERAL.—Under an agreement under
18 this section between a QHP and a HPPC, the
19 HPPC—

20 (A) shall offer, on behalf of the QHP, en-
21 rollment in the QHP to eligible employees, and

22 (B) may offer, on behalf of the QHP, en-
23 rollment in the QHP to eligible residents.

24 (2) TIMING OF OFFER.—The offer of enroll-
25 ment shall be available on a continuous, year-round

1 basis, consistent with section 2104 of the Social Se-
2 curity Act (as added by section 202 of this Act).

3 (c) RECEIPT OF GROSS PREMIUMS.—

4 (1) IN GENERAL.—Under an agreement under
5 this section between a HPPC and a QHP, payment
6 of premiums shall be made, by individuals or em-
7 ployers on their behalf, directly to the HPPC for the
8 benefit of the QHP.

9 (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-
10 miums shall be payable on a monthly basis (or, at
11 the option of an eligible resident, on a quarterly
12 basis). The HPPC may provide for penalties and
13 grace periods for late payment.

14 (3) QHPs RETAIN RISK OF NONPAYMENT.—
15 Nothing in this subsection shall be construed as
16 placing upon a HPPC any risk associated with fail-
17 ure to make prompt payment of premiums (other
18 than the portion of the premium representing the
19 HPPC overhead amount). Each eligible individual
20 who enrolls with a QHP through the HPPC is liable
21 to the QHP for premiums.

22 (d) COLLECTION AND FORWARDING OF PRE-
23 MIUMS.—

24 (1) PREMIUM CHARGED.—Under an agreement
25 under this section between a QHP and a HPPC, the

1 HPPC shall charge, with respect to the enrollment
2 of eligible individuals in the plan through the
3 HPPC, an amount equal to the sum of—

4 (A) the premium rate established by the
5 plan (consistent with section 2104(c) of the So-
6 cial Security Act) for the type of enrollment,
7 and

8 (B) the HPPC overhead amount (estab-
9 lished under subsection (e) for enrollment of in-
10 dividuals through the HPPC).

11 (2) AMOUNT FORWARDED.—Under an agree-
12 ment under this section between a QHP and a
13 HPPC, the HPPC shall forward to each QHP in
14 which an eligible individual has been enrolled an
15 amount equal to the premium rate established by the
16 plan (consistent with section 2104(c) of the Social
17 Security Act) for the type of enrollment.

18 (3) PAYMENTS.—Payments shall be made by
19 the HPPC under this subsection to a QHP within
20 a period (specified by the Secretary and not to ex-
21 ceed 7 days) after receipt of the premium from the
22 employer of the eligible individual or the eligible in-
23 dividual, as the case may be.

24 (4) ADJUSTMENTS FOR DIFFERENCES IN
25 NONPAYMENT RATES.— In accordance with rules es-

1 established by the Secretary, each agreement between
2 a QHP and a HPPC under this section shall provide
3 that, if a HPPC determines that the rates of
4 nonpayment of premiums during grace periods es-
5 tablished under subsection (c)(2) vary appreciably
6 among QHPs, the HPPC shall provide for such ad-
7 justments in the payments made under this sub-
8 section as will place each QHP in the same position
9 as if the rates of nonpayment were the same.

10 (e) HPPC OVERHEAD AMOUNT.—

11 (1) HPPC BUDGET.—Each HPPC shall estab-
12 lish a budget for each year for each HPPC area in
13 accordance with regulations established by the Sec-
14 retary.

15 (2) HPPC OVERHEAD AMOUNT.—Based upon
16 the budget, the HPPC shall compute HPPC over-
17 head amounts so that—

18 (A) the amounts vary by type of enroll-
19 ment based upon factors (specified by the Sec-
20 retary) reflecting the relative average premium
21 amounts established for the different types of
22 enrollment,

23 (B) subject to subparagraph (C), the total
24 of such amounts are projected to equal the
25 budget established under paragraph (1), and

1 (C) the average overhead amount for a
2 type of enrollment does not exceed 5 percent of
3 the average premium amounts imposed for that
4 type of enrollment.

5 **SEC. 226. ENROLLING INDIVIDUALS IN QUALIFIED HEALTH**
6 **PLANS THROUGH A HPPC.**

7 (a) IN GENERAL.—Each HPPC shall offer in accord-
8 ance with this section eligible employees (and, at the op-
9 tion of the HPPC, eligible residents) the opportunity to
10 enroll in a QHP for the HPPC area in which the individ-
11 ual resides.

12 (b) ENROLLMENT PROCESS.—Each HPPC shall es-
13 tablish an enrollment process in accordance with rules es-
14 tablished by the Secretary.

15 (c) DISTRIBUTION OF COMPARATIVE INFORMA-
16 TION.—Each HPPC shall distribute, to eligible individuals
17 and participating employers, information, in comparative
18 form, on the prices, outcomes, enrollee satisfaction, and
19 other information pertaining to the quality of the different
20 QHPs for which it is offering enrollment. Each HPPC also
21 shall make such information available to other interested
22 persons.

23 (d) PERIOD OF COVERAGE.—

24 (1) IN GENERAL.—Except as the Secretary may
25 provide, in the case of an eligible individual who en-

1 rolls with a QHP through a HPPC, coverage under
2 the plan shall begin on such date (not later than the
3 first day of the first month that begins at least 15
4 days after the date of enrollment) as the Secretary
5 shall specify.

6 (2) MINIMUM PERIOD OF ENROLLMENT.—In
7 order to avoid adverse selection, each HPPC may re-
8 quire, consistent with rules of the Secretary, that en-
9 rollment with QHPs be for not less than 1 year
10 (with exceptions permitted for such exceptional cir-
11 cumstances as the Secretary may recognize).

12 **SEC. 227. COORDINATION AMONG HPPCS.**

13 (a) IN GENERAL.—The Secretary shall establish
14 rules consistent with this section for coordination among
15 HPPCs in cases where participating employers are located
16 in one HPPC area and their employees reside in a dif-
17 ferent HPPC area (and are eligible for enrollment with
18 QHPs located in the other area).

19 (b) COORDINATION RULES.—Under the rules estab-
20 lished under subsection (a)—

21 (1) HPPC FOR EMPLOYER.—The HPPC for
22 the principal place of business of an employer shall
23 be responsible—

1 (A) for providing information to the em-
2 ployer's employees on QHPs for areas in which
3 employees reside;

4 (B)(i) for enrolling employees under the
5 QHP selected (even if the QHP selected is not
6 in the same HPPC area as the HPPC) and (ii)
7 if the QHP chosen is not in the same HPPC
8 area as the HPPC, for forwarding the enroll-
9 ment information to the HPPC for the area in
10 which the QHP selected is located; and

11 (C) in the case of premiums to be paid
12 through payroll deduction, to receive such pre-
13 miums and forward them to the HPPC for the
14 area in which the QHP selected is located.

15 (2) HPPC FOR EMPLOYEE RESIDENCE.—The
16 HPPC for the HPPC area in which an employee re-
17 sides shall be responsible for providing other HPPCs
18 with information concerning QHPs being offered in
19 the HPPC's areas.

20 **SEC. 228. DEFINITIONS.**

21 (a) ELIGIBILITY.—In this title:

22 (1) ELIGIBLE INDIVIDUAL.—The term “eligible
23 individual” means, with respect to a HPPC area, an
24 individual who—

1 (A) is an eligible employee (as defined in
2 paragraph (2)),

3 (B) is an eligible resident (as defined in
4 paragraph (4)), or

5 (C) an eligible family member (as defined
6 in paragraph (3)) of an eligible employee or eli-
7 gible resident.

8 (2) ELIGIBLE EMPLOYEE.—The term “eligible
9 employee” means, with respect to a HPPC area, an
10 individual residing in the area who is the employee
11 of a participating employer.

12 (3) ELIGIBLE FAMILY MEMBER.—The term “el-
13 igible family member” means, with respect to an eli-
14 gible employee or other principal enrollee, an individ-
15 ual who is residing in the United States and—

16 (A) is the spouse of the employee or prin-
17 cipal enrollee, or

18 (B) is an unmarried dependent child under
19 22 years of age, including—

20 (i) an adopted child or recognized nat-
21 ural child, and

22 (ii) a stepchild or foster child but only
23 if the child lives with the employee or prin-
24 cipal enrollee in a regular parent-child re-
25 lationship,

1 or such an unmarried dependent child regard-
2 less of age who is incapable of self-support be-
3 cause of mental or physical disability which ex-
4 isted before age 22.

5 (4) ELIGIBLE RESIDENT.—The term “eligible
6 resident” means, with respect to a HPPC area, an
7 individual who—

8 (A) is residing in the area, and

9 (B) is not an eligible employee.

10 (5) PARTICIPATING EMPLOYER.—The term
11 “participating employer” means an employer that
12 has an agreement in effect with a HPPC under sec-
13 tion 224.

14 (b) ABBREVIATIONS.—In this title:

15 (1) HPPC; HEALTH PLAN PURCHASING COOP-
16 ERATIVE.—The terms “health plan purchasing coop-
17 erative” and “HPPC” mean a health plan purchas-
18 ing cooperative established under this part.

19 (2) QUALIFIED HMO; QUALIFIED HEALTH MAIN-
20 TENANCE ORGANIZATION.—The terms “qualified
21 HMO” and “qualified health maintenance organiza-
22 tion” mean a health benefit plan that—

23 (A) is an eligible organization having a
24 contract under section 1876 of the Social Secu-
25 rity Act, or

1 (B) is a qualified health maintenance orga-
2 nization (as defined in section 1310(d) of the
3 Public Health Service Act).

4 (3) QHP; QUALIFIED HEALTH PLAN.—The
5 terms “qualified health plan” and “QHP” mean a
6 health plan approved by the Secretary under section
7 251(a).

8 (c) OTHER TERMS.—In this title:

9 (1) HEALTH BENEFIT PLAN.—The term
10 “health benefit plan” has the meaning given such
11 term in section 2108(3) of the Social Security Act,
12 as added by section 302 of this Act.

13 (2) SMALL EMPLOYER.—The term “small em-
14 ployer” has the meaning given such term in section
15 2103(d)(2) of the Social Security Act (as added by
16 section 302 of this Act).

17 (4) STATE.—The term “State” includes the
18 District of Columbia.

19 (5) TYPE OF ENROLLMENT.—There are 2
20 “types of enrollment”:

21 (A) Coverage only of an individual (re-
22 ferred to in this subtitle as enrollment “on an
23 individual basis”).

1 (B) Coverage of a family consisting of
2 more than 1 individual (referred to in this sub-
3 title as enrollment “on a family basis”).

4 PART 2—REQUIREMENTS FOR QUALIFIED HEALTH
5 PLANS

6 **SEC. 251. APPROVAL PROCESS; QUALIFICATIONS.**

7 (a) IN GENERAL.—The Secretary shall provide a
8 process whereby a health benefit plan (as defined in sec-
9 tion 228(c)(1)) may be approved as a qualified health
10 plan.

11 (b) QUALIFICATIONS.—

12 (1) IN GENERAL.—In order to be approved as
13 a QHP, a plan must—

14 (A) provide, in accordance with section
15 252, for coverage of the core group of benefits;

16 (B) subject to paragraph (2), be a quali-
17 fied health maintenance organization (as de-
18 fined in section 228(b)(2));

19 (C) have been certified under section 2101
20 of the Social Security Act as meeting the stand-
21 ards established under title XXI of such Act
22 (including standards relating to prohibiting dis-
23 crimination based on health status, to open en-
24 rollment, use of community-rated premiums,
25 etc.);

1 (D) meet standards established by the Sec-
2 retary to protect enrollees with respect to po-
3 tential insolvency; and

4 (E) provide, in accordance with the na-
5 tional patient outcomes data reporting program
6 under subtitle C, for the collection and report-
7 ing to the Secretary of certain information re-
8 garding its enrollees and provision of services.

9 (2) WAIVER OF QUALIFIED HMO REQUIRE-
10 MENT.—A HPPC may waive the requirement of
11 paragraph (1)(B) in the case of such plans as it de-
12 termines will promote access to quality, cost effective
13 health care in the HPPC area. However, any such
14 plan that is not a qualified health maintenance orga-
15 nization must meet the following additional require-
16 ments:

17 (A) EFFECTIVE GRIEVANCE PROCE-
18 DURES.—The plan must provide for effective
19 procedures for hearing and resolving grievances
20 between the plan and individuals enrolled under
21 the plan, which procedures meet standards
22 specified by the Secretary.

23 (B) RESTRICTION ON CERTAIN PHYSICIAN
24 INCENTIVE PLANS.—

1 (i) IN GENERAL.—If the plan operates
2 a physician incentive plan (as defined in
3 clause (ii)), the incentive plan must meet
4 the requirements specified in clauses (i)
5 through (iii) of section 1876(i)(8)(A) of
6 the Social Security Act (in the same man-
7 ner as they apply to eligible organizations
8 under section 1876 of such Act).

9 (ii) PHYSICIAN INCENTIVE PLAN DE-
10 FINED.—In this subparagraph, the term
11 “physician incentive plan” means any com-
12 pensation or other financial arrangement
13 between a plan and a physician or physi-
14 cian group that may directly or indirectly
15 have the effect of reducing or limiting serv-
16 ices provided with respect to individuals
17 enrolled under the plan.

18 (C) WRITTEN POLICIES AND PROCEDURES
19 RESPECTING ADVANCE DIRECTIVES.—The plan
20 must meet the requirements of section 1866(f)
21 of the Social Security Act (relating to maintain-
22 ing written policies and procedures respecting
23 advance directives), insofar as such require-
24 ments would apply to the plan if the plan were
25 an eligible organization.

1 (c) PROTECTION AGAINST PROVIDER CLAIMS.—In
2 the case of a failure of a QHP to make payments with
3 respect to an individual enrolled under the plan through
4 a HPPC, under standards established by the Secretary,
5 the individual is not liable to any health care provider or
6 practitioner with respect to the provision of health services
7 within such package of benefits covered in excess of the
8 amount for which the enrollee would have been liable if
9 the plan had made payments in a timely manner.

10 **SEC. 252. BENEFIT PACKAGES.**

11 (a) REQUIREMENT OF OFFERING.—The Secretary
12 may not approve a qualified health plan unless, subject
13 to subsection (b), the plan—

14 (1) offers, as a separate and distinct benefit
15 package, the core benefit package specified pursuant
16 to subsection (c);

17 (2) has entered into arrangements with a suffi-
18 cient number and variety of providers to provide for
19 its enrollees benefits under such core benefit pack-
20 age without imposing cost-sharing in excess of the
21 cost-sharing permitted under such benefit package
22 and (except for an indemnity plan) does not permit
23 providers participating in the plan to charge for
24 services covered under the core benefit package

1 amounts in excess of the cost-sharing permitted
2 under such package; and

3 (3) provides, in the case of individuals covered
4 under more than one qualified health plan, for co-
5 ordination of coverage under such plans in an equi-
6 table manner specified by the Secretary.

7 (b) TREATMENT OF ADDITIONAL, OPTIONAL BENE-
8 FITS.—A QHP may also offer benefits in addition to (and
9 not duplicative of) the core benefit package (including re-
10 ducing cost-sharing below the cost-sharing provided for in
11 such package), if such additional benefits—

12 (1) are offered, and priced, separately from the
13 core benefit package, and

14 (2) are only offered consistent with such stand-
15 ard, incremental benefit packages as the Secretary
16 specifies under subsection (c).

17 (c) SPECIFICATION OF BENEFIT PACKAGES.—

18 (1) IN GENERAL.—The Secretary shall specify
19 the services and cost-sharing to be included in—

20 (A) the core benefit package under this
21 subtitle, and

22 (B) additional incremental benefit pack-
23 ages under this subtitle.

24 (2) CORE BENEFIT PACKAGE.—

1 (A) BASED ON MEDICARE BENEFITS.—Ex-
2 cept as provided in subparagraph (B), the serv-
3 ices and cost-sharing in the core benefit pack-
4 age shall be the same as the services and cost-
5 sharing provided under the medicare program.

6 (B) ADDITIONAL BENEFITS.—The core
7 benefit package also shall include the following:

8 (i) No limit on days of coverage of in-
9 patient hospital services based on a spell of
10 illness.

11 (ii) An annual limitation on out-of-
12 pocket costs for cost-sharing (not including
13 premiums and extra-billing amounts) of
14 \$2,500 for individual enrollment and
15 \$3,000 for family enrollment.

16 (iii) Instead of the deductible for inpa-
17 tient hospital services under part A of title
18 XVIII of the Social Security Act and the
19 general deductible applicable under part B
20 of such title (subject to clause (v)), there
21 shall be imposed an annual deductible of
22 \$300 for each individual (but not to exceed
23 \$600 for all individuals in a family).

24 (iv) Benefits for maternity care, well-
25 child care, and other preventive services

1 (identified by the Secretary), without the
2 imposition of deductibles or other cost-
3 sharing.

4 (v) In the case of qualified health
5 maintenance organizations, cost-sharing
6 for deductibles and copayments shall be
7 nominal, consistent with standards for
8 such cost-sharing permitted of qualified
9 health maintenance organizations under
10 title XIII of the Public Health Service Act.

11 The Secretary may change, on an annual basis,
12 the dollar amounts specified under this sub-
13 paragraph based on changes in an appropriate
14 index.

15 (4) CHANGES IN CORE BENEFIT PACKAGE.—
16 The Secretary, after appropriate advance notice,
17 shall change the core benefit package in order to re-
18 flect changes in the benefits under the medicare pro-
19 gram which are not reflected in paragraph (3).

20 (5) OVERRIDING OF STATE BENEFIT MAN-
21 DATES.—Any State requirement relating to the pro-
22 vision or coverage of benefits under health plans
23 shall not apply to the benefits provided by qualified
24 health plans through HPPCs under this subtitle.

1 **Subtitle C—National Patient Out-**
2 **comes and Enrollee Satisfaction**
3 **Data Reporting Program**

4 **SEC. 271. NATIONAL PATIENT OUTCOMES PROGRAM.**

5 (a) IN GENERAL.—The Secretary shall establish a
6 national data base on patient outcomes (in this section re-
7 ferred to as the “outcomes data base”) in accordance with
8 this section.

9 (b) COLLECTION OF UNIFORM DATA BASE.—In
10 order to collect information in the outcomes data base in
11 a uniform format—

12 (1) By not later than January 1, 1995, the Sec-
13 retary shall define and publish the uniform outcomes
14 data that would be collected.

15 (2) By not later than July 1, 1995, the Sec-
16 retary shall establish, by regulation, the reporting
17 requirements for the routine collection of the out-
18 comes data.

19 (3) By not later than January 1, 1996, the Sec-
20 retary shall require all qualified health maintenance
21 organizations, all other health benefit plans, and all
22 health care providers to begin reporting on an an-
23 nual basis the outcomes data to the Secretary pursu-
24 ant to the regulations.

1 (c) PUBLICATION AND DISTRIBUTION OF NATIONAL
2 OUTCOMES DATA BASE.—The Secretary shall publish and
3 distribute an annual report regarding patient outcomes,
4 including information on individual providers, based on in-
5 formation from the outcomes data base and appropriate
6 utilization information available from the QHPs.

7 **SEC. 272. ENROLLEE HEALTH PLAN SATISFACTION.**

8 (a) IN GENERAL.—The Secretary shall establish a
9 national data base on enrollee satisfaction with health ben-
10 efit plans (including self-insured health benefit plans) (in
11 this section referred to as the “enrollee data base”) in ac-
12 cordance with this section.

13 (b) COLLECTION OF UNIFORM DATA BASE.—In
14 order to collect information in the enrollee data base in
15 a uniform format—

16 (1) By not later than July 1, 1995, the Sec-
17 retary shall define and publish the enrollee satisfac-
18 tion survey to be used by health benefit plans in col-
19 lecting data under this section.

20 (2) By not later than January 1, 1996, the Sec-
21 retary shall require all health benefit plans to begin
22 reporting on an annual basis the data to the Sec-
23 retary pursuant to the regulations.

24 (c) PUBLICATION AND DISTRIBUTION OF DATA
25 BASE.—The Secretary shall publish and distribute an an-

1 nual report regarding enrollee satisfaction with the dif-
2 ferent health plans based on information from the enrollee
3 data base.

4 **SEC. 273. RESEARCH AND DEMONSTRATION.**

5 (a) IN GENERAL.—The Secretary shall provide for
6 research and demonstration projects concerning—

7 (1) new methods for collecting and analyzing
8 outcomes and enrollee satisfaction information under
9 this subtitle, and

10 (2) the use of outcomes information systems by
11 qualified health maintenance organizations, health
12 benefits plans, and providers of health care services.

13 The Secretary may also provide for research and dem-
14 onstration projects concerning the collection and analysis
15 of indicators of system performance (such as health status
16 of community served, prevention of illness, and capacity
17 of delivery system) with respect to integrated health care
18 delivery systems.

19 (b) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated \$20,000,000 in each of
21 fiscal years 1994 through 1998 to carry out this section.

1 **Subtitle D—Study of Universal**
2 **Health Insurance Coverage and**
3 **Cost Containment**

4 **SEC. 291. STUDY.**

5 (a) IN GENERAL.—The Congressional Budget Office
6 shall conduct a study on the different options for providing
7 universal health insurance coverage in the United States.
8 Such study shall identify the following:

9 (1) OPTIONS.—The cost of the different cov-
10 erage options.

11 (2) COST CONTAINMENT.—The effectiveness of
12 the different options in cost containment.

13 (3) REVENUES REQUIRED.—The revenue levels
14 required for the different options.

15 (4) FINANCING OPTIONS.—Options for financ-
16 ing these revenue levels, including—

17 (A) the distributional impact of these reve-
18 nue options, and

19 (B) with respect to the option of imposing
20 a geographic-area specific limit on the tax-fa-
21 vored status of employer payment for health
22 care for employees, former employees, and de-
23 pendents, the revenue, administrative, and dis-
24 tributive impact of imposing such limits.

1 (b) ASSISTANCE OF JOINT TAX COMMITTEE.—The
2 Joint Committee on Tax shall provide such assistance to
3 the Congressional Budget Office as may be required to
4 conduct the study under this section.

5 (c) REPORT.—The Director of the Congressional
6 Budget Office shall submit, by not later than January 1,
7 1994, a report on the study conducted under this section
8 to the Committees on Ways and Means and Energy and
9 Commerce of the House of Representatives and the Com-
10 mittee on Finance of the Senate.

11 **TITLE III—HEALTH SYSTEMS**

12 **REFORM**

13 **Subtitle A—Health Insurance**

14 **Reform**

15 **SEC. 301. EXCISE TAX ON PREMIUMS RECEIVED ON**
16 **HEALTH INSURANCE POLICIES WHICH DO**
17 **NOT MEET CERTAIN REQUIREMENTS.**

18 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
19 nue Code of 1986 (relating to taxes on group health plans)
20 is amended by adding at the end thereof the following new
21 section:

22 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS**
23 **FOR HEALTH INSURANCE.**

24 **“(a) IMPOSITION OF TAX.—**

1 “(1) GENERAL RULE.—There is hereby imposed
2 a tax on any nonqualified health benefit plan.

3 “(2) NONQUALIFIED HEALTH BENEFIT PLAN
4 DEFINED.—For purposes of this section, the term
5 ‘nonqualified health benefit plan’ means any health
6 benefit plan that—

7 “(A) is not certified under section 2101 of
8 the Social Security Act, or

9 “(B) the Secretary of Health and Human
10 Services determines is providing coverage in vio-
11 lation of section 2101(a) of such Act.

12 “(b) AMOUNT OF TAX.—

13 “(1) IN GENERAL.—The amount of tax imposed
14 by subsection (a) shall be equal to—

15 “(A) in the case of an insured health bene-
16 fit plan, 50 percent of the gross premiums re-
17 ceived by the issuer which are attributable to
18 the period during which the plan is a non-
19 qualified health benefit plan, and

20 “(B) in the case of a self-insured health
21 benefit plan, 50 percent of the expenditures
22 under such plan during the period that the plan
23 is a nonqualified health benefit plan.

24 “(2) GROSS PREMIUMS.—For purposes of para-
25 graph (1)(A), gross premiums shall include any con-

1 sideration received with respect to any insured
2 health benefit plan.

3 “(3) CONTROLLED GROUPS.—For purposes of
4 paragraph (1)—

5 “(A) CONTROLLED GROUP OF CORPORA-
6 TIONS.—All corporations which are members of
7 the same controlled group of corporations shall
8 be treated as 1 person. For purposes of the pre-
9 ceding sentence, the term ‘controlled group of
10 corporations’ has the meaning given to such
11 term by section 1563(a), except that—

12 “(i) ‘more than 50 percent’ shall be
13 substituted for ‘at least 80 percent’ each
14 place it appears in section 1563(a)(1), and

15 “(ii) the determination shall be made
16 without regard to subsections (a)(4) and
17 (e)(3)(C) of section 1563.

18 “(B) PARTNERSHIPS, PROPRIETORSHIPS,
19 ETC., WHICH ARE UNDER COMMON CONTROL.—
20 Under regulations prescribed by the Secretary,
21 all trades or business (whether or not incor-
22 porated) which are under common control shall
23 be treated as 1 person. The regulations pre-
24 scribed under this subparagraph shall be based

1 on principles similar to the principles which
2 apply in the case of subparagraph (A).

3 “(c) LIABILITY FOR TAX.—

4 “(1) INSURED PLAN.—In the case of an insured
5 health benefit plan, the issuer of the insurance or
6 subscriber contract under which such plan is pro-
7 vided shall be liable for the tax imposed by this
8 section.

9 “(2) SELF-INSURED PLAN.—In the case of a
10 self-insured plan—

11 “(A) IN GENERAL.—Except as provided in
12 subparagraph (B), the employer maintaining
13 such plan shall be liable for the tax imposed by
14 this section.

15 “(B) MULTIEMPLOYER PLANS, ETC.—In
16 the case of a multiemployer plan or any other
17 plan not maintained by an employer, the plan
18 shall be liable for the tax imposed by this
19 section.

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

21 “(1) HEALTH BENEFIT PLAN.—

22 “(A) IN GENERAL.—The term ‘health ben-
23 efit plan’ means any plan or contract under
24 which any medical benefit is provided to any
25 individual.

1 “(B) CERTAIN PLANS AND CONTRACTS
2 NOT COVERED.—The term ‘health benefit plan’
3 does not include any plan or contract—

4 “(i) which provides for accident only,
5 dental only, or disability only coverage,

6 “(ii) which provides coverage as a
7 supplement to liability insurance, and

8 “(iii) which provides insurance arising
9 out of a workers’ compensation or similar
10 law, or automobile medical-payment insur-
11 ance.

12 “(2) INSURED HEALTH BENEFIT PLAN.—The
13 term ‘insured health benefit plan’ means any health
14 benefit plan provided through insurance, and in-
15 cludes a prepaid hospital or medical service plan, the
16 health benefit plan of a health maintenance organi-
17 zation, and a multiple employer welfare arrangement
18 (as defined in section 3(40) of the Employee Retire-
19 ment Income Security Act of 1974).

20 “(3) MEDICAL BENEFIT.—The term ‘medical
21 benefit’ means any benefit which consists of the pro-
22 viding (through insurance or otherwise) of medical
23 care (as defined in section 213(d)).

24 “(4) SELF-INSURED HEALTH BENEFIT PLAN.—
25 The term ‘self-insured health benefit plan’ means

1 any health benefit plan that is not an insured health
2 benefit plan.”

3 (b) NONDEDUCTIBILITY OF TAX.—Subsection (a) of
4 section 275 of such Code (relating to nondeductibility of
5 certain taxes) is amended by adding at the end thereof
6 the following new paragraph:

7 “(7) Taxes imposed by section 5000A (failure
8 to satisfy certain standards for health insurance).”

9 (c) CLERICAL AMENDMENTS.—

10 (1) So much of chapter 47 of such Code as pre-
11 cedes subsection (a) of section 5000 is amended to
12 read as follows:

13 **“CHAPTER 47—TAXES RELATING TO**
14 **HEALTH BENEFIT PLANS**

“Sec. 5000. Contributions to nonconforming large group health
plans.

“Sec. 5000A. Failure to satisfy certain standards for health insur-
ance.

15 **“SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE**
16 **GROUP HEALTH PLANS.”**

17 (2) The table of chapters for subtitle D of such
18 Code is amended by striking the item relating to
19 chapter 47 and inserting the following new item:

“Chapter 47. Taxes relating to health benefit plans.”

20 **SEC. 302. HEALTH BENEFIT PLAN STANDARDS.**

21 The Social Security Act is amended by adding at the
22 end the following new title:

1 not enrolled as of the date of the determination and
2 the plan may not be continued for plan years begin-
3 ning after the date of such determination until the
4 Secretary (or program) determines that such plan is
5 in compliance with such standards.

6 “(b) STATE APPROVED PROGRAMS.—

7 “(1) IN GENERAL.—If the Secretary determines
8 that a State has in effect an effective regulatory pro-
9 gram for the application of the standards established
10 under section 2102 to health benefit plans, the Sec-
11 retary may approve such program for purposes of
12 certification of health benefit plans under this title.

13 “(2) ANNUAL REPORTS.—As a condition for the
14 continued approval of such a regulatory program,
15 the State shall report to the Secretary annually such
16 information as the Secretary may require with re-
17 spect to the performance of the program. Such infor-
18 mation shall include a list of the health benefit plans
19 certified under the program, the compliance of such
20 plans with the standards established under section
21 2102, and enforcement actions taken to ensure such
22 compliance.

23 “(3) PERIODIC SECRETARIAL REVIEW OF STATE
24 REGULATORY PROGRAMS.—The Secretary annually
25 shall review State regulatory programs approved

1 under paragraph (1) to determine if they continue to
2 apply and enforce the standards. If the Secretary
3 initially determines that a State regulatory program
4 no longer is applying and enforcing such standards,
5 the Secretary shall provide the State an opportunity
6 to adopt such a plan of correction that would bring
7 such program into compliance. If the Secretary
8 makes a final determination that the State regu-
9 latory program, fails to apply and enforce such
10 standards after such an opportunity, the Secretary
11 shall disapprove such program and reassume respon-
12 sibility for certification of all health benefit plans in
13 that State.

14 “(4) GAO AUDITS.—The Comptroller General
15 shall conduct periodic reviews on a sample of State
16 regulatory programs approved under paragraph (1)
17 to determine their compliance with the requirements
18 of such paragraph. The Comptroller General shall
19 report to the Secretary and Congress on the findings
20 of such reviews.

21 “(c) EXCISE TAX SANCTIONS.—For application of
22 excise tax in the case of a nonqualified health benefit plan,
23 see section 5000A of the Internal Revenue Code of 1986.

24 “(d) EFFECTIVE DATE.—The effective date specified
25 in this subsection is January 1, 1994.

1 **“SEC. 2102. ESTABLISHMENT OF STANDARDS.**

2 “(a) ESTABLISHMENT OF STANDARDS.—The Sec-
3 retary shall develop and publish, by not later than October
4 1, 1993, specific standards to implement the requirements
5 of this title and to be applied under section 5000A of the
6 Internal Revenue Code of 1986.

7 “(b) MORE STRINGENT STATE STANDARDS PER-
8 MITTED.—In the case of insured health benefit plans, a
9 State may implement standards that are more stringent
10 than the standards established under this section.

11 “(c) APPLICATION TO ERISA.—The Secretary shall
12 consult with the Secretary of Labor concerning the appli-
13 cation of the requirements of this title to employee welfare
14 benefit plans under title I of the Employee Retirement In-
15 come Security Act of 1974.

16 **“SEC. 2103. REQUIREMENTS APPLICABLE TO ALL HEALTH**
17 **BENEFIT PLANS.**

18 “(a) NO DISCRIMINATION BASED ON HEALTH STA-
19 TUS.—

20 “(1) PROVISION OF SERVICES.—Except as pro-
21 vided under subsections (b) and (c), a health benefit
22 plan may not deny, limit, or condition the coverage
23 under (or benefits of) the plan based on the health
24 status, claims experience, receipt of health care,
25 medical history, or lack of evidence of insurability,
26 of an individual.

1 “(2) PREMIUM CHARGES WITHIN SELF-IN-
2 SURED HEALTH BENEFIT PLANS.—A self-insured
3 health benefit plan may not vary premiums charged
4 based on the health status, claims experience, receipt
5 of health care, medical history, or lack of evidence
6 of insurability, of an individual.

7 “(b) TREATMENT OF PRE-EXISTING CONDITION EX-
8 CLUSIONS FOR ALL SERVICES.—

9 “(1) IN GENERAL.—Subject to the succeeding
10 provisions of this subsection, a health benefit plan
11 may exclude coverage with respect to services related
12 to treatment of a pre-existing condition, but the pe-
13 riod of such exclusion may not exceed 6 months.

14 “(2) NONAPPLICATION TO NEWBORNS.—The
15 exclusion of coverage permitted under paragraph (1)
16 shall not apply to services furnished to newborns.

17 “(3) CREDITING OF PREVIOUS COVERAGE.—

18 “(A) IN GENERAL.—If an individual is in
19 a period of continuous coverage (as defined in
20 subparagraph (B)(i)) with respect to particular
21 services as of the date of initial coverage under
22 a plan, any period of exclusion of coverage with
23 respect to a pre-existing condition for such serv-
24 ices or type of services shall be reduced by 1

1 month for each month in the period of continu-
2 ous coverage.

3 “(B) DEFINITIONS.—In this paragraph:

4 “(i) PERIOD OF CONTINUOUS COV-
5 ERAGE.—The term ‘period of continuous
6 coverage’ means, with respect to particular
7 services, the period beginning on the date
8 an individual is enrolled under a health
9 benefit plan or program (including the
10 medicare program, a State plan under title
11 XIX, continuation coverage under section
12 4980B of the Internal Revenue Code of
13 1986, or a State general medical assistance
14 program) which provides the same or sub-
15 stantially similar benefits with respect to
16 such services and ends on the date the in-
17 dividual is not so enrolled for a continuous
18 period of more than 3 months.

19 “(ii) PRE-EXISTING CONDITION.—The
20 term ‘pre-existing condition’ means, with
21 respect to coverage under a plan, a condi-
22 tion which has been diagnosed or treated
23 during the 3-month period ending on the
24 day before the first date of such coverage,
25 except that such term does not include a

1 condition which was first diagnosed or
2 treated during a period of continuous cov-
3 erage.

4 “(C) STANDARDS FOR SIMILAR BENE-
5 FITS.—The Secretary shall establish such cri-
6 teria for determining if benefits are substan-
7 tially similar as may be necessary to carry out
8 this subsection.

9 “(c) EXCLUSION OF COLLECTIVELY BARGAINED
10 HEALTH BENEFIT PLANS.—In the case of a health bene-
11 fit plan established or maintained under or pursuant to
12 one or more collective bargaining agreements, the plan
13 may exclude from coverage individuals who are not cov-
14 ered under the plan or pursuant to one of such collective
15 bargaining agreements.

16 “(d) SMALL EMPLOYERS CANNOT OFFER SELF-IN-
17 SURED PLANS.—

18 “(1) IN GENERAL.—No health benefit plan of a
19 small employer may be certified under this title un-
20 less such plan is an insured health benefit plan.

21 “(2) SMALL EMPLOYER DEFINED.—

22 “(A) IN GENERAL.—In paragraph (1), the
23 term ‘small employer’ means, with respect to a
24 plan year, an employer that normally employs

1 more than 1 but less than 101 eligible employ-
2 ees on a typical business day during such year.

3 “(B) ELIGIBLE EMPLOYEE.—For purposes
4 of subparagraph (A), the term ‘eligible em-
5 ployee’ means, with respect to an employer, an
6 employee who normally performs on a monthly
7 basis at least 17½ hours of service per week for
8 that employer. For the purposes of this para-
9 graph, the term ‘employee’ includes a self-em-
10 ployed individual.

11 “(3) CONTROLLED GROUPS.—For purposes of
12 paragraph (2)—

13 “(A) CONTROLLED GROUP OF CORPORA-
14 TIONS.—All corporations which are members of
15 the same controlled group of corporations shall
16 be treated as 1 person. For purposes of the pre-
17 ceding sentence, the term ‘controlled group of
18 corporations’ has the meaning given to such
19 term by section 1563(a) of the Internal Reve-
20 nue Code of 1986, except that—

21 “(i) ‘more than 50 percent’ shall be
22 substituted for ‘at least 80 percent’ each
23 place it appears in section 1563(a)(1) of
24 such Code, and

1 “(ii) the determination shall be made
2 without regard to subsections (a)(4) and
3 (e)(3)(C) of section 1563 of such Code.

4 “(B) PARTNERSHIPS, PROPRIETORSHIPS,
5 ETC., WHICH ARE UNDER COMMON CONTROL.—
6 Under regulations prescribed by the Secretary
7 of the Treasury, all trades or business (whether
8 or not incorporated) which are under common
9 control shall be treated as 1 person. The regu-
10 lations prescribed under this subparagraph shall
11 be based on principles similar to the principles
12 which apply in the case of subparagraph (A).

13 “(4) EXCEPTION.—Paragraph (1) shall not
14 apply to a health benefit plan that is exempt from
15 treatment as a multiple employer welfare benefit
16 plan because of section 3(40)(A)(ii) of the Employee
17 Retirement Income Security Act of 1974.

18 **“SEC. 2104. STANDARDS APPLICABLE ONLY TO INSURED**
19 **HEALTH BENEFIT PLANS.**

20 “(a) OPEN ENROLLMENT.—

21 “(1) IN GENERAL.—Subject to the succeeding
22 provisions of this subsection, a carrier that offers an
23 insured health benefit plan to individuals residing
24 (or to groups located) in a State must offer the
25 same plan to any other resident of (or group located

1 in) the State. Such requirement shall apply on a
2 continuous, year-round basis.

3 “(2) RESTRICTIONS OF ENROLLMENT IN THE
4 CASE OF CERTAIN ASSOCIATION COVERAGE.—In the
5 case of an insured health benefit plan offered
6 through an association which is composed exclusively
7 of employers (which may include self-employed indi-
8 viduals) and which has been formed for purposes
9 other than obtaining health insurance, the carrier is
10 not required to offer the plan to individuals or em-
11 ployers who are not employees of such employers or
12 self-employed members of the association, or their
13 dependents.

14 “(3) TREATMENT OF HEALTH MAINTENANCE
15 ORGANIZATIONS.—

16 “(A) GEOGRAPHIC LIMITATIONS.—A
17 health maintenance organization may deny en-
18 rollment with respect to an individual if the in-
19 dividual is residing outside the service area of
20 the organization, but only if such denial is ap-
21 plied uniformly without regard to health status
22 or insurability.

23 “(B) SIZE LIMITS.—A health maintenance
24 organization may apply to the Secretary to
25 cease enrolling new employer groups or individ-

1 uals in its insured health benefit plan (or in a
2 geographic area served by the plan) if—

3 “(i) it ceases to enroll any new em-
4 ployer groups or individuals, and

5 “(ii) it can demonstrate that its finan-
6 cial or administrative capacity to serve pre-
7 viously enrolled groups and individuals
8 (and additional individuals who will be ex-
9 pected to enroll because of affiliation with
10 such previously enrolled groups) will be im-
11 paired if it is required to enroll new em-
12 ployer groups or individuals.

13 “(b) GROUNDS FOR REFUSAL TO ISSUE OR
14 RENEW.—A carrier may refuse to issue or renew or termi-
15 nate a plan only for—

16 “(1) nonpayment of premiums, and

17 “(2) fraud or misrepresentation.

18 “(c) USE OF COMMUNITY-RATED PREMIUM
19 RATES.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 the premium rate charged for an insured health ben-
22 efit plan with similar benefits in a community for a
23 type of enrollment (described in paragraph (4)) shall
24 be—

1 “(A) the same for all enrollments on a
2 group basis, and

3 “(B) the same for all other enrollments.

4 “(2) TRANSITION.—

5 “(A) IN GENERAL.—In the case of an in-
6 sured health benefit plan that charged different
7 premium rates for similar benefits in a commu-
8 nity for a type of enrollment in 1993, notwith-
9 standing paragraph (1) the percentage range
10 (as defined in subparagraph (B)) of premium
11 rates charged—

12 “(i) in 1994 may not be greater than
13 $\frac{2}{3}$ of the premium range of premium rates
14 charged in 1993, and

15 “(ii) in 1995 may not be greater than
16 $\frac{1}{3}$ of the premium range of premium rates
17 charged in 1993.

18 “(B) PREMIUM RANGE DEFINED.—In sub-
19 paragraph (A), the term ‘premium range’
20 means, with respect to premium rates under a
21 plan for similar benefits in a community for a
22 type of enrollment, the quotient (expressed as a
23 percentage) of—

24 “(i) the difference between the highest
25 premium rate for such coverage and the

1 lowest premium rate for such coverage, di-
2 vided by

3 “(ii) the lowest premium rate for such
4 coverage.

5 “(3) SPECIFICATION OF COMMUNITY.—For pur-
6 poses of this subsection, no carrier may use a geo-
7 graphic area that is smaller than a metropolitan sta-
8 tistical area as a community.

9 “(4) TYPES OF ENROLLMENT.—For purposes
10 of this subsection, the types of enrollment in a
11 health benefit plan are individual-only coverage and
12 coverage of a family consisting of more than 1 indi-
13 vidual.

14 “(d) MINIMUM PLAN PERIOD.—A carrier may not
15 offer to, or issue with respect to, an individual or employer
16 an insured health benefit plan with a term of less than
17 12 months.

18 “(e) NOTICES AND RENEWAL PERIODS.—

19 “(1) NOTICE AND SPECIFICATION OF RATES
20 AND ADMINISTRATIVE CHANGES.—

21 “(A) NOTICE.—The carrier of an insured
22 health benefit plan shall provide for notice, at
23 least 30 days before the date of expiration of
24 the plan, of the terms for renewal of the plan.

25 Except with respect to rates and administrative

1 changes, the terms of renewal (including bene-
2 fits) shall be the same as the terms of issuance.

3 “(B) RENEWAL RATES SAME AS ISSUANCE
4 RATES.—The carrier may change the terms for
5 such renewal, but the premium rates charged
6 with respect to such renewal shall be the same
7 as that for a new issue.

8 “(2) PERIOD OF RENEWAL.—The period of re-
9 newal of each insured health benefit plan shall be for
10 a period of not less than 12 months.

11 **“SEC. 2105. PAYMENT OF COMMISSIONS.**

12 “A carrier may not vary the remuneration paid a
13 broker for the sale or renewal of any health benefit plan
14 based, directly or indirectly, on the anticipated or actual
15 claims experience associated with the group or individuals
16 to which the plan was sold.

17 **“SEC. 2106. INSURANCE REQUIREMENT FOR MULTIPLE EM-
18 PLOYER WELFARE ARRANGEMENTS.**

19 “Each insured health benefit plan that is a multiple
20 employer welfare arrangement must be offered by an en-
21 tity licensed under an insurance law of a State.

22 **“SEC. 2107. NONAPPLICATION IN PUERTO RICO AND THE
23 TERRITORIES.**

24 “This title shall not apply outside the 50 States or
25 the District of Columbia.

1 **“SEC. 2108. DEFINITIONS.**

2 “In this title:

3 “(1) CARRIER.—The term ‘carrier’ means any
4 person that offers a health benefit plan, whether
5 through insurance or otherwise, including a licensed
6 insurance company, a prepaid hospital or medical
7 service plan, a health maintenance organization, and
8 a multiple employer welfare arrangement.

9 “(2) GROUP.—The term ‘group’ means 2 or
10 more employees of the same employer who normally
11 perform on a monthly basis at least 17½ hours of
12 service per week for that employer.

13 “(3) HEALTH BENEFIT PLAN.—

14 “(A) IN GENERAL.—The term ‘health ben-
15 efit plan’ means any plan or contract under
16 which any medical benefit is provided to any in-
17 dividual.

18 “(B) CERTAIN PLANS AND CONTRACTS
19 NOT COVERED.—The term ‘health benefit plan’
20 does not include any plan or contract—

21 “(i) which provides for accident only,
22 dental only, or disability only coverage,

23 “(ii) which provides coverage as a
24 supplement to liability insurance, and

25 “(iii) which provides insurance arising
26 out of a workers’ compensation or similar

1 law, or automobile medical-payment insur-
2 ance.

3 “(4) HEALTH MAINTENANCE ORGANIZATION.—
4 The term ‘health maintenance organization’ has the
5 meaning given the term ‘eligible organization’ in sec-
6 tion 1876(b).

7 “(5) INSURED HEALTH BENEFIT PLAN.—The
8 term ‘insured health benefit plan’ means any health
9 benefit plan provided through insurance, and in-
10 cludes a prepaid hospital or medical service plan, the
11 health benefit plan of a health maintenance organi-
12 zation, and a multiple employer welfare arrange-
13 ment.

14 “(6) MEDICAL BENEFIT.—The term ‘medical
15 benefit’ means any benefit which consists of the pro-
16 viding (through insurance or otherwise) of medical
17 care (as defined in section 213(d) of the Internal
18 Revenue Code of 1986).

19 “(7) MULTIPLE EMPLOYER WELFARE AR-
20 RANGEMENT.—The term ‘multiple employer welfare
21 arrangement’ has the meaning given such term in
22 section 3(40) of the Employee Retirement Income
23 Security Act of 1974.

24 “(8) SELF-INSURED HEALTH BENEFIT PLAN.—
25 The term ‘self-insured health benefit plan’ means

1 any health benefit plan not provided through insur-
2 ance.

3 “(9) STATE.—The term ‘State’ means the 50
4 States and the District of Columbia.”.

5 **SEC. 303. ASSURING CONTINUATION OF ACCESS TO COL-**
6 **LEGE AND UNIVERSITY HEALTH BENEFIT**
7 **PLANS BY GRADUATING STUDENTS.**

8 (a) IN GENERAL.—No State shall establish or enforce
9 any law or regulation that prevents the health benefit plan
10 of a college or university from offering eligible individuals
11 continuation of coverage under the plan.

12 (b) CONSTRUCTION.—Nothing in this section shall be
13 construed—

14 (1) as requiring the health benefit plan of a col-
15 lege or university to provide for the continuation
16 coverage described in subsection (a),

17 (2) if such continuation coverage is provided, as
18 requiring such continuation coverage to be made
19 available to other individuals or as requiring facili-
20 ties of the health benefit plan to be made available
21 to any individuals who have not otherwise been asso-
22 ciated with the college or university, or

23 (3) as preventing such a health benefit plan
24 from imposing premiums for such continuation cov-
25 erage.

1 (c) DEFINITIONS.—In this section:

2 (1) The term “college or university” means an
3 institution of higher education (as defined in section
4 1201(a) of the Higher Education Act of 1965).

5 (2) The term “eligible individual” means, with
6 respect to a college or university, an individual
7 who—

8 (A) is enrolled under the health benefit
9 plan of the college or university as a student (or
10 as a dependent of a student), and

11 (B) whose enrollment under the plan would
12 otherwise terminate because of the graduation
13 from the college or university of the individual
14 (or the spouse or parent of the individual).

15 (d) EFFECTIVE DATE.—This section shall take effect
16 on the date of the enactment of this Act.

17 **Subtitle B—Administrative**
18 **Simplification**

19 **SEC. 321. REQUIREMENT FOR UNIFORM HEALTH CLAIMS**
20 **CARDS.**

21 (a) UNIFORM HEALTH CLAIMS CARDS.—

22 (1) REQUIREMENT.—Each health benefit plan
23 (as defined in section 326(a)) shall issue a health
24 claims card that meets the requirements of sub-
25 section (c) for each individual who is entitled to ben-

1 efits under the plan and who is residing in the Unit-
2 ed States. Such card shall be issued to the individual
3 involved or, in the case of an individual enrolled as
4 a dependent of another individual, to that other indi-
5 vidual.

6 (2) DEADLINE FOR APPLICATION OF REQUIRE-
7 MENT.—The deadline specified under this paragraph
8 for the requirement under paragraph (1) is 6
9 months after the date the standards are established
10 under subsection (c).

11 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
12 ALTIES.—

13 (1) IN GENERAL.—In the case of a health bene-
14 fit plan that fails to issue a health claims card in ac-
15 cordance with subsection (a)(1), the plan is subject
16 to a civil money penalty of not to exceed \$100 for
17 each such violation. The provisions of section 1128A
18 of the Social Security Act (other than subsections
19 (a) and (b)) shall apply to a civil money penalty
20 under this subsection in the same manner as such
21 provisions apply to a penalty or proceeding under
22 section 1128A(a) of such Act.

23 (2) EFFECTIVE DATE.—No penalty may be im-
24 posed under paragraph (1) for any failure occurring
25 before the deadline specified in subsection (a)(2).

1 (c) UNIFORM HEALTH CLAIMS CARDS.—

2 (1) IN GENERAL.—The Secretary shall establish
3 standards consistent with this subsection respecting
4 the form and information to be contained on uni-
5 form health claims cards (for purposes of subsection
6 (a)).

7 (2) ELECTRONIC.—

8 (A) IN GENERAL.—Subject to subpara-
9 graph (B), the card shall be in a form similar
10 to that of a credit card and shall have, encoded
11 in electronic form—

12 (i) the identity of the individual,

13 (ii) the health benefit plan in which
14 the individual is enrolled, and

15 (iii) the telephone number or numbers
16 to be used for the verification electronically
17 of entitlement to benefits under the plan
18 under section 322 and for the submission
19 electronically of claims under the plan
20 under section 323.

21 (B) USE OF ELECTRONIC READ-AND-
22 WRITE CARDS.—The Secretary may provide for
23 cards in an electronic form that permits infor-
24 mation on the card to be readily changed. Such
25 information may include information relating to

1 the health coverage status of the individual and
2 the medical history of the individual.

3 (C) PERSONAL IDENTIFIER.—For pur-
4 poses of subparagraph (A) and for purposes of
5 claims processing and related purposes under
6 section 323, the Social Security account number
7 of the individual or, in the case of an infant or
8 other individual to whom such a number has
9 not been issued, such a Social Security account
10 number of a parent or guardian or other num-
11 ber as the Secretary shall specify, shall be used
12 as the personal identifier for the individual.

13 (3) ADDITIONAL INFORMATION.—The card
14 shall include such additional information, in elec-
15 tronic or other form, as the Secretary may require
16 to carry out the purposes of this Act. In addition,
17 the health benefit plan issuing the card may include
18 such additional information on the card as the plan
19 desires, subject to such limitations as the Secretary
20 may provide.

21 (4) DEADLINE.—The Secretary shall first es-
22 tablish the standards for uniform health claims
23 cards under this subsection by not later than 12
24 months after the date of the enactment of this Act.

1 (d) APPLICATION TO MEDICARE AND MEDICAID PRO-
2 GRAMS.—

3 (1) MEDICARE PROGRAM.—The Secretary shall
4 provide, in regulations promulgated to carry out the
5 medicare program, that identification cards issued
6 under that program are modified to the extent re-
7 quired to conform to the standards established under
8 subsection (c), by not later than the deadline speci-
9 fied in subsection (a)(2).

10 (2) STATE MEDICAID PLANS.—As a condition
11 for the approval of a State plan under the medicaid
12 program, effective for calendar quarters beginning
13 on or after the deadline specified in subsection
14 (a)(2), each such plan shall provide, in accordance
15 with regulations of the Secretary, that identification
16 cards issued under the plan are modified to the ex-
17 tent required to conform to the requirements of sub-
18 section (c).

19 **SEC. 322. REQUIREMENT FOR ENTITLEMENT VERIFICA-**
20 **TION SYSTEM.**

21 (a) IN GENERAL.—

22 (1) REQUIREMENT.—Each health benefit plan
23 shall provide for an electronic system, that is cer-
24 tified by the Secretary as meeting the standards es-
25 tablished under subsection (c), for the verification of

1 an individual's entitlement to benefits under such
2 plan.

3 (2) DEADLINE FOR APPLICATION OF REQUIRE-
4 MENT.—The deadline specified under this paragraph
5 for the requirement under paragraph (1) is 6
6 months after the date the standards are established
7 under subsection (c).

8 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
9 ALTIES.—

10 (1) IN GENERAL.—In the case of a health bene-
11 fit plan that fails to provide for an electronic ver-
12 ification system that is certified by the Secretary as
13 meeting the standards established under subsection
14 (c), the plan is subject to a civil money penalty of
15 not to exceed \$100 for each day in which such fail-
16 ure persists. The provisions of section 1128A of the
17 Social Security Act (other than subsections (a) and
18 (b)) shall apply to a civil money penalty under this
19 subsection in the same manner as such provisions
20 apply to a penalty or proceeding under section
21 1128A(a) of such Act.

22 (2) EFFECTIVE DATE.—No penalty may be im-
23 posed under paragraph (1) for any failure occurring
24 before the deadline specified in subsection (a)(2).

1 (c) STANDARDS FOR ENTITLEMENT VERIFICATION
2 SYSTEMS.—

3 (1) IN GENERAL.—The Secretary shall establish
4 standards consistent with this subsection respecting
5 the requirements for certification of entitlement ver-
6 ification systems.

7 (2) INFORMATION AVAILABLE.—Such standards
8 shall require a system to provide information, with
9 respect to individuals, concerning the following:

10 (A) The specific benefits to which the indi-
11 vidual is entitled under the plan.

12 (B) Current status of the individual with
13 respect to fulfillment of deductibles,
14 copayments, and out-of-pocket limits on cost-
15 sharing.

16 (C) Restrictions on providers who may pro-
17 vide covered services, including utilization con-
18 trols (such as preadmission certification).

19 (3) COORDINATION OF BENEFIT INFORMA-
20 TION.—Such standards shall require a system to
21 provide for the transfer among health benefit plans
22 of appropriate information in determining liability in
23 cases in which benefits may be payable under two or
24 more such plans.

1 (4) FORM OF INQUIRY.—Each verification sys-
2 tem shall be capable of accepting inquiries under
3 this subsection from health care providers (and, to
4 the extent provided under paragraph (3), from other
5 health benefit plans) in a variety of electronic and
6 other forms, including—

7 (A) through electronic transmission of in-
8 formation on the uniform health claims card (in
9 a manner similar to that for verification of
10 credit card purchases),

11 (B) through the use of a touch-tone tele-
12 phone line, and

13 (C) through the use of a computer modem.

14 The system shall also provide, for an additional fee,
15 for the acceptance of inquiries in a nonelectronic
16 form.

17 (5) FORM OF RESPONSE.—Each such system
18 shall be capable of responding to such inquiries
19 under this subsection in a variety of electronic and
20 other forms, including—

21 (A) through modem transmission of infor-
22 mation,

23 (B) through computer synthesized voice
24 communication, and

1 (C) through transmission of information to
2 a facsimile (fax) machine.

3 The system shall also provide, for an additional fee,
4 for the response to inquiries in a nonelectronic form.

5 (6) LIMITATION ON FEES.—A health benefit
6 plan may not impose a fee for the acceptance or re-
7 sponse to an inquiry under this subsection except
8 where the acceptance or response is in a
9 nonelectronic form.

10 (7) PUBLIC DOMAIN SOFTWARE TO PROVID-
11 ERS.—The Secretary shall provide for the develop-
12 ment, and shall make available without charge to
13 health service providers and health benefit plans,
14 such computer software as will enable—

15 (A) such providers to make inquiries, and
16 receive responses, electronically respecting the
17 eligibility and benefits of an individual under
18 health benefit plans, and

19 (B) such plans to make inquiries, and re-
20 ceive responses, electronically respecting liability
21 of other plans for the provision or payment of
22 benefits.

23 (8) DEADLINE.—The Secretary shall first es-
24 tablish the standards under this subsection (and
25 shall develop and make available the software under

1 paragraph (7)) by not later than 12 months after
2 the date of the enactment of this Act.

3 (d) APPLICATION TO MEDICARE AND MEDICAID PRO-
4 GRAMS.—

5 (1) MEDICARE PROGRAM.—The Secretary shall
6 provide, in regulations promulgated to carry out the
7 medicare program, that there is established an enti-
8 tlement verification system that meets the standards
9 established under subsection (c), by not later than
10 the deadline specified in subsection (a)(2).

11 (2) STATE MEDICAID PLANS.—As a condition
12 for the approval of a State plan under the medicaid
13 program, effective for calendar quarters beginning
14 on or after the deadline specified in subsection
15 (a)(2), each such plan shall provide, in accordance
16 with regulations of the Secretary, that there is es-
17 tablished an entitlement verification system that
18 meets the standards established under subsection
19 (c).

20 **SEC. 323. REQUIREMENTS FOR UNIFORM CLAIMS AND**
21 **ELECTRONIC CLAIMS DATA SET.**

22 (a) REQUIREMENTS.—

23 (1) SUBMISSION OF CLAIMS.—Each health serv-
24 ice provider that furnishes services in the United
25 States for which payment may be made under a

1 health benefit plan shall submit any claim for pay-
2 ment for such services only in a form and manner
3 consistent with standards established under sub-
4 section (c).

5 (2) ACCEPTANCE OF CLAIMS.—A health benefit
6 plan may not reject a claim for payment under the
7 plan on the basis of the form or manner in which
8 the claim is submitted if the claim is submitted in
9 accordance with the standards established under
10 subsection (c).

11 (3) EFFECTIVE DATE.—This subsection shall
12 apply to claims for services furnished on or after the
13 date that is 6 months after the date standards are
14 established under subsection (c).

15 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
16 ALTIES.—

17 (1) IN GENERAL.—

18 (A) PROVIDERS.—In the case of a health
19 service provider that submits a claim in viola-
20 tion of subsection (a)(1), the provider is subject
21 to a civil money penalty of not to exceed \$100
22 (or, if greater, the amount of the claim) for
23 each such violation.

24 (B) PLANS.—In the case of a health bene-
25 fit plan that rejects a claim in violation of sub-

1 section (a)(2), the plan is subject to a civil
2 money penalty of not to exceed \$100 (or, if
3 greater, the amount of the claim) for each such
4 violation.

5 (2) PROCESS.—The provisions of section 1128A
6 of the Social Security Act (other than subsections
7 (a) and (b)) shall apply to a civil money penalty
8 under paragraph (1) in the same manner as such
9 provisions apply to a penalty or proceeding under
10 section 1128A(a) of such Act.

11 (3) SUNSET FOR PENALTY.—No civil money
12 penalty may be imposed under this subsection for
13 submission (or rejection) of any claim on or after
14 the date that is 36 months after the effective date
15 specified in subsection (a)(3).

16 (c) STANDARDS RELATING TO UNIFORM CLAIMS AND
17 ELECTRONIC CLAIMS DATA SET.—

18 (1) ESTABLISHMENT OF STANDARDS.—The
19 Secretary shall establish standards that—

20 (A) relate to the form and manner of sub-
21 mission of claims for benefits under a health
22 benefit plan, and

23 (B) define the data elements to be con-
24 tained in a uniform electronic claims data set to
25 be used with respect to such claims.

1 (2) SCOPE OF INFORMATION.—

2 (A) IN GENERAL.—The standards under
3 this subsection are intended to cover substan-
4 tially most claims that are filed under health
5 benefit plans. Such information need not in-
6 clude all elements that may potentially be re-
7 quired to be reported under utilization review
8 provisions of plans.

9 (B) ENSURING ACCOUNTABILITY FOR
10 CLAIMS SUBMITTED ELECTRONICALLY.—In es-
11 tablishing such standards, the Secretary, in
12 consultation with appropriate agencies, shall in-
13 clude such methods of ensuring provider re-
14 sponsibility and accountability for claims sub-
15 mitted electronically that are designed to con-
16 trol fraud and abuse in the submission of such
17 claims.

18 (C) COMPONENTS.—In establishing such
19 standards the Secretary shall—

20 (i) with respect to data elements, de-
21 fine data fields, formats, and medical no-
22 menclature, and plan benefit and insurance
23 information;

1 (ii) develop a single, uniform coding
2 system for diagnostic and procedure codes;
3 and

4 (iii) provide for standards for the uni-
5 form electronic transmission of such ele-
6 ments.

7 (3) COORDINATION WITH STANDARDS FOR
8 ELECTRONIC MEDICAL RECORDS.—In establishing
9 standards under this subsection, the Secretary shall
10 assure that—

11 (A) the development of such standards is
12 coordinated with the development of the stand-
13 ards for electronic medical records under sec-
14 tion 324, and

15 (B) the coding of data elements under the
16 uniform electronic claims data set and the cod-
17 ing of the same elements in the uniform hos-
18 pital clinical data set are consistent.

19 (4) USE OF TASK FORCES.—In adopting stand-
20 ards under this subsection—

21 (A) the Secretary shall take into account
22 the recommendations of current task forces, in-
23 cluding at least the Workgroup on Electronic
24 Data Interchange, National Uniform Billing
25 Committee, the Uniform Claim Task Force, and

1 the Computer-based Patient Record Institute,
2 and

3 (B) the Secretary shall provide that the
4 electronic transmission standards are consist-
5 ent, to the extent practicable, with the applica-
6 ble standards established by the Accredited
7 Standards Committee X-12 of the American
8 National Standards Institute.

9 (5) UNIFORM, UNIQUE PROVIDER IDENTIFICA-
10 TION CODES.—In establishing standards under this
11 subsection—

12 (A) the Secretary shall provide for a
13 unique identifier code for each health service
14 provider that furnishes services for which a
15 claim may be submitted under a health benefit
16 plan, and

17 (B) in the case of a provider that has a
18 unique identifier issued for purposes of the
19 medicare program, the code provided under
20 subparagraph (A) shall be the same as such
21 unique identifier.

22 (6) PUBLIC DOMAIN SOFTWARE TO PROVID-
23 ERS.—The Secretary shall provide for the develop-
24 ment, and shall make available without charge to
25 health service providers, such computer software as

1 will enable the providers to submit claims and to re-
2 ceive verification of claims status electronically.

3 (7) STANDARDS FOR PAPER CLAIMS.—The
4 standards shall provide for a uniform paper claims
5 form which is consistent with data elements required
6 for the submission of claims electronically.

7 (8) STANDARDS FOR CLAIMS FOR CLINICAL
8 LABORATORY TESTS.—The standards shall provide
9 that claims for clinical laboratory tests for which
10 benefits are provided under a health benefit plan
11 shall be submitted directly by the person or entity
12 that performed (or supervised the performance of)
13 the tests to the plan in a manner consistent with
14 (and subject to such exceptions as are provided
15 under) the requirement for direct submission of such
16 claims under the medicare program.

17 (9) DEADLINE.—The Secretary shall first pro-
18 vide for the standards for the uniform claims under
19 this subsection (and shall develop and make avail-
20 able the software under paragraph (6)) by not later
21 than 1 year after the date of the enactment of this
22 Act.

23 (d) USE UNDER MEDICARE AND MEDICAID PRO-
24 GRAMS.—

1 (1) REQUIREMENT FOR PROVIDERS.—In the
2 case of a health service provider that submits a
3 claim for services furnished under the medicare pro-
4 gram or medicaid program in violation of subsection
5 (a)(1), no payment shall be made under such pro-
6 gram for such services.

7 (2) REQUIREMENTS OF INTERMEDIARIES AND
8 CARRIERS UNDER MEDICARE PROGRAM.—The Sec-
9 retary shall provide, in regulations promulgated to
10 carry out title XVIII of the Social Security Act, that
11 the claims process provided under that title is modi-
12 fied to the extent required to conform to the stand-
13 ards established under subsection (c).

14 (3) REQUIREMENTS OF STATE MEDICAID
15 PLANS.—As a condition for the approval of State
16 plans under the medicaid program, effective as of
17 the effective date specified in subsection (a)(3), each
18 such plan shall provide, in accordance with regula-
19 tions of the Secretary, that the claims process pro-
20 vided under the plan is modified to the extent re-
21 quired to conform to the standards established under
22 subsection (c).

1 **SEC. 324. ELECTRONIC MEDICAL RECORDS AND REPORT-**
2 **ING.**

3 (a) STANDARDS FOR ELECTRONIC MEDICAL
4 RECORDS FOR HOSPITALS.—

5 (1) PROMULGATION OF STANDARDS.—

6 (A) IN GENERAL.—Between July 1, 1994,
7 and January 1, 1995, the Secretary shall pro-
8 mulgate standards described in paragraph (2)
9 for hospitals concerning electronic medical
10 records.

11 (B) REVISION.—The Secretary may from
12 time to time revise the standards promulgated
13 under this paragraph.

14 (2) CONTENTS OF STANDARDS.—The standards
15 promulgated under paragraph (1) shall include at
16 least the following:

17 (A) A definition of a uniform hospital clini-
18 cal data set, including a definition of the set of
19 comprehensive data elements, for use by utiliza-
20 tion and quality control peer review organiza-
21 tions.

22 (B) Standards for an electronic patient
23 care information system with data obtained at
24 the point of care.

1 (C) A specification of, and manner of pres-
2 entation of, the individual data elements of the
3 set and system under this paragraph.

4 (D) Standards concerning the transmission
5 of electronic medical data.

6 (E) Standards relating to confidentiality of
7 patient-specific information, which include the
8 physical security of electronic data and the use
9 of keys, passwords, encryption, and other
10 means to ensure the protection of the confiden-
11 tiality and privacy of electronic data.

12 (3) COORDINATION WITH STANDARDS FOR UNI-
13 FORM ELECTRONIC CLAIMS DATA SET.—In establish-
14 ing standards under this subsection, the Secretary
15 shall assure that—

16 (A) the development of such standards is
17 coordinated with the development of the stand-
18 ards for the uniform electronic claims data set
19 under section 323, and

20 (B) the coding of data elements under the
21 uniform hospital clinical data set and the cod-
22 ing of the same elements under the uniform
23 electronic claims data set are consistent.

24 (4) CONSULTATION.—in establishing standards
25 under this subsection, the Secretary shall—

1 (A) consult with the American National
2 Standards Institute, hospitals, health benefit
3 plans, and other interested parties, and

4 (B) take into consideration, in developing
5 standards under paragraph (2)(A), the data set
6 used by the utilization and quality control peer
7 review program under part B of title XI of the
8 Social Security Act.

9 (b) REQUIREMENT FOR APPLICATION OF ELEC-
10 TRONIC RECORDS STANDARDS TO HOSPITALS.—

11 (1) AS CONDITION OF MEDICARE PARTICIPA-
12 TION.—As of January 1, 1996, each hospital, as a
13 requirement of each participation agreement under
14 section 1866 of the Social Security Act, shall, in ac-
15 cordance with the standards promulgated under sub-
16 section (a)(1)—

17 (A) maintain clinical data included in the
18 uniform hospital clinical data set under sub-
19 section (a)(2)(A) in electronic form on all inpa-
20 tients,

21 (B) upon request of the Secretary or of a
22 utilization and quality control peer review orga-
23 nization (with which the Secretary has entered
24 into a contract under part B of title XI of such

1 Act), transmit electronically data requested
2 from such data set, and

3 (C) upon request of the Secretary, or of a
4 fiscal intermediary or carrier, transmit elec-
5 tronically any data (with respect to a claim)
6 from such data set.

7 (2) APPLICATION OF PRESENTATION AND
8 TRANSMISSION STANDARDS TO ELECTRONIC TRANS-
9 MISSION TO FEDERAL AGENCIES.—Effective Janu-
10 ary 1, 1996, if a hospital is required under a Fed-
11 eral program to transmit a data element that is sub-
12 ject to a standard, promulgated under subsection
13 (a)(1), described in subparagraph (C) or (D) of sub-
14 section (a)(2), the head of the Federal agency re-
15 sponsible for such program (if not otherwise author-
16 ized) is authorized to require the provider to present
17 and transmit the data element electronically in ac-
18 cordance with such a standard.

19 (c) LIMITATION ON DATA REQUIREMENTS WHERE
20 STANDARDS IN EFFECT.—

21 (1) IN GENERAL.—On or after January 1,
22 1996, a health benefit plan may not require, for the
23 purpose of utilization review or as a condition of
24 providing benefits or making payments under the
25 plan, that a hospital—

1 (A) provide any data element not in the
2 uniform hospital clinical data set specified
3 under the standards promulgated under sub-
4 section (a), or

5 (B) transmit or present any such data ele-
6 ment in a manner inconsistent with such stand-
7 ards applicable to such transmission or presen-
8 tation.

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

19 (3) APPLICATION TO MEDICARE PROGRAM.—Ef-
20 fective as of January 1, 1996, neither the Secretary,
21 nor any carrier or fiscal intermediary, nor any utili-
22 zation and quality control peer review organization
23 may require, for the purpose of utilization review or
24 as a condition of providing benefits or making pay-

1 ments under the medicare program, that a hos-
2 pital—

3 (A) provide any data element not in the
4 uniform hospital clinical data set specified
5 under the standards promulgated under sub-
6 section (a), or

7 (B) transmit or present any such data ele-
8 ment in a manner inconsistent with such stand-
9 ards applicable to such transmission or presen-
10 tation.

11 (4) APPLICATION TO MEDICAID PROGRAM.—As
12 a condition for the approval of State plans under the
13 medicaid program and in accordance with regula-
14 tions of the Secretary, effective as of January 1,
15 1996, each such plan may not require that a hos-
16 pital, for the purpose of utilization review or as a
17 condition of providing benefits or making payments
18 under the plan—

19 (A) provide any data element not in the
20 uniform hospital clinical data set specified
21 under the standards promulgated under sub-
22 section (a), or

23 (B) transmit or present any such data ele-
24 ment in a manner inconsistent with such stand-

1 ards applicable to such transmission or presen-
2 tation.

3 (d) PREEMPTION OF STATE QUILL PEN LAWS.—

4 (1) IN GENERAL.—Any provision of State law
5 that requires medical or health insurance records
6 (including billing information) to be maintained in
7 written, rather than electronic, form shall deemed to
8 be satisfied if the records are maintained in an elec-
9 tronic form that meets standards established by the
10 Secretary under paragraph (2).

11 (2) SECRETARIAL AUTHORITY.—Not later than
12 1 year after the the date of the enactment of this
13 Act, the Secretary shall issue regulations to carry
14 out paragraph (1). The regulations shall provide for
15 an electronic substitute that is in the form of a
16 unique identifier (assigned to each authorized indi-
17 vidual) that serves the functional equivalent of a sig-
18 nature. The regulations may provide for such excep-
19 tions to paragraph (1) as the Secretary determines
20 to be necessary to prevent fraud and abuse, to pre-
21 vent the illegal distribution of controlled substances,
22 and in such other cases as the Secretary deems ap-
23 propriate.

24 (3) EFFECTIVE DATE.—Paragraph (1) shall
25 take effect on the first day of the first month that

1 begins more than 30 days after the date the Sec-
2 retary issues the regulations referred to in para-
3 graph (2).

4 **SEC. 325. UNIFORM HOSPITAL COST REPORTING.**

5 Each hospital, as a requirement under a participation
6 agreement under section 1866(a) of the Social Security
7 Act for each cost reporting period beginning during or
8 after fiscal year 1993, shall provide for the reporting of
9 information to the Secretary with respect to any hospital
10 care provided in a uniform manner consistent with stand-
11 ards established by the Secretary to carry out section
12 4007(c) of the Omnibus Budget Reconciliation Act of
13 1987 and in an electronic form consistent with standards
14 established by the Secretary.

15 **SEC. 326. DEFINITIONS.**

16 (a) HEALTH BENEFIT PLAN.—In this subtitle:

17 (1) IN GENERAL.—The term “health benefit
18 plan” means, except as provided in paragraphs (2)
19 through (4), any public or private entity or program
20 that provides for payments for health care services,
21 including—

22 (A) a group health plan (as defined in sec-
23 tion 5000(b)(1) of the Internal Revenue Code
24 of 1986), and

1 (B) any other health insurance arrange-
2 ment, including any arrangement consisting of
3 a hospital or medical expense incurred policy or
4 certificate, hospital or medical service plan con-
5 tract, or health maintenance organization sub-
6 scriber contract.

7 (2) PLANS EXCLUDED.—Such term does not in-
8 clude—

9 (A) accident-only, credit, or disability in-
10 come insurance;

11 (B) coverage issued as a supplement to li-
12 ability insurance;

13 (C) an individual making payment on the
14 individual's own behalf (or on behalf of a rel-
15 ative or other individual) for deductibles, coin-
16 surance, or services not covered under a health
17 benefit plan; and

18 (D) such other plans as the Secretary may
19 determine, because of the limitation of benefits
20 to a single type or kind of health care, such as
21 dental services, or other reasons should not be
22 subject to the requirements of this section.

23 (3) PLANS INCLUDED.—Such term includes—

24 (A) worker's compensation or similar in-
25 surance, and

1 (B) automobile medical-payment insurance.

2 (4) TREATMENT OF DIRECT FEDERAL PROVI-
3 SION OF SERVICES.—Such term does not include a
4 Federal program that provides directly for the provi-
5 sion of health services to beneficiaries.

6 (b) HEALTH SERVICE PROVIDER.—In this subtitle,
7 the term “health service provider” includes a provider of
8 services (as defined in section 1861(u) of the Social Secu-
9 rity Act), physician, supplier, and other person furnishing
10 health care services.

11 **Subtitle C—Fraud and Abuse**

12 **PART 1—NATIONAL HEALTH CARE FRAUD CONTROL** 13 **PROGRAM**

14 **SEC. 341. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-** 15 **GRAM**

16 (a) ESTABLISHMENT OF PROGRAM.—

17 (1) ESTABLISHMENT.—Not later than January
18 1, 1994, the Secretary shall establish in the Office
19 of the Inspector General of the Department of
20 Health and Human Services a program—

21 (A) to coordinate Federal, State, and local
22 law enforcement programs to control fraud and
23 abuse with respect to the delivery of and pay-
24 ment for health care in the United States,

1 (B) to conduct investigations, audits, eval-
2 uations, and inspections relating to the delivery
3 of and payment for health care in the United
4 States, and

5 (C) to facilitate the enforcement of the
6 provisions of sections 1128, 1128A, and 1128B
7 of the Social Security Act and other statutes
8 applicable to health care fraud and abuse.

9 (2) COORDINATION WITH LAW ENFORCEMENT
10 AGENCIES.—In carrying out the program established
11 under paragraph (1), the Secretary shall consult
12 with, and arrange for the sharing of data and re-
13 sources with, the Attorney General and State law
14 enforcement agencies, State medicaid fraud and
15 abuse units, and State agencies responsible for the
16 licensing and certification of health care providers.

17 (3) REGULATIONS.—

18 (A) IN GENERAL.—The Secretary shall by
19 regulation establish standards to carry out the
20 program under paragraph (1).

21 (B) INFORMATION STANDARDS.—

22 (i) IN GENERAL.—Such standards
23 shall include standards relating to the fur-
24 nishing of information by health insurers
25 (including self-insured health benefit

1 plans), providers, and others to enable the
2 Secretary to carry out the program (in-
3 cluding coordination with law enforcement
4 agencies under paragraph (2)).

5 (ii) CONFIDENTIALITY.—Such stand-
6 ards shall include procedures to assure
7 that such information is provided and uti-
8 lized in a manner that protects the con-
9 fidentiality of the information and the pri-
10 vacy of individuals receiving health care
11 services.

12 (iii) QUALIFIED IMMUNITY FOR PRO-
13 VIDING INFORMATION.—The provisions of
14 section 1157(a) of the Social Security Act
15 (relating to limitation on liability) shall
16 apply to a person providing information to
17 the Secretary under the program under
18 this section, with respect to the Secretary's
19 performance of duties under the program,
20 in the same manner as such section applies
21 to information provided to organizations
22 with a contract under part B of title XI of
23 such Act, with respect to the performance
24 of such a contract.

1 (C) DISCLOSURE OF OWNERSHIP INFOR-
2 MATION.—

3 (i) IN GENERAL.—Such standards
4 shall include standards relating to the dis-
5 closure of ownership information described
6 in clause (ii).

7 (ii) OWNERSHIP INFORMATION DE-
8 SCRIBED.—The ownership information de-
9 scribed in this clause includes—

10 (I) covered items and services
11 provided by an entity;

12 (II) the names and unique physi-
13 cian identification numbers of all phy-
14 sicians with an ownership or invest-
15 ment interest in the entity (as de-
16 scribed in section 1877(a)(2)(A) of
17 the Social Security Act) or whose im-
18 mediate relatives have such an owner-
19 ship or investment interest; and

20 (III) the names of all other indi-
21 viduals with such an ownership or in-
22 vestment interest in the entity.

23 (D) INTEGRITY OF ISSUANCE OF PRO-
24 VIDER IDENTIFICATION CODES.—Such stand-
25 ards shall, insofar as they relate to the issuance

1 of unique provider codes (described in section
2 323(c)(5))—

3 (i) include standards relating to the
4 information (including ownership informa-
5 tion described in subparagraph (C)(ii) and
6 other information needed in the adminis-
7 tration of the program) to be required for
8 the issuance of such codes, and

9 (ii) provide for the issuance of such a
10 code upon the presentation of such infor-
11 mation as would be sufficient to provide
12 for the issuance of similar codes under the
13 medicare program.

14 (4) AUTHORIZATION OF APPROPRIATIONS FOR
15 INVESTIGATORS AND OTHER PERSONNEL.—

16 (A) IN GENERAL.—In addition to any
17 other amounts authorized to be appropriated to
18 the Secretary for health care anti-fraud and
19 abuse activities for a fiscal year, there are au-
20 thorized to be appropriated additional amounts
21 described in subparagraph (B) to enable the
22 Secretary to conduct investigations of allega-
23 tions of health care fraud and otherwise carry
24 out the program established under paragraph
25 (1) in a fiscal year.

1 (B) AMOUNTS DESCRIBED.—The amounts
2 referred to in subparagraph (A) are as follows:

3 (i) For fiscal year 1995,
4 \$300,000,000.

5 (ii) For fiscal year 1996,
6 \$350,000,000.

7 (iii) For fiscal year 1997,
8 \$400,000,000.

9 (iv) For fiscal year 1998,
10 \$450,000,000.

11 (5) ENSURING ACCESS TO DOCUMENTATION.—

12 (A) The Inspector General of the Department of
13 Health and Human Services is authorized to exercise
14 the authority described in paragraphs (4) and (5) of
15 section 6 of the Inspector General Act of 1978 (re-
16 lating to subpoenas and administration of oaths)
17 with respect to the activities under the all-payor
18 fraud and abuse control program established under
19 this subsection to the same extent as such Inspector
20 General may exercise such authorities to perform the
21 functions assigned to such official by such Act.

22 (B) Section 1128(b) of the Social Security Act
23 (42 U.S.C. 1320a-7(b)) is amended by adding at
24 the end the following new paragraph:

1 “(15) FAILURE TO SUPPLY REQUESTED
2 INFORMATION TO THE INSPECTOR GENERAL.—
3 Any individual or entity that fails fully and ac-
4 curately to provide, upon request of the Inspec-
5 tor General of the Department of Health and
6 Human Services, records, documents, and other
7 information necessary for the purposes of carry-
8 ing out activities under the all-payor fraud and
9 abuse control program established under section
10 341 of the Health Care Cost Containment and
11 Reform Act of 1993.”.

12 (b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE
13 TRUST FUND.—

14 (1) ESTABLISHMENT.—

15 (A) IN GENERAL.—There is hereby created
16 on the books of the Treasury of the United
17 States a trust fund to be known as the “Anti-
18 Fraud and Abuse Trust Fund” (in this section
19 referred to as the “Trust Fund”). The Trust
20 Fund shall consist of such gifts and bequests as
21 may be made as provided in subparagraph (B)
22 and such amounts as may be deposited in, or
23 appropriated to, such Trust Fund as provided
24 in this subtitle, section 143(b), and title XI of
25 the Social Security Act.

1 (B) AUTHORIZATION TO ACCEPT GIFTS.—

2 The Managing Trustee of the Trust Fund is
3 authorized to accept on behalf of the United
4 States money gifts and bequests made uncondi-
5 tionally to the Trust Fund, for the benefit of
6 the Trust Fund, or any activity financed
7 through the Trust Fund.

8 (2) MANAGEMENT.—

9 (A) IN GENERAL.—The Trust Fund shall
10 be managed by the Secretary through a Manag-
11 ing Trustee designated by the Secretary.

12 (B) INVESTMENT OF FUNDS.—It shall be
13 the duty of the Managing Trustee to invest
14 such portion of the Trust Fund as is not, in the
15 trustee's judgment, required to meet current
16 withdrawals. Such investments may be made
17 only in interest-bearing obligations of the Unit-
18 ed States or in obligations guaranteed as to
19 both principal and interest by the United
20 States. For such purpose such obligations may
21 be acquired (i) on original issue at the issue
22 price, or (ii) by purchase of outstanding obliga-
23 tions at market price. The purposes for which
24 obligations of the United States may be issued
25 under chapter 31 of title 31, United States

1 Code, are hereby extended to authorize the issu-
2 ance at par of public-debt obligations for pur-
3 chase by the Trust Fund. Such obligations is-
4 sued for purchase by the Trust Fund shall have
5 maturities fixed with due regard for the needs
6 of the Trust Fund and shall bear interest at a
7 rate equal to the average market yield (com-
8 puted by the Managing Trustee on the basis of
9 market quotations as of the end of the calendar
10 month next preceding the date of such issue) on
11 all marketable interest-bearing obligations of
12 the United States then forming a part of the
13 public debt which are not due or callable until
14 after the expiration of 4 years from the end of
15 such calendar month, except that where such
16 average is not a multiple of $\frac{1}{8}$ of 1 percent, the
17 rate of interest on such obligations shall be the
18 multiple of $\frac{1}{8}$ of 1 percent nearest such market
19 yield. The Managing Trustee may purchase
20 other interest-bearing obligations of the United
21 States or obligations guaranteed as to both
22 principal and interest by the United States, on
23 original issue or at the market price, only where
24 the Trustee determines that the purchase of
25 such other obligations is in the public interest.

1 (C) Any obligations acquired by the Trust
2 Fund (except public-debt obligations issued ex-
3 clusively to the Trust Fund) may be sold by the
4 Managing Trustee at the market price, and
5 such public-debt obligations may be redeemed
6 at par plus accrued interest.

7 (D) The interest on, and the proceeds from
8 the sale or redemption of, any obligations held
9 in the Trust Fund shall be credited to and form
10 a part of the Trust Fund.

11 (E) The receipts and disbursements of the
12 Secretary in the discharge of the functions of
13 the Secretary shall not be included in the totals
14 of the budget of the United States Government.
15 For purposes of part C of the Balanced Budget
16 and Emergency Deficit Control Act of 1985,
17 the Secretary and the Trust Fund shall be
18 treated in the same manner as the Federal Re-
19 tirement Thrift Investment Board and the
20 Thrift Savings Fund, respectively. The United
21 States is not liable for any obligation or liability
22 incurred by the Trust Fund.

23 (3) USE OF FUNDS.—Amounts in the Trust
24 Fund shall be used to assist the Inspector General
25 of the Department of Health and Human Services in

1 carrying out the all-payor fraud and abuse control
2 program established under subsection (a) in the fis-
3 cal year involved.

4 **SEC. 342. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
5 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
6 **ABUSE AGAINST ANY HEALTH BENEFIT PLAN.**

7 (a) CIVIL MONETARY PENALTIES.—Section 1128A
8 of the Social Security Act (42 U.S.C. 1320a-7a) is amend-
9 ed as follows:

10 (1) In subsection (a)(1), in the matter before
11 subparagraph (A), by inserting “or of any health
12 benefit plan,” after “subsection (i)(1),”.

13 (2) In subsection (b)(1)(A), by inserting “or
14 under a health benefit plan” after “title XIX”.

15 (3) In subsection (f), by amending paragraph
16 (2) to read as follows:

17 “(2) In the case of amounts recovered arising
18 out of claim under a health benefit plan, the portion
19 of amounts recovered as is determined to have been
20 paid out of the Federal Hospital Insurance Trust
21 Fund and the Federal Supplementary Medical In-
22 surance Trust Fund, and the portion of amounts re-
23 covered arising out of a claim under title XIX that
24 is not paid to the State agency under paragraph
25 (1)(A), such amounts (and such portions) shall be

1 paid to the Anti-Fraud and Abuse Trust Fund es-
2 tablished under section 341(b) of the Health Care
3 Cost Containment and Reform Act of 1993.”.

4 (4) In subsection (i)—

5 (A) in paragraph (2), by inserting “or
6 under a health benefit plan” before the period
7 at the end, and

8 (B) in paragraph (5), by inserting “or
9 under a health benefit plan” after “or XX”.

10 (b) CRIMES.—

11 (1) SOCIAL SECURITY ACT.—Section 1128B of
12 such Act (42 U.S.C. 1320a–7b) is amended as fol-
13 lows:

14 (A) In the heading, by adding at the end
15 the following: “OR HEALTH BENEFIT PLANS”.

16 (B) In subsection (a)(1)—

17 (i) by striking “title XVIII or” and
18 inserting “title XVIII,”, and

19 (ii) by adding at the end the follow-
20 ing: “or a health benefit plan (as defined
21 in section 1128(i)),”.

22 (C) In subsection (a)(5), by striking “title
23 XVIII or a State health care program” and in-
24 serting “title XVIII, a State health care pro-
25 gram, or a health benefit plan”.

1 (D) In the second sentence of subsection

2 (a)—

3 (i) by inserting after “title XIX” the
4 following: “or a health benefit plan”, and

5 (ii) by inserting after “the State” the
6 following: “or the plan”.

7 (E) In subsection (b)(1), by striking “title
8 XVIII or a State health care program” each
9 place it appears and inserting “title XVIII, a
10 State health care program, or a health benefit
11 plan”.

12 (F) In subsection (b)(2), by striking “title
13 XVIII or a State health care program” each
14 place it appears and inserting “title XVIII, a
15 State health care program, or a health benefit
16 plan”.

17 (G) In subsection (b)(3), by striking “title
18 XVIII or a State health care program” each
19 place it appears in subparagraphs (A) and (C)
20 and inserting “title XVIII, a State health care
21 program, or a health benefit plan”.

22 (H) In subsection (d)(2)—

23 (i) by striking “title XIX,” and insert-
24 ing “title XIX or under a health benefit
25 plan,”, and

1 (ii) by striking “State plan,” and in-
2 serting “State plan or the health benefit
3 plan,”.

4 (2) TREBLE DAMAGES FOR CRIMINAL SANC-
5 TIONS.—Section 1128B of such Act (42 U.S.C.
6 1320a–7b) is amended by adding at the end the fol-
7 lowing new subsection:

8 “(f) In addition to the fines that may be imposed
9 under subsection (a), (b), or (c), any individual found to
10 have violated the provisions of any of such subsections
11 may be subject to treble damages.”.

12 (3) IDENTIFICATION OF COMMUNITY SERVICE
13 OPPORTUNITIES.—Section 1128B of such Act (42
14 U.S.C. 1320a–7b) is further amended by adding at
15 the end the following new subsection:

16 “(g) The Secretary shall—

17 “(1) identify opportunities for the satisfaction
18 of community service obligations that a court may
19 impose upon the conviction of an offense under this
20 section, and

21 “(2) make information concerning such oppor-
22 tunities available to Federal and State law enforce-
23 ment officers.”.

24 (d) HEALTH BENEFIT PLAN DEFINED.—Section
25 1128 of such Act (42 U.S.C. 1320a–7) is amended by re-

1 designating subsection (i) as subsection (j) and by insert-
2 ing after subsection (h) the following new subsection:

3 “(i) HEALTH BENEFIT PLAN DEFINED.—For pur-
4 poses of sections 1128A and 1128B, the term ‘health ben-
5 efit plan’ means a health benefit program other than the
6 medicare program, the medicaid program, or a State
7 health care program.”.

8 (e) CONFORMING AMENDMENT.—Section
9 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a-
10 7(b)(8)(B)(ii)) is amended by striking “1128A” and in-
11 serting “1128A (other than a penalty arising from a
12 health benefit plan, as defined in subsection (i))”.

13 **SEC. 343. PROHIBITION AGAINST OFFERING INDUCEMENTS**
14 **TO INDIVIDUALS ENROLLED UNDER OR EM-**
15 **PLOYED BY PROGRAMS OR PLANS.**

16 (a) INDUCEMENTS TO INDIVIDUALS ENROLLED
17 UNDER MEDICARE.—Section 1128A(a)(1) of the Social
18 Security Act (42 U.S.C. 1320a-7a(a)(1)) is amended—

19 (1) by striking “or” at the end of paragraph
20 (1)(D);

21 (2) by striking “, or” at the end of paragraph
22 (2) and inserting a semicolon;

23 (3) by striking the semicolon at the end of
24 paragraph (3) and inserting “; or”; and

1 (4) by inserting after paragraph (3) the follow-
2 ing new paragraph:

3 “(4) routinely transfers anything for less than
4 fair market value to (or for the benefit of) an indi-
5 vidual entitled to benefits under the medicare pro-
6 gram in order to influence the individual to receive
7 from a particular provider, practitioner, or supplier
8 a covered item or service for which payment may be
9 made under such program;”.

10 (b) INDUCEMENTS TO EMPLOYEES.—Section
11 1128A(a)(1) of such Act (42 U.S.C. 1320a–7a(a)(1)), as
12 amended by subsection (a), is further amended—

13 (1) by striking “or” at the end of paragraph
14 (3);

15 (2) by striking the semicolon at the end of
16 paragraph (4) and inserting “; or”; and

17 (3) by inserting after paragraph (4) the follow-
18 ing new paragraph:

19 “(5) pays a bonus, reward, or other incentive to
20 an employee to induce the employee to encourage in-
21 dividuals to seek or obtain covered items or services
22 for which payment may be made under the medicare
23 program, a State health care program, or a health
24 benefit plan where the amount of the incentive is in
25 proportion to the activities of the employee in en-

1 couraging individuals to seek or obtain covered items
2 or services;”.

3 **SEC. 344. INTERMEDIATE SANCTIONS FOR MEDICARE**
4 **HEALTH MAINTENANCE ORGANIZATIONS.**

5 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
6 ANY PROGRAM VIOLATIONS.—

7 (1) IN GENERAL.—Section 1876(i)(1) of the
8 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
9 amended by striking “the Secretary may terminate”
10 and all that follows and inserting the following: “in
11 accordance with procedures established under para-
12 graph (9), the Secretary may at any time terminate
13 any such contract or may impose the intermediate
14 sanctions described in paragraph (6)(B) or (6)(C)
15 (whichever is applicable) on the eligible organization
16 if the Secretary determines that the organization—

17 “(A) has failed substantially to carry out
18 the contract;

19 “(B) is carrying out the contract in a man-
20 ner inconsistent with the efficient and effective
21 administration of this section;

22 “(C) is operating in a manner that is not
23 in the best interests of the individuals covered
24 under the contract; or

1 “(D) no longer substantially meets the ap-
2 plicable conditions of subsections (b), (c), (e),
3 and (f).”.

4 (2) OTHER INTERMEDIATE SANCTIONS
5 FOR MISCELLANEOUS PROGRAM VIOLATIONS.—
6 Section 1876(i)(6) of such Act (42 U.S.C.
7 1395mm(i)(6)) is amended by adding at the
8 end the following new subparagraph:

9 “(C) In the case of an eligible organization for
10 which the Secretary makes a determination under
11 paragraph (1) the basis of which is not described in
12 subparagraph (A), the Secretary may apply the fol-
13 lowing intermediate sanctions:

14 “(i) civil money penalties of not more than
15 \$25,000 for each determination under para-
16 graph (1) if the deficiency that is the basis of
17 the determination has directly adversely af-
18 fected (or has the substantial likelihood of ad-
19 versely affecting) an individual covered under
20 the organization’s contract;

21 “(ii) civil money penalties of not more than
22 \$10,000 for each week beginning after the initi-
23 ation of procedures by the Secretary under
24 paragraph (9) during which the deficiency that

1 is the basis of a determination under paragraph
2 (1) exists; and

3 “(iii) suspension of enrollment of individ-
4 uals under this section after the date the Sec-
5 retary notifies the organization of a determina-
6 tion under paragraph (1) and until the Sec-
7 retary is satisfied that the deficiency that is the
8 basis for the determination has been corrected
9 and is not likely to recur.”.

10 (3) PROCEDURES FOR IMPOSING SANCTIONS.—

11 Section 1876(i) of such Act (42 U.S.C. 1395mm(i))
12 is amended by adding at the end the following new
13 paragraph:

14 “(9) The Secretary may terminate a contract with an
15 eligible organization under this section or may impose the
16 intermediate sanctions described in paragraph (6) on the
17 organization in accordance with formal investigation and
18 compliance procedures established by the Secretary under
19 which—

20 “(A) the Secretary provides the organization
21 with the opportunity to develop and implement a
22 corrective action plan to correct the deficiencies that
23 were the basis of the Secretary’s determination
24 under paragraph (1);

1 “(B) the Secretary shall impose more severe
2 sanctions on organizations that have a history of de-
3 ficiencies or that have not taken steps to correct de-
4 ficiencies the Secretary has brought to their atten-
5 tion;

6 “(C) there are no unreasonable or unnecessary
7 delays between the finding of a deficiency and the
8 imposition of sanctions; and

9 “(D) the Secretary provides the organization
10 with reasonable notice and opportunity for hearing
11 (including the right to appeal an initial decision) be-
12 fore imposing any sanction or terminating the con-
13 tract.”.

14 (4) CONFORMING AMENDMENTS.—(A) Section
15 1876(i)(6)(B) of such Act (42 U.S.C.
16 1395mm(i)(6)(B)) is amended by striking the sec-
17 ond sentence.

18 (B) Section 1876(i)(6) of such Act (42 U.S.C.
19 1395mm(i)(6)) is further amended by adding at the
20 end the following new subparagraph:

21 “(D) The provisions of section 1128A (other
22 than subsections (a) and (b)) shall apply to a civil
23 money penalty under subparagraph (A) or (B) in the
24 same manner as they apply to a civil money penalty
25 or proceeding under section 1128A(a).”.

1 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
2 TIONS.—

3 (1) REQUIREMENT FOR WRITTEN AGREE-
4 MENT.—Section 1876(i)(7)(A) of the Social Security
5 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by
6 striking “an agreement” and inserting “a written
7 agreement”.

8 (2) DEVELOPMENT OF MODEL AGREEMENT.—
9 Not later than July 1, 1993, the Secretary of Health
10 and Human Services shall develop a model of the
11 agreement that an eligible organization with a risk-
12 sharing contract under section 1876 of the Social
13 Security Act must enter into with an entity provid-
14 ing peer review services with respect to services pro-
15 vided by the organization under section
16 1876(i)(7)(A) of such Act.

17 (3) REPORT BY GAO.—

18 (A) STUDY.—The Comptroller General
19 shall conduct a study of the costs incurred by
20 eligible organizations with risk-sharing con-
21 tracts under section 1876(b) of such Act of
22 complying with the requirement of entering into
23 a written agreement with an entity providing
24 peer review services with respect to services pro-
25 vided by the organization, together with an

1 analysis of how information generated by such
2 entities is used by the Secretary of Health and
3 Human Services to assess the quality of serv-
4 ices provided by such eligible organizations.

5 (B) REPORT TO CONGRESS.—Not later
6 than July 1, 1995, the Comptroller General
7 shall submit a report to the Committee on
8 Ways and Means and the Committee on Energy
9 and Commerce of the House of Representatives
10 and the Committee on Finance of the Senate on
11 the study conducted under subparagraph (A).

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply with respect to contract years be-
14 ginning on or after January 1, 1994.

15 PART 2—BAN ON IMPROPER PHYSICIAN REFERRALS
16 **SEC. 351. APPLICATION OF MEDICARE BAN ON SELF-RE-**
17 **FERRALS TO ALL PAYORS.**

18 Section 1877 of the Social Security Act (42 U.S.C.
19 1395nn) is amended—

20 (1) in subsection (a)—

21 (A) in paragraph (1)(A), by striking “for
22 which payment otherwise may be made under
23 this title” and inserting “for which a charge is
24 imposed”, and

1 (B) in paragraph (1)(B), by striking
2 “under this title”;

3 (2) by amending paragraph (1) of subsection
4 (g) to read as follows:

5 “(1) DENIAL OF PAYMENT.—No payment may
6 be made under this title, under another Federal
7 health care program, or under a State health care
8 program (as defined in section 1128(h)) for a des-
9 ignated health service for which a claim is presented
10 in violation of subsection (a)(1)(B). No individual,
11 third party payor, or other entity is liable for pay-
12 ment for designated health services for which a
13 claim is presented in violation of such subsection.”;
14 and

15 (3) in subsection (g)(3), by striking “for which
16 payment may not be made under paragraph (1)”
17 and inserting “for which such a claim may not be
18 presented under subsection (a)(1)”.

19 **SEC. 352. EXTENSION OF SELF-REFERRAL BAN TO ADDI-**
20 **TIONAL SPECIFIED SERVICES.**

21 (a) IN GENERAL.—Section 1877 of the Social Secu-
22 rity Act is further amended—

23 (1) by striking “clinical laboratory services”
24 and “CLINICAL LABORATORY SERVICES” and insert-
25 ing “designated health services” and “DESIGNATED

1 HEALTH SERVICES”, respectively, each place either
2 appears in subsections (a)(1), (b)(2)(A)(ii)(I),
3 (b)(4), (d)(1), (d)(2), and (d)(3), and

4 (2) by adding at the end the following new sub-
5 section:

6 “(i) DESIGNATED HEALTH SERVICES DEFINED.—In
7 this section, the term ‘designated health services’ means—

8 “(1) clinical laboratory services;

9 “(2) physical therapy services;

10 “(3) radiology services, including magnetic reso-
11 nance imaging, computerized axial tomography
12 scans, and ultrasound services;

13 “(4) radiation therapy services;

14 “(5) the furnishing of durable medical equip-
15 ment;

16 “(6) the furnishing of parenteral and enteral
17 nutrition equipment and supplies;

18 “(7) the furnishing of outpatient prescription
19 drugs;

20 “(8) ambulance services;

21 “(9) home infusion therapy services;

22 “(10) occupational therapy services; and

23 “(11) inpatient and outpatient hospital services
24 (including services furnished at a psychiatric or re-
25 habilitation hospital).”.

1 (b) CONFORMING AMENDMENTS.—Section 1877 of
2 such Act is further amended—

3 (1) in subsection (d)(2), by striking “labora-
4 tory” and inserting “entity”,

5 (2) in subsection (g)(1), by striking “clinical
6 laboratory service” and inserting “designated health
7 service”, and

8 (3) in subsection (h)(7)(B), by striking “clinical
9 laboratory service” and inserting “designated health
10 service”.

11 **SEC. 353. CHANGES IN EXCEPTIONS AND OTHER PROVI-**
12 **SIONS RELATING TO COMPENSATION AR-**
13 **RANGEMENTS.**

14 (a) MULTIPLE LOCATIONS FOR GROUP PRAC-
15 TICES.—Section 1877(b)(2)(A)(ii)(II) of the Social Secu-
16 rity Act is amended by striking “centralized provision”
17 and inserting “provision of some or all”.

18 (b) TREATMENT OF COMPENSATION ARRANGE-
19 MENTS.—

20 (1) RENTAL OF OFFICE SPACE AND EQUIP-
21 MENT.—Paragraph (1) of section 1877(e) of such
22 Act is amended to read as follows:

23 “(1) RENTAL OF OFFICE SPACE; RENTAL OF
24 EQUIPMENT.—

1 “(A) OFFICE SPACE.—Payments made by
2 a lessee to a lessor for the use of premises if—

3 “(i) the lease is set out in writing,
4 signed by the parties, and specifies the
5 premises covered by the lease,

6 “(ii) the aggregate space rented or
7 leased is reasonable and necessary for the
8 legitimate business purposes of the lease or
9 rental,

10 “(iii) the lease provides for a term of
11 rental or lease for at least one year,

12 “(iv) in the case of a lease that is in-
13 tended to provide the lessee with access to
14 the premises for periodic intervals of time,
15 rather than on a full-time basis, the lease
16 specifies exactly the schedule of such inter-
17 vals, their length, and the rent for such in-
18 tervals,

19 “(v) the rental charges over the term
20 of the lease are set in advance, are consist-
21 ent with fair market value, and are not de-
22 termined in a manner that takes into ac-
23 count the volume or value of any referrals
24 or other business generated between the
25 parties,

1 “(vi) the lease would be commercially
2 reasonable even if no referrals were made
3 between the parties, and

4 “(vii) the compensation arrangement
5 meets such other requirements as the Sec-
6 retary may impose by regulation as needed
7 to protect against program or patient
8 abuse.

9 “(B) EQUIPMENT.—Payments made by a
10 lessee of equipment to the lessor of the equip-
11 ment for the use of the equipment if—

12 “(i) the lease is set out in writing,
13 signed by the parties, and specifies the
14 equipment covered by the lease,

15 “(ii) the equipment rented or leased is
16 reasonable and necessary for the legitimate
17 business purposes of the lease or rental,

18 “(iii) the lease provides for a term of
19 rental or lease of at least one year,

20 “(iv) in the case of a lease that is in-
21 tended to provide the lessee with use of the
22 equipment for periodic intervals of time,
23 rather than on a full-time basis, the lease
24 specifies exactly the schedule of such inter-

1 vals, their length, and the rent for such in-
2 tervals,

3 “(v) the rental charges over the term
4 of the lease are set in advance, are consist-
5 ent with fair market value, and are not de-
6 termined in a manner that takes into ac-
7 count the volume or value of any referrals
8 or other business generated between the
9 parties,

10 “(vi) the lease would be commercially
11 reasonable even if no referrals were made
12 between the parties, and

13 “(vii) the compensation arrangement
14 meets such other requirements as the Sec-
15 retary may impose by regulation as needed
16 to protect against program or patient
17 abuse.”.

18 (2) BONA FIDE EMPLOYMENT RELATION-
19 SHIPS.—Paragraph (2) of such section is amended—

20 (A) by striking “WITH HOSPITALS”,

21 (B) by striking “An arrangement” and all
22 that follows through “if” and inserting “Any
23 amount paid by an employer to an employee
24 who has a bona fide employment relationship
25 with the employer for employment, or paid by

1 a hospital pursuant to an arrangement with a
2 physician (or immediate family member) for the
3 provision of administrative services, if”,

4 (C) in subparagraphs (A), (B), and (D), by
5 striking “arrangement” and inserting “employ-
6 ment relationship or arrangement”, and

7 (D) in subparagraph (C), by striking “to
8 the hospital”.

9 (3) ADDITIONAL EXCEPTIONS.—Such sub-
10 section is further amended by adding at the end the
11 following new paragraphs:

12 “(7) PAYMENTS TO A PHYSICIAN FOR OTHER
13 ITEMS OR SERVICES.—

14 “(A) IN GENERAL.—Payments made by an
15 entity to a physician (or family member) who is
16 not employed by the entity as compensation for
17 services specified in subparagraph (B), if—

18 “(i) the compensation agreement is
19 set out in writing and specifies the services
20 to be provided by the parties, the com-
21 pensation for each unit of service provided
22 under the agreement, and the schedule for
23 the provision of such services,

24 “(ii) the compensation paid over the
25 term of the agreement is consistent with

1 fair market value and is not determined in
2 a manner that takes into account the vol-
3 ume or value of any referrals or other busi-
4 ness generated between the parties,

5 “(iii) the compensation is provided
6 pursuant to an agreement which would be
7 commercially reasonable even if no refer-
8 rals were made to the entity, and

9 “(iv) the compensation arrangement
10 meets such other requirements as the Sec-
11 retary may impose by regulation as needed
12 to protect against program or patient
13 abuse.

14 “(B) SPECIFIED SERVICES.—For purposes
15 of subparagraph (A), the services specified in
16 this subparagraph are any of the following:

17 “(i) Consultative services that—

18 “(I) relate to results that have
19 been obtained that are outside estab-
20 lished parameters, or are specifically
21 requested by the referring physician
22 on a specified patient,

23 “(II) are furnished by a physi-
24 cian other than the referring physi-
25 cian (or by another physician who is

1 a member of the same group prac-
2 tice), and

3 “(III) for which the physician
4 furnishes a written report for that pa-
5 tient.

6 “(ii) Interpretation of tissue pathology
7 or Pap smear slides or the provision of
8 other cytology services.

9 “(iii) Phlebotomy services for pater-
10 nity or toxicology testing where the serv-
11 ices are furnished by a physician other
12 than the physician referring the individual
13 for such testing (or by another physician
14 who is a member of the same group prac-
15 tice).

16 “(iv) Employment-related health care
17 services, including a payment by a self-in-
18 sured employer for services rendered to
19 employee applicants, employees, or their
20 families under the terms of a health bene-
21 fit plan.

22 “(v) Services as a clinical consultant
23 to the entity as required for certification of
24 the provider under section 353 of the Pub-
25 lic Health Service Act.

1 “(vi) Services required by local, State,
2 or Federal licensure, accreditation, or
3 other health and safety provisions.

4 “(vii) Services billed in the name of a
5 group practice provided by a physician
6 under contract to the group practice for
7 services not otherwise available directly
8 through a physician who is a member of
9 the group.

10 “(8) PAYMENTS BY A PHYSICIAN FOR ITEMS
11 AND SERVICES.—Payments made by a physician—

12 “(A) to a laboratory in exchange for the
13 provision of clinical laboratory services, or

14 “(B) to an entity as compensation for
15 other items or services if the items or services
16 are furnished at a price that is consistent with
17 fair market value and are generally available to
18 referrers and non-referrers alike on similar
19 terms and conditions.

20 “(9) PAYMENTS FOR PATHOLOGY SERVICES OF
21 A GROUP PRACTICE.—Payments made to a group
22 practice for pathology services under an agreement
23 if—

24 “(A) the agreement is set out in writing
25 and specifies the services to be provided by the

1 parties and the compensation for services pro-
2 vided under the agreement,

3 “(B) the compensation paid over the term
4 of the agreement is consistent with fair market
5 value and is not determined in a manner that
6 takes into account the volume or value of any
7 referrals or other business generated between
8 the parties,

9 “(C) the compensation is provided pursu-
10 ant to an agreement which would be commer-
11 cially reasonable even if no referrals were made
12 to the entity; and

13 “(D) the compensation arrangement be-
14 tween the parties meets such other require-
15 ments as the Secretary may impose by regula-
16 tion as needed to protect against program or
17 patient abuse.”.

18 (c) TREATMENT OF GROUP PRACTICES.—

19 (1) USE OF BILLING NUMBERS, ETC.—Section
20 1877 of the Social Security Act is amended—

21 (A) in subsection (b)(2)(B), by inserting
22 “under a billing number assigned to the group
23 practice” after “member”,

1 (B) in subsection (h)(4)(B), by inserting
2 “and under a billing number assigned to the
3 group” after “in the name of the group”, and

4 (C) in subsection (h)(4)(C), by striking
5 “by members of the group”.

6 (2) TREATMENT OF CLINICAL LABORATORY
7 SERVICES FURNISHED UNDER ARRANGEMENTS BE-
8 TWEEN HOSPITALS AND GROUP PRACTICES.—

9 (A) IN GENERAL.—Section 1877(h)(4) of
10 such Act is amended—

11 (i) in subparagraph (B) (as amended
12 by paragraph (1)(B)), by inserting “(or
13 are billed in the name of a hospital for
14 which the group provides clinical labora-
15 tory services pursuant to an arrangement
16 that meets the requirements of subpara-
17 graph (B))” after “assigned to the group”;

18 (ii) by redesignating subparagraphs
19 (A) through (D) as clauses (i) through
20 (iv), respectively;

21 (iii) by inserting “(A)” after “. —”;

22 and

23 (iv) by adding at the end the following
24 new subparagraph:

1 “(B) The requirements of this subparagraph,
2 with respect to an arrangement for clinical labora-
3 tory services provided by the laboratory of a group
4 and billed in the name of a hospital, are that—

5 “(i) with respect to services provided to an
6 inpatient of the hospital, the arrangement is
7 pursuant to the provision of inpatient hospital
8 services under section 1861(b)(3);

9 “(ii) the arrangement began before Decem-
10 ber 19, 1989, and has continued in effect with-
11 out interruption since such date;

12 “(iii) the laboratory provides substantially
13 all of the clinical laboratory services to the hos-
14 pital’s patients;

15 “(iv) the arrangement is pursuant to an
16 agreement that is set out in writing and that
17 specifies the services to be provided by the par-
18 ties and the compensation for services provided
19 under the agreement;

20 “(v) the compensation paid over the term
21 of the agreement is consistent with fair market
22 value and the compensation per unit of services
23 is fixed in advance and is not determined in a
24 manner that takes into account the volume or

1 value of any referrals or other business gen-
2 erated between the parties;

3 “(vi) the compensation is provided pursu-
4 ant to an agreement which would be commer-
5 cially reasonable even if no referrals were made
6 to the entity; and

7 “(vii) the arrangement between the parties
8 meets such other requirements as the Secretary
9 may impose by regulation as needed to protect
10 against program or patient abuse.”.

11 (B) CONFORMING AMENDMENT.—Section
12 1877(b)(2)(B) of such Act is amended by in-
13 serting “(or by a hospital for which such a
14 group practice provides clinical laboratory serv-
15 ices pursuant to an arrangement that meets the
16 requirements of subsection (h)(4)(B))” after
17 “by a group practice of which such physician is
18 a member”.

19 (3) TREATMENT OF CERTAIN FACULTY PRAC-
20 TICE PLANS.—The last sentence of section
21 1877(h)(4)(A) of such Act, as redesignated by para-
22 graph (1)(A), is amended by inserting “, institution
23 of higher education, or medical school” after “hos-
24 pital”.

1 (d) EXPANDING RURAL PROVIDER EXCEPTION TO
2 COVER COMPENSATION ARRANGEMENTS.—

3 (1) IN GENERAL.—Section 1877(b) of such Act
4 is further amended—

5 (A) by redesignating paragraph (5) as
6 paragraph (7), and

7 (B) by inserting after paragraph (4) the
8 following new paragraph:

9 “(5) RURAL PROVIDERS.—In the case of des-
10 ignated services if—

11 “(A) the entity furnishing the services is in
12 a rural area (as defined in section
13 1886(d)(2)(D)), and

14 “(B) substantially all of the services fur-
15 nished by the entity to individuals entitled to
16 benefits under this title are furnished to such
17 individuals who reside in such a rural area.”.

18 (2) CONFORMING AMENDMENTS.—Section
19 1877(d) of such Act is amended—

20 (A) by striking paragraph (2), and

21 (B) by redesignating paragraph (3) as
22 paragraph (2).

23 (e) EXEMPTION OF COMPENSATION ARRANGEMENTS
24 INVOLVING CERTAIN TYPES OF REMUNERATION.—Sec-
25 tion 1877(h)(1) of such Act is amended—

1 (1) by striking subparagraph (B);

2 (2) in subparagraph (A), by inserting before the
3 period the following: “(other than an arrangement
4 involving only remuneration described in subpara-
5 graph (B))”; and

6 (3) by adding at the end the following new sub-
7 paragraph:

8 “(B) Remuneration described in this subpara-
9 graph is any remuneration consisting of any of the
10 following:

11 “(i) The forgiveness of amounts owed for
12 inaccurate tests or procedures, mistakenly per-
13 formed tests or procedures, or the correction of
14 minor billing errors.

15 “(ii) The provision of items, devices, or
16 supplies of minor value that are used to—

17 “(I) collect, transport, process, or
18 store specimens for the entity providing
19 the item, device, or supply, or

20 “(II) communicate the results of tests
21 or procedures for such entity.

22 “(iii) The furnishing by an entity of lab-
23 oratory services to a group practice affiliated
24 with the entity, if the entity provides all or sub-

1 stantially all of the clinical laboratory services
2 of the group practice.”.

3 (f) MISCELLANEOUS AND TECHNICAL CORREC-
4 TIONS.—Section 1877 of such Act is amended—

5 (1) in the fourth sentence of subsection (f)—

6 (A) by striking “provided” and inserting
7 “furnished”, and

8 (B) by striking “provides” and inserting
9 “furnish”;

10 (2) in the fifth sentence of subsection (f)—

11 (A) by striking “providing” each place it
12 appears and inserting “furnishing”,

13 (B) by striking “with respect to the provid-
14 ers” and inserting “with respect to the enti-
15 ties”, and

16 (C) by striking “diagnostic imaging serv-
17 ices of any type” and inserting “magnetic reso-
18 nance imaging, computerized axial tomography
19 scans, and ultrasound services”; and

20 (3) in subsection (a)(2)(B), by striking “sub-
21 section (h)(1)(A)” and inserting “subsection (h)(1)”.

22 **SEC. 354. EFFECTIVE DATES.**

23 (a) EXPANSION OF COVERAGE AND PAYORS.—The
24 amendments made by sections 351 and 352 shall apply
25 with respect to a referral by a physician for designated

1 health services (as described in section 1877(i) of the So-
2 cial Security Act) made on or after the first day of the
3 first month beginning 2 years after the date of the enact-
4 ment of this Act.

5 (b) CHANGES IN EXCEPTIONS, ETC.—The amend-
6 ments made by section 353 shall apply to referrals made
7 on or after January 1, 1992.

8 **Subtitle D—Other Provisions**

9 **SEC. 361. MALPRACTICE REFORM.**

10 (a) STUDY BY PHYSICIAN PAYMENT REVIEW COM-
11 MISSION.—The Physician Payment Review Commission
12 shall conduct a study of—

13 (1) the need for tort reforms with respect to
14 medical malpractice liability claims, including the
15 need to establish or impose alternative dispute reso-
16 lution requirements on such claims; and

17 (2) the impact of such reforms on—

18 (A) expenditures for health care services
19 and on access to such services,

20 (B) the quality of health care services, and

21 (C) access of injured patients to the medi-
22 cal malpractice system.

23 (b) REPORT.—Not later than September 30, 1993,
24 the Commission shall submit a report to Congress on the
25 study conducted under paragraph (1) and shall include in

1 such study such recommendations as the Commission con-
2 siders appropriate.

3 **TITLE IV—EXPANSIONS OF**
4 **HEALTH BENEFITS AND**
5 **OTHER HEALTH INITIATIVES**
6 **Subtitle A—Medicaid Benefit**
7 **Improvements**

8 **SEC. 401. FLOOR ON MEDICAID PAYMENT LEVELS FOR IN-**
9 **PATIENT HOSPITAL SERVICES AND PHYSI-**
10 **CIAANS' SERVICES.**

11 (a) INPATIENT HOSPITAL SERVICES.—

12 (1) IN GENERAL.—(A) A State plan under title
13 XIX of the Social Security Act shall not be consid-
14 ered to meet the requirement of section
15 1902(a)(13)(A) of such Act (insofar as it requires
16 payments to hospitals for inpatient hospital services
17 that are reasonable and adequate to meet the costs
18 which must be incurred by efficiently and economi-
19 cally operated facilities), as of October 1, 1996, un-
20 less the State has submitted to the Secretary of
21 Health and Human Services (in this subsection re-
22 ferred to as the “Secretary”), by not later than such
23 date, an amendment to such plan that assures that,
24 in the aggregate, the amount of payments for inpa-
25 tient hospital services provided in subsection (d) hos-

1 pitals (as defined in section 1886(d)(1)(B) of such
2 Act) under the plan is not less than—

3 (i) in the case of services furnished during
4 fiscal year 1997, 80 percent (or, if greater, the
5 percent specified in subparagraph (B)) of the
6 amount of payments for such services that
7 would be made under title XVIII of such Act
8 (without regard to any deductible imposed
9 under section 1813(a) of such Act or any limi-
10 tation on the coverage of inpatient hospital
11 services under such title) for such services if
12 covered under such title;

13 (ii) in the case of services furnished during
14 fiscal year 1998, 85 percent (or, if greater, the
15 percent specified in subparagraph (B)) of the
16 amount of payments for such services that
17 would be made under title XVIII of such Act
18 (without regard to any deductible imposed
19 under section 1813(a) of such Act or any limi-
20 tation on the coverage of inpatient hospital
21 services under such title) for such services if
22 covered under such title; and

23 (iii) in the case of services furnished dur-
24 ing any succeeding fiscal year, 90 percent of the
25 amount of payments for such services that

1 would be made under title XVIII of such Act
2 (without regard to any deductible imposed
3 under section 1813(a) of such Act or any limi-
4 tation on the coverage of inpatient hospital
5 services under such title) for such services if
6 covered under such title.

7 (B) The percent specified in this subparagraph
8 is the quotient of—

9 (i) the total payments made under the
10 State plan under title XIX of the Social Secu-
11 rity Act in fiscal year 1993 with respect to in-
12 patient hospital services, divided by

13 (ii) the amount of payments for such serv-
14 ices that would be made under title XVIII of
15 such Act (without regard to any deductible im-
16 posed under section 1813(a) of such Act or any
17 limitation on the coverage of inpatient hospital
18 services under such title) for such services in
19 such fiscal year if covered under such title,
20 expressed as a percentage, or, if less, 90 percent.

21 (C) In computing amounts under subparagraph
22 (A), the Secretary shall adjust for differences in case
23 mix, volume, the age and disability of the popu-
24 lations covered by the two programs, and other rel-
25 evant factors identified by the Secretary.

1 (2) REVIEW.—The Secretary, by not later than
2 90 days after the date of submission of a plan
3 amendment under paragraph (1), shall—

4 (A) review each such amendment for com-
5 pliance with the requirement of section
6 1902(a)(13)(A) of the Social Security Act; and

7 (B) approve or disapprove each such
8 amendment.

9 If the Secretary disapproves such an amendment,
10 the State shall immediately submit a revised amend-
11 ment which meets such requirement.

12 (3) COLLECTION OF DATA.—The Secretary may
13 provide for such collection of data on payment for
14 inpatient hospital services as may be necessary to
15 carry out this subsection.

16 (4) NONWAIVABILITY.—The provisions of this
17 subsection may not be waived by the Secretary.

18 (b) PHYSICIANS' SERVICES.—

19 (1) IN GENERAL.—Section 1902 of the Social
20 Security Act (42 U.S.C. 1396a) is amended—

21 (A) in subsection (a)(13)—

22 (i) by striking “and” at the end of
23 subparagraph (E);

1 (ii) by striking the semicolon at the
2 end of subparagraph (F) and inserting “;
3 and”; and

4 (iii) by adding at the end the follow-
5 ing new subparagraph:

6 “(G) for payment for physicians’ services
7 through a methodology under which the amount
8 of payment for such services furnished during a
9 calendar quarter is not less than the amount
10 specified in subsection (z);”; and

11 (B) by adding at the end the following new
12 subsection:

13 “(z)(1) For purposes of subsection (a)(13)(G), the
14 amount specified in this subsection is—

15 “(A) for physicians’ services furnished during a
16 calendar quarter in fiscal year 1997, 60 percent (or,
17 if greater, the percent specified in paragraph (2)) of
18 the applicable fee schedule amount established under
19 section 1848 for services furnished in such year,

20 “(B) for physicians’ services furnished during a
21 calendar quarter in fiscal year 1998, 70 percent (or,
22 if greater, the percent specified in subparagraph
23 (B)) of the applicable fee schedule amount estab-
24 lished under section 1848 for services furnished in
25 such year, and

1 “(C) for physicians’ services furnished during a
2 calendar quarter in a succeeding fiscal year, 90 per-
3 cent (or, if greater, the percent specified in subpara-
4 graph (B)) of the applicable fee schedule amount es-
5 tablished under section 1848 for services furnished
6 in such year.

7 “(2) The percent specified in this paragraph is the
8 quotient of—

9 “(A) the total payments made under the State
10 plan under title XIX of the Social Security Act in
11 fiscal year 1993 for physicians’ services, divided by

12 “(B) the amount of payments for such services
13 that would be made under title XVIII of such Act
14 (without regard to any deductible or coinsurance)
15 for such services in such fiscal year if covered under
16 such title,

17 expressed as a percentage, or, if less, 90 percent.”.

18 (2) TRANSMITTAL OF PAYMENT INFORMATION
19 TO STATES.—Section 1848(i) of such Act (42 U.S.C.
20 1395w-4(i)) is amended by adding at the end the
21 following new paragraph:

22 “(4) TRANSMITTAL OF PHYSICIAN PAYMENT IN-
23 FORMATION TO STATES.—Not later than August 1
24 of 1996 (and of each year thereafter), the Secretary
25 shall transmit such information to the States as is

1 necessary to enable the States to carry out the re-
2 quirements of section 1902(a)(13)(G) of the Social
3 Security Act (as added by section 401(b)(1) of the
4 Health Care Cost Containment and Reform Act of
5 1993).”.

6 (3) RELATION TO PAYMENTS FOR OBSTETRICAL
7 AND PEDIATRIC SERVICES.—Section 1926 of such
8 Act (42 U.S.C. 1396r-7) is amended by adding at
9 the end the following new subsection:

10 “(e) Payment rates established under this section
11 with respect to services shall in no case be less than the
12 minimum payment amounts specified under section
13 1902(z) with respect to such services. The fact that pay-
14 ment amounts with respect to such services are consistent
15 with the payment rates required under such section shall
16 not be the basis for a determination that the payment
17 amounts comply with the requirements of this section.”.

18 (4) EFFECTIVE DATE.—The amendments made
19 by this subsection shall apply to payments under
20 title XIX of the Social Security Act for calendar
21 quarters beginning on or after October 1, 1997.

22 **SEC. 402. MEDICAID ELIGIBILITY EXPANSION.**

23 (a) IN GENERAL.—

24 (1) BENEFITS FOR LOW-INCOME INDIVID-
25 UALS.—Section 1902(a)(10)(A)(i) of the Social Se-

1 security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amend-
2 ed—

3 (A) by striking “or” at the end of
4 subclause (VI);

5 (B) by striking the semicolon at the end of
6 subclause (VII) and inserting “, or”; and

7 (C) by adding at the end the following new
8 subclause:

9 “(VIII) who are described in sub-
10 section (aa)(1);”.

11 (2) INDIVIDUALS DESCRIBED.—

12 (A) IN GENERAL.—Section 1902 of such
13 Act (42 U.S.C. 1396a), as amended by section
14 401(b), is amended by adding at the end the
15 following new subsection:

16 “(aa)(1) Individuals described in this paragraph
17 are—

18 “(A) for quarters beginning on or after October
19 1, 1996, women during pregnancy (and during the
20 60-day period beginning on the last day of the preg-
21 nancy) or individuals who have not attained 6 years
22 of age;

23 “(B) for quarters beginning on or after October
24 1, 1997, individuals not described in subparagraph
25 (A) who have not attained 11 years of age;

1 “(C) for quarters beginning on or after October
2 1, 1998, individuals not described in subparagraph
3 (A) or (B) who have not attained 19 years of age;
4 and

5 “(D) for quarters beginning on or after October
6 1, 1999, individuals not described in a preceding
7 subparagraph who have not attained 65 years of
8 age,
9 who are not described in any of subclauses (I) through
10 (VII) of subsection (a)(10)(A)(i) and whose family income
11 does not exceed the income level described in paragraph
12 (2) for a family of the size of the family.

13 “(2)(A) The income level described in this paragraph
14 is the percent provided under subparagraph (B) of the of-
15 ficial poverty line (as defined by the Office of Management
16 and Budget, and revised annually in accordance with sec-
17 tion 673(2) of the Omnibus Budget Reconciliation Act of
18 1981) applicable to a family of the size involved.

19 “(B) The percentage provided in this subparagraph
20 is—

21 “(i) for individuals described in subparagraph
22 (A), (B), or (C) of paragraph (1), 200 percent; and

23 “(ii) with respect to any other individual, for
24 purposes of determining eligibility for medical assist-
25 ance on or after—

1 “(I) October 1, 1999, is 50 percent,

2 “(II) October 1, 2000, is 100 percent,

3 “(III) October 1, 2001, is 150 percent,

4 and

5 “(IV) October 1, 2002, is 200 percent.

6 “(3) Notwithstanding subsection (a)(17), for individ-
7 uals who are eligible for medical assistance because of sub-
8 section (a)(10)(A)(i)(VIII)—

9 “(A) no resource standard shall be applied;

10 “(B) the income standard to be applied is the
11 appropriate income standard established under para-
12 graph (2); and

13 “(C) family income shall be determined in ac-
14 cordance with the methodology that is not more re-
15 strictive than the methodology employed under the
16 State plan under part A or E of title IV (except to
17 the extent such methodology is inconsistent with
18 clause (D) of subsection (a)(17)), and costs incurred
19 for medical care or for any other type of remedial
20 care shall not be taken into account.

21 Any different treatment provided under this paragraph for
22 such individuals shall not, because of subsection (a)(17),
23 require or permit such treatment for other individuals.

24 “(4)(A) In the case of any State which is providing
25 medical assistance to its residents under a waiver granted

1 under section 1115, the Secretary shall require the State
2 to provide medical assistance for individuals described in
3 paragraph (1) in the same manner as the State would be
4 required to provide such assistance for such individuals
5 if the State had in effect a plan approved under this title.

6 “(B) In the case of a State which is not one of the
7 50 States or the District of Columbia, the State need not
8 meet the requirement of subsection (a)(10)(A)(i)(VIII)
9 and, for purposes of paragraph (2)(A), the State may sub-
10 stitute for the percentages provided under such paragraph
11 any percentages that are less than such percentages.

12 “(5) The Secretary may not require that an individ-
13 ual apply for eligibility under subclauses (I) through (VII)
14 of subsection (a)(10)(A)(i) as a condition of being deter-
15 mined to be eligible for medical assistance under this title
16 as an individual described in paragraph (1).”.

17 (B) CONFORMING AMENDMENT.—Section
18 1905(a) of such Act (42 U.S.C. 1396d(a)) is
19 amended—

20 (i) by striking “or” at the end of
21 clause (ix),

22 (ii) by adding “or” at the end of
23 clause (x), and

24 (iii) by inserting after clause (x) the
25 following new clause:

1 “(xi) individuals described in section
2 1902(aa)(1),”.

3 (b) RESTRICTIONS ON BENEFITS PROVIDED.—Sec-
4 tion 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10))
5 is amended in the matter following subparagraph (F)—

6 (1) by striking “; and (XI) the making” and in-
7 serting “, (XI) the making”;

8 (2) by striking “and (XI) the medical” and in-
9 serting “(XII) the medical”; and

10 (3) by striking the semicolon at the end and in-
11 serting the following: “ and (XIII) the medical as-
12 sistance required to be made available to an individ-
13 ual described in subsection (aa)(1) shall not include
14 nursing facility services, home and community-based
15 services (as defined in section 1915(d)(5)(C)(i)),
16 services in an intermediate care facility for the men-
17 tally retarded, and community supported living ar-
18 rangements services;”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 subsections (a) and (b) shall apply to quarters beginning
21 on or after October 1, 1996, without regard to whether
22 or not regulations to carry out such amendments have
23 been promulgated by such date.

1 **SEC. 403. FULL FEDERAL PAYMENT FOR INCREASED**
2 **COSTS.**

3 Section 1903 of the Social Security Act (42 U.S.C.
4 1396b) is amended by adding at the end the following new
5 subsection:

6 “(w)(1) Notwithstanding subsection (a), with respect
7 to new mandated expenditures (as defined in paragraph
8 (2)) in a quarter, instead of the amounts otherwise paid
9 to a State under subsection (a) for a quarter with respect
10 to such expenditures, there shall be paid to the State an
11 amount equal to 100 percent of the amount of such ex-
12 penditures.

13 “(2) In this subsection, the term ‘new mandated ex-
14 penditures’ means the sum of the following expenditures
15 under the State plan during a quarter:

16 “(A) The amount by which (i) the minimum
17 amount of expenditures for medical assistance for
18 inpatient hospital services (consistent with section
19 401(a) of the Health Care Cost Containment and
20 Reform Act of 1993), exceeds (ii) the amount of ex-
21 penditures for such assistance which the Secretary
22 determines would have been payable under the plan
23 (as such plan was in effect as of the date of the en-
24 actment of this subsection).

25 “(B) The amount by which (i) the minimum
26 amount of expenditures under the plan for medical

1 assistance for physicians' services (consistent with
2 section 1902(a)(13)(G)) for the quarter, exceeds (ii)
3 the amount of expenditures under the plan for such
4 assistance which the Secretary determines would
5 have been payable under the plan (as such plan was
6 in effect as of the date of the enactment of this sub-
7 section) for the quarter.

8 “(C) The amount of expenditures for medical
9 assistance attributable to individuals with respect to
10 whom the State plan would not be required to pro-
11 vide such assistance but for the amendments made
12 by section 402.

13 “(D) The amount of expenses reasonably attrib-
14 utable to the expenditures described in subpara-
15 graphs (A) through (C).”.

16 **Subtitle B—Expansion of Medicare** 17 **Benefits**

18 PART 1—PREVENTIVE BENEFITS

19 **SEC. 411. ANNUAL SCREENING MAMMOGRAPHY.**

20 (a) ANNUAL SCREENING MAMMOGRAPHY FOR
21 WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the So-
22 cial Security Act (42 U.S.C. 1395m(b)(2)(A)) is amend-
23 ed—

24 (1) in clause (iv), by striking “but under 65
25 years of age,”; and

1 (2) by striking clause (v).

2 (b) EFFECTIVE DATE.—The amendments made by
3 subsection (a) shall apply to screening mammography per-
4 formed on or after January 1, 1995.

5 **SEC. 412. COVERAGE OF COLORECTAL SCREENING.**

6 (a) IN GENERAL.—Section 1834 of the Social Secu-
7 rity Act (42 U.S.C. 1395m) is amended by inserting after
8 subsection (c) the following new subsection:

9 “(d) FREQUENCY AND PAYMENT LIMITS FOR
10 SCREENING FECAL-OCCULT BLOOD TESTS AND SCREEN-
11 ING FLEXIBLE SIGMOIDOSCOPIES.—

12 “(1) SCREENING FECAL-OCCULT BLOOD
13 TESTS.—

14 “(A) PAYMENT LIMIT.—In establishing fee
15 schedules under section 1833(h) with respect to
16 screening fecal-occult blood tests provided for
17 the purpose of early detection of colon cancer,
18 except as provided by the Secretary under para-
19 graph (3)(A), the payment amount established
20 for tests performed—

21 “(i) in 1995 shall not exceed \$5; and

22 “(ii) in a subsequent year, shall not
23 exceed the limit on the payment amount
24 established under this subsection for such
25 tests for the preceding year, adjusted by

1 the applicable adjustment under section
2 1833(h) for tests performed in such year.

3 “(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B),
4 no payment may be made under this part for
5 a screening fecal-occult blood test provided to
6 an individual for the purpose of early detection
7 of colon cancer—

8
9 “(i) if the individual is under 50 years
10 of age; or

11 “(ii) if the test is performed within 11
12 months after a previous screening fecal-oc-
13 cult blood test.

14 “(2) SCREENING FLEXIBLE SIGMOID-
15 OSCOPIES.—

16 “(A) PAYMENT AMOUNT.—The Secretary
17 shall establish a payment amount under section
18 1848 with respect to screening flexible
19 sigmoidoscopies provided for the purpose of
20 early detection of colon cancer that is consistent
21 with payment amounts under such section for
22 similar or related services, except that such
23 payment amount shall be established without
24 regard to subsection (a)(2)(A) of such section.

1 “(B) FREQUENCY LIMIT.—Subject to revi-
2 sion by the Secretary under paragraph (3)(B),
3 no payment may be made under this part for
4 a screening flexible sigmoidoscopy provided to
5 an individual for the purpose of early detection
6 of colon cancer—

7 “(i) if the individual is under 50 years
8 of age; or

9 “(ii) if the procedure is performed
10 within 59 months after a previous screen-
11 ing flexible sigmoidoscopy.

12 “(3) REDUCTIONS IN PAYMENT LIMIT AND RE-
13 VISION OF FREQUENCY.—

14 “(A) REDUCTIONS IN PAYMENT LIMIT.—
15 The Secretary shall review from time to time
16 the appropriateness of the amount of the pay-
17 ment limit established for screening fecal-occult
18 blood tests under paragraph (1)(A). The Sec-
19 retary may, with respect to tests performed in
20 a year after 1997, reduce the amount of such
21 limit as it applies nationally or in any area to
22 the amount that the Secretary estimates is re-
23 quired to assure that such tests of an appro-
24 priate quality are readily and conveniently
25 available during the year.

1 “(B) REVISION OF FREQUENCY.—

2 “(i) REVIEW.—The Secretary, in con-
3 sultation with the Director of the National
4 Cancer Institute, shall review periodically
5 the appropriate frequency for performing
6 screening fecal-occult blood tests and
7 screening flexible sigmoidoscopies based on
8 age and such other factors as the Sec-
9 retary believes to be pertinent.

10 “(ii) REVISION OF FREQUENCY.—The
11 Secretary, taking into consideration the re-
12 view made under clause (i), may revise
13 from time to time the frequency with
14 which such tests and procedures may be
15 paid for under this subsection, but no such
16 revision shall apply to tests or procedures
17 performed before January 1, 1998.

18 “(4) LIMITING CHARGES OF NONPARTICIPATING
19 PHYSICIANS.—

20 “(A) IN GENERAL.—In the case of a
21 screening flexible sigmoidoscopy provided to an
22 individual for the purpose of early detection of
23 colon cancer for which payment may be made
24 under this part, if a nonparticipating physician
25 provides the procedure to an individual enrolled

1 under this part, the physician may not charge
2 the individual more than the limiting charge (as
3 defined in section 1848(g)(2)).

4 “(B) ENFORCEMENT.—If a physician or
5 supplier knowing and willfully imposes a charge
6 in violation of subparagraph (A), the Secretary
7 may apply sanctions against such physician or
8 supplier in accordance with section
9 1842(j)(2).”.

10 (b) CONFORMING AMENDMENTS.—(1) Paragraphs
11 (1)(D) and (2)(D) of section 1833(a) of such Act (42
12 U.S.C. 1395l(a)) are each amended by striking “sub-
13 section (h)(1),” and inserting “subsection (h)(1) or section
14 1834(d)(1),”.

15 (2) Section 1833(h)(1)(A) of such Act (42 U.S.C.
16 1395l(h)(1)(A)) is amended by striking “The Secretary”
17 and inserting “Subject to paragraphs (1) and (3)(A) of
18 section 1834(d), the Secretary”.

19 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) of
20 such Act (42 U.S.C. 1395w-4(a)(2)(A)) are each amended
21 by striking “a service” and inserting “a service (other
22 than a screening flexible sigmoidoscopy provided to an
23 individual for the purpose of early detection of colon
24 cancer)”.

1 (4) Section 1862(a) of such Act (42 U.S.C. 1395y(a))
2 is amended—

3 (A) in paragraph (1)—

4 (i) in subparagraph (E), by striking “and”
5 at the end,

6 (ii) in subparagraph (F), by striking the
7 semicolon at the end and inserting “, and”, and

8 (iii) by adding at the end the following new
9 subparagraph:

10 “(G) in the case of screening fecal-occult
11 blood tests and screening flexible sigmoid-
12 oscopies provided for the purpose of early detec-
13 tion of colon cancer, which are performed more
14 frequently than is covered under section
15 1834(d);” and

16 (B) in paragraph (7), by striking “paragraph
17 (1)(B) or under paragraph (1)(F)” and inserting
18 “subparagraphs (B), (F), or (G) of paragraph (1)”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to screening fecal-occult blood tests
21 and screening flexible sigmoidoscopies performed on or
22 after January 1, 1995.

23 **SEC. 413. COVERAGE OF CERTAIN IMMUNIZATIONS.**

24 (a) IN GENERAL.—Section 1861(s)(10) of the Social
25 Security Act (42 U.S.C. 1395x(s)(10)) is amended—

1 (1) in subparagraph (A)—

2 (A) by striking “, subject to section
3 4071(b) of the Omnibus Budget Reconciliation
4 Act of 1987,” and

5 (B) by striking “; and” and inserting a
6 comma;

7 (2) in subparagraph (B), by striking the semi-
8 colon at the end and inserting “, and”; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(C) tetanus-diphtheria booster and its ad-
12 ministration;”.

13 (b) LIMITATION ON FREQUENCY.—Section
14 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as
15 amended by section 412(b)(4)(A), is amended—

16 (1) in subparagraph (F), by striking “and” at
17 the end;

18 (2) in subparagraph (G), by striking the semi-
19 colon at the end and inserting “, and”; and

20 (3) by adding at the end the following new sub-
21 paragraph:

22 “(H) in the case of an influenza vaccine,
23 which is administered within the 11 months
24 after a previous influenza vaccine, and, in the
25 case of a tetanus-diphtheria booster, which is

1 administered within the 119 months after a
2 previous tetanus-diphtheria booster;”.

3 (c) CONFORMING AMENDMENT.—Section 1862(a)(7)
4 of such Act (42 U.S.C. 1395y(a)(7)), as amended by sec-
5 tion 412(b)(4)(B), is amended by striking “or (G)” and
6 inserting “(G), or (H)”.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to influenza vaccines and tetanus-
9 diphtheria boosters administered on or after January 1,
10 1995.

11 **SEC. 414. COVERAGE OF WELL-CHILD CARE.**

12 (a) IN GENERAL.—Section 1861(s)(2) of the Social
13 Security Act (42 U.S.C. 1395x(s)(2)) is amended—

14 (1) by striking “and” at the end of subpara-
15 graph (O);

16 (2) by striking the semicolon at the end of sub-
17 paragraph (P) and inserting “; and”; and

18 (3) by adding at the end the following new sub-
19 paragraph:

20 “(Q) well-child services (as defined in sub-
21 section (ll)(1)) provided to an individual entitled to
22 benefits under this title who is under 7 years of
23 age;”.

24 (b) SERVICES DEFINED.—Section 1861 of such Act
25 (42 U.S.C. 1395x) is amended—

1 (1) by redesignating the subsection (jj) as sub-
2 section (kk); and

3 (2) by inserting after subsection (kk) (as so re-
4 designated) the following new subsection:

5 “Well-Child Services

6 “(l)(1) The term ‘well-child services’ means well-
7 child care, including routine office visits, routine immuni-
8 zations (including the vaccine itself), routine laboratory
9 tests, and preventive dental care, provided in accordance
10 with the periodicity schedule established with respect to
11 the services under paragraph (2).

12 “(2) The Secretary, in consultation with the Amer-
13 ican Academy of Pediatrics, the Advisory Committee on
14 Immunization Practices, and other entities considered ap-
15 propriate by the Secretary, shall establish a schedule of
16 periodicity which reflects the appropriate frequency with
17 which the services referred to in paragraph (1) should be
18 provided to healthy children.”.

19 (c) CONFORMING AMENDMENTS.—(1) Section
20 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as
21 amended by sections 412(b)(4)(A) and 413(b), is amend-
22 ed—

23 (A) in subparagraph (G), by striking “and” at
24 the end;

1 (B) in subparagraph (H), by striking the semi-
2 colon at the end and inserting “, and”; and

3 (C) by adding at the end the following new sub-
4 paragraph:

5 “(I) in the case of well-child services, which are
6 provided more frequently than is provided under the
7 schedule of periodicity established by the Secretary
8 under section 1861(ll)(2) for such services;”.

9 (2) Section 1862(a)(7) of such Act (42 U.S.C.
10 1395y(a)(7)), as amended by sections 412(b)(4)(B) and
11 413(c), is amended by striking “or (H)” and inserting
12 “(H), or (I)”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to well-child services provided on
15 or after January 1, 1995.

16 **SEC. 415. DEMONSTRATION PROJECTS FOR COVERAGE OF**
17 **OTHER PREVENTIVE SERVICES.**

18 (a) ESTABLISHMENT.—The Secretary shall establish
19 and provide for a series of ongoing demonstration projects
20 under which the Secretary shall provide for coverage of
21 the preventive services described in subsection (c) under
22 the medicare program in order to determine—

23 (1) the feasibility and desirability of expanding
24 coverage of medical and other health services under
25 the medicare program to include coverage of such

1 services for all individuals enrolled under part B of
2 title XVIII of the Social Security Act; and

3 (2) appropriate methods for the delivery of
4 those services to medicare beneficiaries.

5 (b) SITES FOR PROJECT.—The Secretary shall pro-
6 vide for the conduct of the demonstration projects estab-
7 lished under subsection (a) at the sites at which the Sec-
8 retary conducts the demonstration program established
9 under section 9314 of the Consolidated Omnibus Budget
10 Reconciliation Act of 1985 and at such other sites as the
11 Secretary considers appropriate.

12 (c) SERVICES COVERED UNDER PROJECTS.—The
13 Secretary shall cover the following services under the se-
14 ries of demonstration projects established under sub-
15 section (a):

16 (1) Glaucoma screening.

17 (2) Cholesterol screening and cholesterol-reduc-
18 ing drug therapies.

19 (3) Screening and treatment for osteoporosis,
20 including tests for bone-marrow density and hor-
21 mone replacement therapy.

22 (4) Screening services for pregnant women, in-
23 cluding ultra-sound and clamydial testing and ma-
24 ternal serum alfa-protein.

1 (5) One-time comprehensive assessment for in-
2 dividuals beginning at age 65 or 75.

3 (6) Prostate-specific antigen (PSA) testing.

4 (7) Other services considered appropriate by the
5 Secretary.

6 (d) REPORTS TO CONGRESS.—Not later than October
7 1, 1996, and every 2 years thereafter, the Secretary shall
8 submit a report to the Committee on Finance of the Sen-
9 ate and the Committee on Ways and Means and the Com-
10 mittee on Energy and Commerce of the House of Rep-
11 resentatives describing findings made under the dem-
12 onstration projects conducted pursuant to subsection (a)
13 during the preceding 2-year period and the Secretary's
14 plans for the demonstration projects during the succeeding
15 2-year period.

16 (e) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated from the Federal Sup-
18 plementary Medical Insurance Trust Fund for expenses
19 incurred in carrying out the series of demonstration
20 projects established under subsection (a) the following
21 amounts:

22 (1) \$4,000,000 for fiscal year 1995.

23 (2) \$4,000,000 for fiscal year 1996.

24 (3) \$5,000,000 for fiscal year 1997.

25 (4) \$5,000,000 for fiscal year 1998.

1 (5) \$6,000,000 for fiscal year 1999.

2 PART 2—COVERAGE OF PRESCRIPTION DRUGS

3 **SEC. 421. COVERAGE OF OUTPATIENT PRESCRIPTION**
4 **DRUGS.**

5 (a) DESCRIPTION OF COVERED OUTPATIENT
6 DRUGS.—Section 1861 of the Social Security Act (42
7 U.S.C. 1395x) is amended—

8 (1) in subsection (s)(2), by amending subpara-
9 graph (J) to read as follows:

10 “(J) covered outpatient drugs (as defined in
11 subsection (t)); and”; and

12 (2) in subsection (t)—

13 (A) by inserting “and paragraph (2)” after
14 “subsection (m)(5)”,

15 (B) by striking “(t)” and inserting
16 “(t)(1)”, and

17 (C) by adding at the end the following new
18 paragraphs:

19 “(2) Subject to paragraph (3), the term ‘covered out-
20 patient drug’ means—

21 “(A) a drug which may be dispensed only upon
22 prescription and—

23 “(i) which is approved for safety and effec-
24 tiveness as a prescription drug under section
25 505 or 507 of the Federal Food, Drug, and

1 Cosmetic Act or which is approved under sec-
2 tion 505(j) of such Act;

3 “(ii)(I) which was commercially used or
4 sold in the United States before the date of the
5 enactment of the Drug Amendments of 1962 or
6 which is identical, similar, or related (within the
7 meaning of section 310.6(b)(1) of title 21 of the
8 Code of Federal Regulations) to such a drug,
9 and (II) which has not been the subject of a
10 final determination by the Secretary that it is
11 a ‘new drug’ (within the meaning of section
12 201(p) of the Federal Food, Drug, and Cos-
13 metic Act) or an action brought by the Sec-
14 retary under section 301, 302(a), or 304(a) of
15 such Act to enforce section 502(f) or 505(a) of
16 such Act; or

17 “(iii)(I) which is described in section
18 107(c)(3) of the Drug Amendments of 1962
19 and for which the Secretary has determined
20 there is a compelling justification for its medi-
21 cal need, or is identical, similar, or related
22 (within the meaning of section 310.6(b)(1) of
23 title 21 of the Code of Federal Regulations) to
24 such a drug, and (II) for which the Secretary
25 has not issued a notice of an opportunity for a

1 hearing under section 505(e) of the Federal
2 Food, Drug, and Cosmetic Act on a proposed
3 order of the Secretary to withdraw approval of
4 an application for such drug under such section
5 because the Secretary has determined that the
6 drug is less than effective for all conditions of
7 use prescribed, recommended, or suggested in
8 its labeling;

9 “(B) a biological product which—

10 “(i) may only be dispensed upon prescrip-
11 tion,

12 “(ii) is licensed under section 351 of the
13 Public Health Service Act, and

14 “(iii) is produced at an establishment li-
15 censed under such section to produce such
16 product; and

17 “(C) insulin certified under section 506 of the
18 Federal Food, Drug, and Cosmetic Act.

19 “(3)(A) The term ‘covered outpatient drug’ does not
20 include any drug, biological product, or insulin provided
21 as, as part of, or as incident to, any of the following (and
22 for which payment may be included under this title):

23 “(i) Inpatient hospital services (described in
24 subsection (b)(2)).

1 “(ii) Extended care services (described in sub-
2 section (h)(5)).

3 “(iii) Physicians’ services under subparagraph
4 (A) or (B) of subsection (s)(2).

5 “(iv) Dialysis supplies under subsection
6 (s)(2)(F).

7 “(v) Antigens under subsection (s)(2)(G).

8 “(vi) Blood clotting factors for hemophiliacs
9 under subsection (s)(2)(I).

10 “(vii) Services of a physician assistant, nurse
11 practitioner, or clinical nurse specialist under sub-
12 section (s)(2)(K).

13 “(viii) Pneumococcal, hepatitis B, or influenza
14 vaccines under subsection (s)(10).

15 “(ix) Rural health clinic services (under sub-
16 section (aa)(1)).

17 “(x) Comprehensive outpatient rehabilitation fa-
18 cility services (under subsection (cc)(1)).

19 “(xi) Hospice care (as defined in subsection
20 (dd)(1)).

21 “(xii) Certified nurse-midwife service (as de-
22 fined in subsection (gg)(1)).

23 “(xiii) Inpatient or outpatient rural primary
24 care hospital services (as defined in subsection
25 (mm)).

1 “(xiv) A covered surgical procedure in an ambu-
2 latory surgical center (under section
3 1832(a)(2)(F)(i)).

4 “(B) The term ‘covered outpatient drug’ does not in-
5 clude any drug that is intravenously administered in a
6 home setting.”.

7 (b) DEDUCTIBLE AND PAYMENT AMOUNTS.—(1)
8 Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1))
9 is amended—

10 (A) by striking “1834(h)(1), (M)” and inserting
11 “1834(h)(1), (N)”;

12 (B) by striking “(r)(2)) and (N)” and inserting
13 “(r)(2)), (O)”;

14 (C) by striking the semicolon at the end and in-
15 serting the following “, and (P) with respect to ex-
16 penses incurred for covered outpatient drugs, the
17 amounts paid shall be the amounts determined
18 under section 1834(d)(2);”.

19 (2) Section 1833(a)(2) of such Act (42 U.S.C.
20 1395l(a)(2)) is amended by inserting “(other than covered
21 outpatient drugs)” after “(2) in the case of services”.

22 (3) Section 1833(b) of such Act (42 U.S.C. 1395l(b))
23 is amended—

24 (A) in clause (1), by inserting “or for covered
25 outpatient drugs” after “1861(s)(10)(A)”, and

1 (B) in clause (2), by inserting “or with respect
2 to covered outpatient drugs” after “home health
3 services”.

4 (4) Section 1834 of the Social Security Act (42
5 U.S.C. 1395m), as amended by section 412(a), is amended
6 by inserting after subsection (d) the following new sub-
7 section:

8 “(e) PAYMENT FOR COVERED OUTPATIENT
9 DRUGS.—

10 “(1) DEDUCTIBLE.—

11 “(A) APPLICATION.—

12 “(i) IN GENERAL.—Except as pro-
13 vided in clauses (ii) and (iii), payment
14 shall be made under paragraph (2) only
15 with respect to expenses incurred by an in-
16 dividual for covered outpatient drugs dur-
17 ing a calendar year on or after such date
18 in the year as the Secretary determines
19 that the individual has incurred expenses
20 in the year for covered outpatient drugs
21 (during a period in which the individual is
22 entitled to benefits under this part) equal
23 to the amount of the prescription drug de-
24 ductible specified in subparagraph (C) for
25 that year.

1 “(ii) DEDUCTIBLE NOT APPLIED TO
2 1ST YEAR IMMUNOSUPPRESSIVES.—The
3 prescription drug deductible established
4 under this paragraph shall not apply to
5 drugs described in section 1861(t)(2)(A)
6 used in immunosuppressive therapy and
7 furnished, to an individual who receives an
8 organ transplant for which payment is
9 made under this title, within 1 year after
10 the date of the transplant.

11 “(B) RESPONSE TO APPLICATION.—If the
12 system described in section 1842(o)(4) has not
13 been established and an individual applies to
14 the Secretary to establish that the individual
15 has met the requirement of subparagraph (A),
16 the Secretary shall promptly notify the individ-
17 ual (and, if the application was submitted by or
18 through a participating pharmacy, the phar-
19 macy) as to the date (if any) as of which the
20 individual has met such requirement.

21 “(C) PRESCRIPTION DRUG DEDUCTIBLE
22 AMOUNT.—The prescription drug deductible
23 specified in this subparagraph for—

24 “(i) 1997 is \$850,

25 “(ii) 1998 is \$900,

1 “(iii) 1999 is \$950, and

2 “(iv) any succeeding year, is the
3 amount specified for the previous year, in-
4 creased by the percentage increase in the
5 allocation for the class of services consist-
6 ing of prescription drugs for such year (at-
7 tributable to the medicare program) over
8 such allocation for the previous year, as
9 determined in accordance with subtitle A
10 of title I of the Health Care Cost Contain-
11 ment and Reform Act of 1993.

12 “(2) PAYMENT AMOUNT.—

13 “(A) IN GENERAL.—Subject to the pre-
14 scription drug deductible established under
15 paragraph (1)(A) and except as provided in
16 subparagraph (B), the amounts payable under
17 this part with respect to a covered outpatient
18 drug is equal to 80 percent of the lesser of—

19 “(i) the actual charge for the drug, or

20 “(ii) the applicable payment limit es-
21 tablished under paragraph (3).

22 “(B) TREATMENT OF CERTAIN COST-
23 BASED PREPAID ORGANIZATIONS.—In applying
24 subparagraph (A) in the case of an organization
25 under a reasonable cost reimbursement contract

1 under section 1876 and in the case of an orga-
2 nization receiving payment under section
3 1833(a)(1)(A) and providing coverage of cov-
4 ered outpatient drugs, the Secretary shall pro-
5 vide for an appropriate adjustment in the pay-
6 ment amounts otherwise made to reflect the ag-
7 gregate increase in payments that would other-
8 wise be made with respect to enrollees in such
9 an organization if payments were made other
10 than under such clause or such a contract on
11 an individual-by-individual basis.

12 “(3) PAYMENT LIMITS.—

13 “(A) PAYMENT LIMIT FOR NON-MULTIPLE
14 SOURCE DRUGS AND MULTIPLE-SOURCE DRUGS
15 WITH RESTRICTIVE PRESCRIPTIONS.—In the
16 case of a drug that either is not a multiple
17 source drug (as defined in paragraph (9)(A)) or
18 is a multiple source drug and has a restrictive
19 prescription (as defined in paragraph (9)(B)),
20 the payment limit for the drug under this para-
21 graph for a payment calculation period is equal
22 to the lesser of—

23 “(i) the 90th percentile of the actual
24 charges (computed on a statewide basis,
25 carrier-wide basis, or other appropriate ge-

1 ographic area basis, as specified by the
2 Secretary) for the drug for the second pre-
3 vious payment calculation period, adjusted
4 (as the Secretary determines to be appro-
5 priate) to reflect the number of tablets (or
6 other dosage units) dispensed; or

7 “(ii) the amount of the administrative
8 allowance (established under paragraph
9 (4)) plus the product of—

10 “(I) the number of tablets (or
11 other dosage units) dispensed, and

12 “(II) the per tablet or unit aver-
13 age wholesale price for such drug (as
14 determined under subparagraph (C)
15 for the period for purposes of this
16 subparagraph).

17 “(B) PAYMENT LIMIT FOR MULTIPLE
18 SOURCE DRUGS WITHOUT RESTRICTIVE PRE-
19 SCRIPTIONS.—In the case of a drug that is a
20 multiple source drug but does not have a re-
21 strictive prescription, the payment limit for the
22 drug under this paragraph for a payment cal-
23 culation period is equal to the amount of the
24 administrative allowance (established under
25 paragraph (4)) plus the product of—

1 “(i) the number of tablets (or other
2 dosage units) dispensed, and

3 “(ii) the unweighted median of the
4 per tablet or unit average wholesale prices
5 (determined under subparagraph (C) for
6 purposes of this subparagraph) for such
7 drug for the period.

8 “(C) DETERMINATION OF UNIT PRICE.—

9 “(i) IN GENERAL.—For purposes of
10 this paragraph, the Secretary shall deter-
11 mine, with respect to the dispensing of a
12 covered outpatient drug in a payment cal-
13 culation period (beginning on or after Jan-
14 uary 1, 1997), the per tablet or unit aver-
15 age wholesale price for the drug.

16 “(ii) BASIS FOR DETERMINATIONS.—

17 “(I) DETERMINATION FOR NON-
18 MULTIPLE-SOURCE DRUGS.—For pur-
19 poses of subparagraph (A), such de-
20 termination shall be based on a bian-
21 nual survey conducted by the Sec-
22 retary of a representative sample of
23 direct sellers, wholesalers, or phar-
24 macies (as appropriate) of wholesale
25 (or comparable direct) prices (exclud-

1 ing discounts to pharmacies); except
2 that if, because of low volume of sales
3 for the drug or other appropriate rea-
4 sons or in the case of covered out-
5 patient drugs during 1997, the Sec-
6 retary determines that such a survey
7 is not appropriate with respect to a
8 specific drug, such determination shall
9 be based on published average whole-
10 sale (or comparable direct) prices for
11 the drug.

12 “(II) DETERMINATION FOR MUL-
13 TIPLE-SOURCE DRUGS.—For purposes
14 of subparagraph (B), the Secretary
15 may base the determination under
16 this subparagraph on the published
17 average wholesale (or comparable di-
18 rect) prices for the drug or on a bian-
19 nual survey conducted by the Sec-
20 retary of a representative sample of
21 direct sellers, wholesalers, or phar-
22 macists (as appropriate) of wholesale
23 (or comparable direct) prices (exclud-
24 ing discounts to pharmacies).

1 “(III) COMPLIANCE WITH SUR-
2 VEY REQUIRED.—If a wholesaler or
3 direct seller of a covered outpatient
4 drug refuses, after being requested by
5 the Secretary, to provide the informa-
6 tion required in a survey under this
7 clause, or deliberately provides infor-
8 mation that is false, the Secretary
9 may impose a civil money penalty of
10 not to exceed \$10,000 for each such
11 refusal or provision of false informa-
12 tion. The provisions of section 1128A
13 (other than subsections (a) and (b))
14 shall apply to civil money penalties
15 under the previous sentence in the
16 same manner as such provisions apply
17 to a penalty or proceeding under sec-
18 tion 1128A(a). Information gathered
19 pursuant to the survey shall not be
20 disclosed except as the Secretary de-
21 termines to be necessary to carry out
22 the purposes of this part.

23 “(iii) QUANTITY AND TIMING.—Such
24 determination shall be based on the price
25 or prices for purchases in reasonable quan-

1 tities and shall be made for a payment cal-
2 culation period based on prices for the first
3 day of the first month of the previous pay-
4 ment calculation period.

5 “(iv) GEOGRAPHIC BASIS.—The Sec-
6 retary shall make such determination, and
7 calculate the payment limits under this
8 paragraph, on a national basis; except that
9 the Secretary may make such determina-
10 tion, and calculate such payment limits, on
11 a regional basis to take account of limita-
12 tions on the availability of drug products
13 and variations among regions in the aver-
14 age wholesale prices for a drug product.

15 “(4) ADMINISTRATIVE ALLOWANCE FOR PUR-
16 POSES OF PAYMENT LIMITS.—

17 “(A) IN GENERAL.—Except as provided in
18 subparagraph (B), for drugs dispensed in—

19 “(i) 1997, the administrative allow-
20 ance under this paragraph is—

21 “(I) \$5.00 for drugs dispensed by
22 a participating pharmacy, or

23 “(II) \$3.00 for drugs dispensed
24 by another pharmacy; or

1 “(ii) a subsequent year, the adminis-
2 trative allowance under this paragraph is
3 the administrative allowance under this
4 paragraph for the preceding year increased
5 by the percentage increase (if any) in the
6 implicit price deflator for gross national
7 product (as published by the Department
8 of Commerce in its ‘Survey of Current
9 Business’) over the 12-month period end-
10 ing with August of such preceding year.

11 Any allowance determined under the clause (ii)
12 which is not a multiple of 1 cent shall be round-
13 ed to the nearest multiple of 1 cent.

14 “(B) ADJUSTMENT IN ALLOWANCE FOR
15 MAIL SERVICE PHARMACIES.—The Secretary
16 may, by regulation and after consultation with
17 pharmacists, elderly groups, and private insur-
18 ers, reduce the administrative allowances estab-
19 lished under subparagraph (A) for any drug
20 dispensed by a mail service pharmacy (as de-
21 fined by the Secretary) based on differences be-
22 tween such pharmacies and other pharmacies
23 with respect to operating costs and other econo-
24 mies.

1 “(5) ASSURING APPROPRIATE PRESCRIBING
2 AND DISPENSING PRACTICES.—

3 “(A) IN GENERAL.—The Secretary shall
4 establish a program to identify (and to educate
5 physicians and pharmacists concerning)—

6 “(i) instances or patterns of unneces-
7 sary or inappropriate prescribing or dis-
8 pensing practices for covered outpatient
9 drugs;

10 “(ii) instances or patterns of sub-
11 standard care with respect to such drugs;
12 and

13 “(iii) potential adverse reactions.

14 “(B) STANDARDS.—In carrying out the
15 program under subparagraph (A), the Secretary
16 shall establish for each covered outpatient drug
17 standards for the prescribing of the drug which
18 are based on accepted medical practice. In es-
19 tablishing such standards, the Secretary shall
20 incorporate standards from such current au-
21 thoritative compendia as the Secretary may se-
22 lect; except that the Secretary may modify such
23 a standard by regulation on the basis of sci-
24 entific and medical information that such

1 standard is not consistent with the safe and ef-
2 fective use of the drug.

3 “(C) PROHIBITION OF FORMULARY.—
4 Nothing in this title (other than section
5 1862(c)) shall be construed as authorizing the
6 Secretary to exclude from coverage or to deny
7 payment—

8 “(i) for any specific covered out-
9 patient drug, or specific class of covered
10 outpatient drug; or

11 “(ii) for any specific use of such a
12 drug for a specific indication unless such
13 exclusion is pursuant to section 1862(a)(1)
14 based on a finding by the Secretary that
15 such use is not safe or is not effective.

16 “(6) TREATMENT OF CERTAIN PREPAID ORGA-
17 NIZATIONS.—

18 “(A) GENERAL RULE COUNTING PREPAID
19 PLAN EXPENSES TOWARDS THE PRESCRIPTION
20 DRUG DEDUCTIBLE.—Except as provided in
21 subparagraph (B), expenses incurred by (or on
22 behalf of) a medicare beneficiary for covered
23 outpatient drugs shall be counted (consistent
24 with subparagraph (C)) toward the prescription
25 drug deductible established under paragraph

1 (1) whether or not, at the time the expenses
2 were incurred, the beneficiary was enrolled in a
3 plan under section 1833(a)(1)(A) or under sec-
4 tion 1876.

5 “(B) TREATMENT OF DRUG BUY-OUT PLAN
6 EXPENSES.—In the case of a medicare bene-
7 ficiary enrolled in a month in a drug buy-out
8 plan (as defined in subparagraph (D))—

9 “(i) expenses incurred by the bene-
10 ficiary for covered outpatient drugs reim-
11 bursed under the plan shall not be counted
12 towards the prescription drug deductible,
13 but

14 “(ii) if the individual disenrolls from
15 the plan during the year, the beneficiary is
16 deemed to have incurred, for each month
17 of such enrollment, expenses for covered
18 outpatient drugs in an amount equal to the
19 actuarial value (with respect to such
20 month) of the deductible for covered out-
21 patient drugs (as computed by the Sec-
22 retary for purposes of section 1876(e)(1))
23 applicable on the average to individuals in
24 the United States.

1 “(C) TREATMENT OF EXPENSES FOR COV-
2 ERED OUTPATIENT DRUGS INCURRED WHILE
3 ENROLLED IN A PREPAID PLAN OTHER THAN A
4 DRUG BUY-OUT PLAN.—The Secretary may not
5 enter into a contract with an organization
6 under section 1876, or provide for payment
7 under section 1833(a)(1)(A) with respect to an
8 organization which provides reimbursement for
9 covered outpatient drugs, with respect to a plan
10 that is not a drug buy-out plan, unless the or-
11 ganization provides assurances, satisfactory to
12 the Secretary, that—

13 “(i) the organization will maintain
14 and make available, for its enrollees and in
15 coordination with the appropriate carriers
16 under this part, an accounting of expenses
17 incurred by (or on behalf of) enrollees
18 under the plan for covered outpatient
19 drugs; and

20 “(ii) the organization will take into
21 account, in any deductibles established
22 under the plan in a year with respect to
23 covered outpatient drugs under this part,
24 the amounts of expenses for covered out-
25 patient drugs incurred in the year by (or

1 on behalf of) the beneficiary and otherwise
2 counted towards the prescription drug de-
3 ductible in the year.

4 “(D) DRUG BUY-OUT PLAN DEFINED.—In
5 this paragraph, the term ‘drug buy-out plan’
6 means a plan under section 1833(a)(1)(A) or
7 offered by an organization under section 1876
8 and with respect to which—

9 “(i) the amount of any deductible
10 under the plan with respect to covered out-
11 patient drugs under this title,
12 is less than 50 percent of—

13 “(ii) the prescription drug deductible
14 specified in paragraph (1)(C).

15 “(E) MEDICARE BENEFICIARY DEFINED.—
16 In this subsection, the term ‘medicare bene-
17 ficiary’ means, with respect to a month, an in-
18 dividual covered for benefits under this part for
19 the month.

20 “(F) TREATMENT OF PLAN CHARGES.—In
21 the case of covered outpatient drugs furnished
22 by an eligible organization under section
23 1876(b) or an organization described in section
24 1833(a)(1)(A) which does not impose charges
25 on covered outpatient drugs dispensed to its

1 members, for purposes of this subsection the
2 actual charges of the organization shall be the
3 organization's standard charges to members,
4 and other individuals, not entitled to benefits
5 with respect to such drugs.

6 “(7) PHYSICIAN GUIDE.—

7 “(A) IN GENERAL.—The Secretary shall
8 develop, and update annually, an information
9 guide for physicians concerning the comparative
10 average wholesale prices of at least 500 of the
11 most commonly prescribed covered outpatient
12 drugs. Such guide shall, to the extent prac-
13 ticable, group covered outpatient drugs (includ-
14 ing multiple source drugs) in a manner useful
15 to physicians by therapeutic category or with
16 respect to the conditions for which they are pre-
17 scribed. Such guide shall specify the average
18 wholesale prices on the basis of the amount of
19 the drug required for a typical daily therapeutic
20 regimen.

21 “(B) MAILING GUIDE.—The Secretary
22 shall provide for mailing, in January of each
23 year (beginning with 1997), a copy of the guide
24 developed and updated under subparagraph
25 (A)—

1 “(i) to each hospital with an agree-
2 ment in effect under section 1866;

3 “(ii) to each physician (as defined in
4 section 1861(r)(1)) who routinely provides
5 services under this part; and

6 “(iii) to Social Security offices, senior
7 citizen centers, and other appropriate
8 places.

9 “(8) REPORTS ON UTILIZATION AND EFFECTS
10 ON PRICES.—

11 “(A) COMPILATION OF INFORMATION.—

12 The Secretary shall compile information on—

13 “(i) manufacturers’ prices for covered
14 outpatient drugs, and on charges of phar-
15 macists for covered outpatient drugs, and

16 “(ii) the use of covered outpatient
17 drugs by individuals entitled to benefits
18 under this part.

19 The information compiled under clause (i) shall
20 include a comparison of the increases in prices
21 and charges for covered outpatient drugs dur-
22 ing each 6-month period (beginning with Janu-
23 ary 1997) with the semiannual average increase
24 in such prices and charges during the 5 years
25 beginning with 1992.

1 “(B) REPORTS.—The Secretary shall sub-
2 mit to the Committees on Ways and Means and
3 Energy and Commerce of the House of Rep-
4 resentatives and the Committee on Finance of
5 the Senate a report, in May and November of
6 1998 and 1999 and in May of each succeeding
7 year, providing the information compiled under
8 subparagraph (A). For each such report sub-
9 mitted after 1999, the report shall include an
10 explanation of the extent to which the increases
11 in outlays for covered outpatient drugs under
12 this part are due to the factors described in
13 subparagraphs (A)(i) and (A)(ii).

14 “(9) DEFINITIONS.—In this subsection:

15 “(A) MULTIPLE SOURCE DRUG.—

16 “(i) IN GENERAL.—The term ‘mul-
17 tiple source drug’ means, with respect to a
18 payment calculation period, a covered out-
19 patient drug for which there are 2 or more
20 drug products which—

21 “(I) are rated as therapeutically
22 equivalent (under the Food and Drug
23 Administration’s most recent publica-
24 tion of ‘Approved Drug Products with

1 Therapeutic Equivalence Evalua-
2 tions’);

3 “(II) except as provided in clause
4 (ii), are pharmaceutically equivalent
5 and bioequivalent, as defined in clause
6 (iii) and as determined by the Food
7 and Drug Administration; and

8 “(III) are sold or marketed dur-
9 ing the period.

10 “(ii) EXCEPTION.—Subclause (II) of
11 clause (i) shall not apply if the Food and
12 Drug Administration changes by regulation
13 (after an opportunity for public comment
14 of 90 days) the requirement that, for pur-
15 poses of the publication described in clause
16 (i)(I), in order for drug products to be
17 rated as therapeutically equivalent, they
18 must be pharmaceutically equivalent and
19 bioequivalent, as defined in clause (iii).

20 “(iii) DEFINITIONS.—For purposes of
21 this subparagraph:

22 “(I) PHARMACEUTICALLY EQUIV-
23 ALENT.—Drug products are pharma-
24 ceutically equivalent if the products
25 contain identical amounts of the same

1 active drug ingredient in the same
2 dosage form and meet compendial or
3 other applicable standards of strength,
4 quality, purity, and identity.

5 “(II) BIOEQUIVALENT.—Drugs
6 are bioequivalent if they do not
7 present a known or potential
8 bioequivalence problem or, if they do
9 present such a problem, are shown to
10 meet an appropriate standard of
11 bioequivalence.

12 “(III) SOLD OR MARKETED.—A
13 drug is considered to be sold or mar-
14 keted during a period if it is listed in
15 the publications referred to in clause
16 (i)(I), unless the Secretary determines
17 that such sale or marketing is not ac-
18 tually taking place.

19 “(B) RESTRICTIVE PRESCRIPTION.—A
20 drug has a ‘restrictive prescription’ only if—

21 “(i) in the case of a written prescrip-
22 tion, the prescription for the drug indi-
23 cates, in the handwriting of the physician
24 or other person prescribing the drug and
25 with an appropriate phrase (such as ‘brand

1 medically necessary') recognized by the
2 Secretary, that the particular drug must be
3 dispensed; or

4 “(ii) in the case of a prescription is-
5 sued by telephone—

6 “(I) the physician or other per-
7 son prescribing the drug (through use
8 of such an appropriate phrase) states
9 that the particular drug must be dis-
10 pensed, and

11 “(II) the physician or other per-
12 son submits to the pharmacy involved,
13 within 30 days after the date of the
14 telephone prescription, a written con-
15 firmation which is in the handwriting
16 of the physician or other person pre-
17 scribing the drug and which indicates
18 with such appropriate phrase that the
19 particular drug was required to have
20 been dispensed.

21 “(C) PAYMENT CALCULATION PERIOD.—

22 The term ‘payment calculation period’ means
23 the 6-month period beginning with January of
24 each year and the 6-month period beginning
25 with July of each year.’.

1 (c) PARTICIPATING PHARMACIES; CIVIL MONEY
2 PENALTIES.—

3 (1) PARTICIPATING PHARMACIES.—Section
4 1842 of such Act (42 U.S.C. 1395t) is amended—

5 (A) in subsection (h)(1), by inserting be-
6 fore the period at the end of the second sen-
7 tence the following: “, except that, with respect
8 to a supplier of covered outpatient drugs, the
9 term ‘participating supplier’ means a participat-
10 ing pharmacy (as defined in subsection
11 (o)(1))”;

12 (B) in subsection (h)(4), is amended by
13 adding at the end the following: “In publishing
14 directories under this paragraph, the Secretary
15 shall provide for separate directories (wherever
16 appropriate) for participating pharmacies.”;
17 and

18 (C) by inserting after subsection (n) the
19 following new subsection:

20 “(o)(1) For purposes of this section, the term ‘par-
21 ticipating pharmacy’ means, with respect to covered out-
22 patient drugs dispensed on or after January 1, 1997, an
23 entity which is authorized under a State law to dispense
24 covered outpatient drugs and which has entered into an

1 agreement with the Secretary, providing at least the fol-
2 lowing:

3 “(A) The entity agrees to accept payment under
4 this part on an assignment-related basis for all cov-
5 ered outpatient drugs dispensed to an individual en-
6 titled to benefits under this part (in this subsection
7 referred to as a ‘medicare beneficiary’) during a year
8 after—

9 “(i) the Secretary has notified the entity,
10 through the electronic system described in para-
11 graph (4); or

12 “(ii) in the absence of such a system, the
13 entity is otherwise notified that the Secretary
14 has determined,
15 that the individual has met the prescription drug de-
16 ductible with respect to such drugs under section
17 1834(e)(1) for the year.

18 “(B) The entity agrees—

19 “(i) not to refuse to dispense covered out-
20 patient drugs stocked by the entity to any medi-
21 care beneficiary; and

22 “(ii) not to charge medicare beneficiaries
23 (regardless of whether or not the beneficiaries
24 are enrolled under a prepaid health plan or with
25 eligible organization under section 1876) more

1 for such drugs than the amount it charges to
2 the general public (as determined by the Sec-
3 retary in regulations).

4 “(C) The entity agrees to keep patient records
5 (including records on expenses) for all covered out-
6 patient drugs dispensed to all medicare beneficiaries.

7 “(D) The entity agrees to submit information
8 (in a manner specified by the Secretary to be nec-
9 essary to administer this title) on all purchases of
10 covered outpatient drugs dispensed to medicare
11 beneficiaries.

12 “(E) The entity agrees—

13 “(i) to offer to counsel, or to offer to pro-
14 vide information (consistent with State law re-
15 specting the provision of such information) to,
16 each medicare beneficiary on the appropriate
17 use of a drug to be dispensed and whether there
18 are potential interactions between the drug and
19 other drugs dispensed to the beneficiary; and

20 “(ii) to advise the beneficiary on the avail-
21 ability (consistent with State laws respecting
22 substitution of drugs) of therapeutically equiva-
23 lent covered outpatient drugs.

1 “(F) The entity agrees to provide the informa-
2 tion requested by the Secretary in surveys under sec-
3 tion 1834(e)(3)(C)(ii).

4 Nothing in this paragraph shall be construed as requiring
5 a pharmacy operated by an eligible organization (described
6 in section 1876(b)) or an organization described in section
7 1833(a)(1)(A) for the exclusive benefit of its members to
8 dispense covered outpatient drugs to individuals who are
9 not members of the organization.

10 “(2) The Secretary shall provide to each participating
11 pharmacy—

12 “(A) a distinctive emblem (suitable for display
13 to the public) indicating that the pharmacy is a par-
14 ticipating pharmacy; and

15 “(B) upon request, such electronic equipment
16 and technical assistance (other than the costs of ob-
17 taining, maintaining, or expanding telephone service)
18 as the Secretary determines may be necessary for
19 the pharmacy to submit claims using the electronic
20 system established under paragraph (4).

21 “(3) The Secretary shall provide for periodic audits
22 of participating pharmacies to assure—

23 “(A) compliance with the requirements for par-
24 ticipation under this title; and

1 “(B) the accuracy of information submitted by
2 the pharmacies under this title.

3 “(4) The Secretary shall establish, by not later than
4 January 1, 1997, a point-of-sale electronic system for use
5 by carriers and participating pharmacies in the submission
6 of information respecting covered outpatient drugs dis-
7 pensed to medicare beneficiaries under this part.

8 “(5) Notwithstanding subsection (b)(3)(B), payment
9 for covered outpatient drugs may be made on the basis
10 of an assignment described in clause (ii) of that subsection
11 only to a participating pharmacy.”.

12 (2) CIVIL MONEY PENALTIES FOR VIOLATION
13 OF PARTICIPATION AGREEMENT, FOR EXCESSIVE
14 CHARGES FOR NONPARTICIPATING PHARMACIES AND
15 FOR FAILURE TO PROVIDE SURVEY INFORMATION.—
16 Section 1128A(a) of such Act (42 U.S.C. 1320a-
17 7a(a)), as amended by subsections (a) and (b) of
18 section 243, is amended—

19 (A) by striking “or” at the end of para-
20 graph (1);

21 (B) in paragraph (2)(C), by inserting “or
22 to be a participating pharmacy under section
23 1842(o)” after “1842(h)(1)”;

24 (C) by striking “or” at the end of para-
25 graph (4);

1 (D) by adding “or” at the end of para-
2 graph (5); and

3 (E) by inserting after paragraph (5) the
4 following new paragraph:

5 “(6) in the case of a participating or
6 nonparticipating pharmacy (as defined for purposes
7 of part B of title XVIII)—

8 (A) presents or causes to be presented to
9 any person a request for payment for covered
10 outpatient drugs dispensed to an individual en-
11 titled to benefits under part B of title XVIII
12 and for which the amount charged by the phar-
13 macy is greater than the amount the pharmacy
14 charges the general public (as determined by
15 the Secretary in regulations), or

16 (B) fails to provide the information re-
17 quested by the Secretary in a survey under sec-
18 tion 1834(e)(3)(C)(ii);”.

19 (d) LIMITATION ON LENGTH OF PRESCRIPTION.—
20 Section 1862(c) of such Act (42 U.S.C. 1395y(c)) is
21 amended—

22 (1) by redesignating subparagraphs (A) through
23 (D) of paragraph (1) as clauses (i) through (iv);

24 (2) in paragraph (2)(A), by striking “paragraph
25 (1)” and inserting “subparagraph (A)”;

1 (3) by redesignating subparagraphs (A) and
2 (B) of paragraph (2) as clauses (i) and (ii);

3 (4) by redesignating paragraphs (1) and (2) as
4 subparagraphs (A) and (B);

5 (5) by inserting “(1)” after “(c)”; and

6 (6) by adding at the end the following new
7 paragraph:

8 “(2) No payment may be made under part B for any
9 expense incurred for a covered outpatient drug if the drug
10 is dispensed in a quantity exceeding a supply of 30 days
11 or such longer period of time (not to exceed 90 days, ex-
12 cept in exceptional circumstances) as the Secretary may
13 authorize.”.

14 (e) USE OF CARRIERS, FISCAL INTERMEDIARIES,
15 AND OTHER ENTITIES IN ADMINISTRATION.—

16 (1) AUTHORIZING USE OF OTHER ENTITIES IN
17 ELECTRONIC CLAIMS SYSTEM.—Section 1842(f) of
18 such Act (42 U.S.C. 1395u(f)) is amended—

19 (A) by striking “and” at the end of para-
20 graph (1);

21 (B) by striking the period at the end of
22 paragraph (2) and inserting “; and”; and

23 (C) by adding at the end the following new
24 paragraph:

1 “(3) with respect to implementation and oper-
2 ation (and related functions) of the electronic system
3 established under subsection (o)(4), a voluntary as-
4 sociation, corporation, partnership, or other non-
5 governmental organization, which the Secretary de-
6 termines to be qualified to conduct such activities.”.

7 (2) ADDITIONAL FUNCTIONS OF CARRIERS.—
8 Section 1842(b)(3) of such Act (42 U.S.C.
9 1395u(b)(3)) is amended—

10 (A) by striking “and” at the end of sub-
11 paragraph (H);

12 (B) by adding “and” at the end of sub-
13 paragraph (L);

14 (C) by redesignating subparagraph (L) as
15 subparagraph (I); and

16 (D) by inserting after subparagraph (I) (as
17 so redesignated) the following new subpara-
18 graphs:

19 “(J) if it makes determinations or payments
20 with respect to covered outpatient drugs, will—

21 “(i) receive information transmitted under
22 the electronic system established under sub-
23 section (o)(4), and

24 “(ii) respond to requests by participating
25 pharmacies (and individuals entitled to benefits

1 under this part) as to whether or not such an
2 individual has met the prescription drug de-
3 ductible established under section
4 1834(e)(1)(A) for a year; and

5 “(K) will enter into such contracts with organi-
6 zations described in subsection (f)(3) as the Sec-
7 retary determines may be necessary to implement
8 and operate (and for related functions with respect
9 to) the electronic system established under sub-
10 section (o)(4) for covered outpatient drugs under
11 this part;”.

12 (3) SPECIAL CONTRACT PROVISIONS FOR ELEC-
13 TRONIC CLAIMS SYSTEM.—

14 (A) PAYMENT ON OTHER THAN A COST
15 BASIS.—Section 1842(c)(1)(A) of such Act (42
16 U.S.C. 1395u(c)(1)(A)) is amended—

17 (i) by inserting “(i)” after
18 “(c)(1)(A)”;

19 (ii) in the first sentence, by inserting
20 “, except as provided in clause (ii),” after
21 “under this part, and”; and

22 (iii) by adding at the end the follow-
23 ing new clause:

24 “(ii) To the extent that a contract under this section
25 provides for implementation and operation (and related

1 functions) of the electronic system established under sub-
2 section (o)(4) for covered outpatient drugs, the Secretary
3 may provide for payment for such activities based on any
4 method of payment determined by the Secretary to be ap-
5 propriate.”.

6 (B) APPLICATION OF DIFFERENT PER-
7 FORMANCE STANDARDS.—The Secretary of
8 Health and Human Services, before entering
9 into contracts under section 1842 of the Social
10 Security Act with respect to the implementation
11 and operation (and related functions) of the
12 electronic system for covered outpatient drugs,
13 shall establish standards with respect to per-
14 formance with respect to such activities. The
15 provisions of section 1153(e)(2) and paragraphs
16 (1) and (2) of section 1153(h) of such Act shall
17 apply to such activities in the same manner as
18 they apply to contracts with peer review organi-
19 zations, instead of the requirements of the last
20 2 sentences of section 1842(b)(2) of such Act.

21 (C) USE OF REGIONAL CARRIERS.—Section
22 1842(b)(2)(A) of such Act (42 U.S.C.
23 1395u(b)(2)(A)) is amended by adding at the
24 end the following new sentence: “With respect
25 to activities relating to implementation and op-

1 eration (and related functions) of the electronic
2 system established under subsection (o)(4), the
3 Secretary may enter into contracts with carriers
4 under this section to perform such activities on
5 a regional basis.”.

6 (4) DELAY IN APPLICATION OF COORDINATED
7 BENEFITS WITH MEDIGAP.—The provisions of sub-
8 paragraph (B) of section 1842(h)(3) of the Social
9 Security Act shall not apply to covered outpatient
10 drugs (other than drugs described in section
11 1861(s)(2)(J) of such Act as of the date of the en-
12 actment of this Act) dispensed before January 1,
13 1999.

14 (5) BATCH PROMPT PROCESSING OF CLAIMS.—
15 Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

16 (A) in paragraphs (2)(A) and (3)(A), by
17 striking “Each” and inserting “Except as pro-
18 vided in paragraph (3), each”;

19 (B) by adding at the end the following new
20 paragraph:

21 “(4)(A) Each contract under this section which pro-
22 vides for the disbursement of funds, as described in sub-
23 section (a)(1)(B), with respect to claims for payment for
24 covered outpatient drugs shall provide for a payment cycle
25 under which each carrier will, on a monthly basis, make

1 a payment with respect to all claims which were received
2 and approved for payment in the period since the most
3 recent date on which such a payment was made with re-
4 spect to the participating pharmacy or individual submit-
5 ting the claim.

6 “(B) If payment is not issued, mailed, or otherwise
7 transmitted within 5 days of when such a payment is re-
8 quired to be made under subparagraph (A), interest shall
9 be paid at the rate used for purposes of section 3902(a)
10 of title 31, United States Code (relating to interest pen-
11 alties for failure to make prompt payments) for the period
12 beginning on the day after such 5-day period and ending
13 on the date on which payment is made.”.

14 (f) MODIFICATION OF HMO/CMP CONTRACTS.—

15 (1) SEPARATE ACTUARIAL DETERMINATION
16 FOR COVERED OUTPATIENT DRUG BENEFIT.—Sec-
17 tion 1876(e)(1) of such Act (42 U.S.C.
18 1395mm(e)(1)) is amended by adding at the end
19 thereof the following new sentence: “The preceding
20 sentence shall be applied separately with respect to
21 covered outpatient drugs.”.

22 (2) ADDITIONAL OPTIONAL BENEFITS.—Section
23 1876(g)(3)(A) of such Act (42 U.S.C.
24 1395mm(g)(3)(A)) is amended by striking “rate”
25 and inserting “rates”.

1 (g) CONFORMING AMENDMENTS.—

2 (1) The first sentence of section 1866(a)(2)(A)
3 (42 U.S.C. 1395cc(a)(2)(A)) is amended—

4 (A) by inserting “1834(e),” after
5 “1833(b),”; and

6 (B) by inserting “and in the case of cov-
7 ered outpatient drugs, applicable coinsurance
8 percent (specified in section 1834(e)(2)(C)) of
9 the lesser of the actual charges for the drugs or
10 the payment limit (established under section
11 1834(e)(3))” after “established by the Sec-
12 retary”.

13 (2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5))
14 is amended by striking “section 1862(c)” and insert-
15 ing “section 1862(c)(1)”.

16 (h) EFFECTIVE DATES.—

17 (1) IN GENERAL.—Except as otherwise pro-
18 vided in this subsection, the amendments made by
19 this section shall apply to items dispensed on or
20 after July 1, 1997.

21 (2) CARRIERS.—The amendments made by sub-
22 section (e) shall take effect on the date of the enact-
23 ment of this Act; except that the amendments made
24 by subsection (e)(5) shall take effect on January 1,

1 1998, but shall not be construed as requiring pay-
2 ment before February 1, 1998.

3 (3) HMO/CMP ENROLLMENTS.—The amend-
4 ment made by subsection (f) shall apply to enroll-
5 ments effected on or after January 1, 1997.

6 **SEC. 422. ESTABLISHMENT OF PRESCRIPTION DRUG PAY-**
7 **MENT REVIEW COMMISSION.**

8 Part B of title XVIII of the Social Security Act is
9 amended by inserting after section 1846 the following new
10 section:

11 “PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

12 “SEC. 1847. (a)(1) The Director of the Congressional
13 Office of Technology Assessment (in this section referred
14 to as the ‘Director’ and the ‘Office’, respectively) shall
15 provide for the appointment of a Prescription Drug Pay-
16 ment Review Commission (in this section referred to as
17 the ‘Commission’), to be composed of individuals with ex-
18 pertise in the provision and financing of covered out-
19 patient drugs appointed by the Director (without regard
20 to the provisions of title 5, United States Code, governing
21 appointments in the competitive service).

22 “(2) The Commission shall consist of 11 individuals.
23 Members of the Commission shall first be appointed by
24 no later than January 1, 1996, for a term of 3 years, ex-
25 cept that the Director may provide initially for such short-

1 er terms as will insure that (on a continuing basis) the
2 terms of no more than 4 members expire in any one year.

3 “(3) The membership of the Commission shall in-
4 clude recognized experts in the fields of health care eco-
5 nomics, medicine, pharmacology, pharmacy, and prescrip-
6 tion drug reimbursement, as well as at least one individual
7 who is a medicare beneficiary.

8 “(b)(1) The Commission shall submit to Congress an
9 annual report no later than May 1 of each year, beginning
10 with 1997, concerning methods of determining payment
11 for covered outpatient drugs under this part.

12 “(2) Such report, in 1998 and thereafter, shall in-
13 clude, with respect to the previous year, information on—

14 “(A) increases in manufacturers’ prices for cov-
15 ered outpatient drugs and in charges of pharmacists
16 for covered outpatient drugs,

17 “(B) the level of utilization of covered out-
18 patient drugs by medicare beneficiaries, and

19 “(C) administrative costs relating to covered
20 outpatient drugs.

21 “(3) The report submitted in 1998 shall include the
22 Commissions’s recommendations regarding the feasibility
23 and desirability of establishing coverage rules for covered
24 outpatient drugs under which the Secretary may exclude
25 from coverage or deny payment—

1 (3) by striking the semicolon at the end of
2 clause (iii) and inserting “, and”; and

3 (4) by adding at the end the following new
4 clause:

5 “(iv) for making available prescribed drugs
6 for qualified medicare beneficiaries described in
7 section 1905(p)(1), qualified disabled and work-
8 ing individuals described in section 1905(s),
9 and individuals described in clause (iii);”.

10 (b) FULL FEDERAL PAYMENT FOR INCREASED
11 COSTS.—Section 1903(w)(2) of such Act, as added by sec-
12 tion 403, is amended—

13 (1) in subparagraph (D), by striking “(C)” and
14 inserting “(D)”;

15 (2) by redesignating subparagraph (D) as sub-
16 paragraph (E); and

17 (3) by inserting after subparagraph (C) the fol-
18 lowing new subparagraph:

19 “(D) The amount of expenditures for medical
20 assistance attributable to individuals with respect to
21 whom the State plan would not be required to pro-
22 vide such assistance but for the amendments made
23 by section 423(a) of the Health Care Cost Contain-
24 ment and Reform Act of 1993.”.

1 (c) CONFORMING AMENDMENT.—Section
2 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is
3 amended in clause (VIII) of the matter following subpara-
4 graph (E) by striking “1905(p)(3),” and inserting
5 “1905(p)(3) and for prescribed drugs,”.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to calendar quarters beginning on
8 or after January 1, 1996, without regard to whether or
9 not regulations to implement such amendments are pro-
10 mulgated by such date.

11 PART 3—QUALIFIED MEDICARE BENEFICIARY

12 ENROLLMENT

13 **SEC. 431. QUALIFIED MEDICARE BENEFICIARY ENROLL-**
14 **MENT.**

15 (a) ENROLLMENT.—The Secretary of Health and
16 Human Services shall establish and implement a method
17 for obtaining information from newly eligible medicare
18 beneficiaries that may be used (beginning with fiscal year
19 1997) to determine whether such beneficiaries may be eli-
20 gible for medical assistance for medicare cost-sharing
21 under State medicaid plans as qualified medicare bene-
22 ficiaries, and for transmitting such information to the
23 State in which such a beneficiary resides. If, under such
24 method, the Secretary determines that an individual is eli-
25 gible for medical assistance for such cost-sharing under

1 the medicaid plan of a State, the Secretary shall enroll
2 the individual in such plan for quarters beginning after
3 the date on which the Secretary makes such determina-
4 tion.

5 (b) EXPLANATIONS IN ANNUAL NOTICE OF BENE-
6 FITS.—

7 (1) IN GENERAL.—Section 1804 of the Social
8 Security Act (42 U.S.C. 1395b-2) is amended—

9 (A) by striking “and” at the end of para-
10 graph (2);

11 (B) by striking the period at the end of
12 paragraph (3) and inserting “, and”; and

13 (C) by inserting after paragraph (3) the
14 following new paragraph:

15 “(4) a general description in clear language of
16 the availability of and the requirements for obtaining
17 medical assistance for medicare cost-sharing under
18 State plans approved under title XIX.”.

19 (2) EFFECTIVE DATE.—The amendments made
20 by paragraph (1) shall apply to annual notices under
21 section 1804 of the Social Security Act for years be-
22 ginning with 1996.

1 **Subtitle C—Health Insurance**
2 **Deduction for the Self-Employed**

3 **SEC. 441. DEDUCTION FOR HEALTH INSURANCE COSTS OF**
4 **SELF-EMPLOYED INDIVIDUALS MADE PERMA-**
5 **NENT AND INCREASED.**

6 (a) DEDUCTION MADE PERMANENT.—

7 (1) IN GENERAL.—Subsection (l) of section 162
8 of the Internal Revenue Code of 1986 (relating to
9 special rules for health insurance costs of self-em-
10 ployed individuals) is amended by striking paragraph
11 (6).

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall apply to taxable years begin-
14 ning after June 30, 1992.

15 (b) INCREASE IN DEDUCTION.—

16 (1) IN GENERAL.—Paragraph (1) of section
17 162(l) of such Code is amended by striking “25 per-
18 cent of”.

19 (2) EFFECTIVE DATE.—The amendment made
20 by paragraph (1) shall apply to taxable years begin-
21 ning after December 31, 1993.

1 idence, or an alien otherwise permanently residing in
2 the United States under color of law.

3 **“SEC. 2202. ENROLLMENT PERIODS.**

4 “(a) IN GENERAL.—An eligible individual may enroll
5 in the program under this title only in such manner and
6 form as may be prescribed by regulations, and only during
7 an enrollment period prescribed in or under this section.

8 “(b) GENERAL ENROLLMENT PERIOD.—There shall
9 be a general enrollment period during the month of Sep-
10 tember of each year (beginning with 1995).

11 “(c) INITIAL SPECIAL ENROLLMENT PERIODS.—

12 “(1) BIRTH.—With respect to each eligible indi-
13 vidual who becomes an eligible individual by reason
14 of birth during a month after the end of first gen-
15 eral enrollment period, there shall be a special en-
16 rollment period during the 30-day period beginning
17 on the date of the birth.

18 “(2) OBTAINING LAWFUL RESIDENT STATUS.—
19 With respect to each eligible individual who does not
20 meet the requirements of paragraphs (2) and (3) of
21 section 2201(a) at the time of birth and who be-
22 comes an eligible individual during a month after the
23 end of the first general enrollment period, there shall
24 be a special enrollment period during the 30-day pe-

1 riod beginning on the first date on which the individ-
2 ual is an eligible individual.

3 “(d) CONTINUATION SPECIAL ENROLLMENT PERI-
4 ODS.—In the case of an eligible individual—

5 “(1) who at the time the individual first be-
6 comes an eligible individual (or, if later, the first
7 month of the first general enrollment period) is en-
8 rolled in a group health plan (including continuation
9 coverage under such a plan), and

10 “(2) whose coverage under such a plan (includ-
11 ing continuation coverage under such a plan) is ter-
12 minated due to a qualifying event (within the mean-
13 ing of section 4980B(f)(3) of the Internal Revenue
14 Code of 1986) or due to expiration of the period of
15 continuation coverage,

16 there shall be a special enrollment period during the 3-
17 month period beginning 1 month before the effective date
18 of termination of coverage under such a plan.

19 **“SEC. 2203. EMPLOYMENT-BASED ENROLLMENT.**

20 “(a) IN GENERAL.—Subject to subsection (d), the
21 Secretary shall permit the sponsor of a group health plan
22 to elect to offer coverage to eligible children under a group
23 health plan through enrollment under this title in accord-
24 ance with this section. Except as specifically provided in
25 this section, the terms and period of the coverage effected

1 pursuant to such election shall be the same as the terms
2 and period of coverage that would be provided if the indi-
3 vidual were enrolled under this title not pursuant to such
4 election.

5 “(b) CONDITIONS FOR ELECTION.—An election is
6 available under this section with respect to a group health
7 plan only if the sponsor provides assurances, satisfactory
8 to the Secretary, that the following conditions are met:

9 “(1) OFFER TO ALL ELIGIBLE CHILDREN.—The
10 offer of coverage under the election must be made
11 (at such times, including at the time of initial em-
12 ployment, and in such manner as the Secretary de-
13 termines to be consistent with the provisions of this
14 title) to every eligible child for every individual to
15 whom health benefits are made available under the
16 plan.

17 “(2) PAYMENT TOWARDS PREMIUM.—

18 “(A) IN GENERAL.—Under the election,
19 the plan shall provide for payment of the pre-
20 miums imposed under this title and may not
21 collect from any such child or the parent or
22 guardian of such a child more than 20 percent
23 of the amount of such premiums paid by the
24 plan with respect to such a child.

1 “(B) TREATMENT OF CONTINUATION COV-
2 ERAGE.—Subparagraph (A) shall not apply to
3 children of those individuals who are eligible for
4 benefits under the group health plan only on
5 the basis of continuation coverage (such as that
6 described in section 4980B of the Internal Rev-
7 enue Code of 1986).

8 “(3) NO MANDATED ENROLLMENT.—The plan
9 may not require an individual, as a condition for the
10 receipt of benefits under the group health plan, to
11 accept the offer of enrollment under the election.

12 “(c) TERMINATION OF ELECTION.—If the Secretary
13 determines that a group health plan has failed to meet
14 the conditions described in subsection (b), the Secretary,
15 after notice and opportunity for correction, shall terminate
16 the election and shall provide individuals enrolled under
17 the election the opportunity to enroll directly as individ-
18 uals under this title.

19 “(d) LIMITATION.—In the case of a sponsor of a
20 group health plan that offers coverage (other than under
21 the election under this section) for some or all classes of
22 eligible children as of any date, the election under this sec-
23 tion shall not be available during the 2-year period follow-
24 ing such date.

1 **“SEC. 2204. COVERAGE PERIOD.**

2 “(a) IN GENERAL.—No payments may be made
3 under this title with respect to the expenses of an eligible
4 child unless such expenses were incurred by such child
5 during a period which, with respect to the individual, is
6 a coverage period provided under this section.

7 “(b) ENROLLMENT DURING GENERAL ENROLLMENT
8 PERIOD.—In the case of an eligible child who enrolls
9 under this title during a general enrollment period in a
10 year, the period during which the individual is entitled to
11 benefits under the program under this title shall begin on
12 January 1 of the following year.

13 “(c) ENROLLMENT DURING SPECIAL ENROLLMENT
14 PERIODS.—

15 “(1) BIRTH.—In the case of an eligible child
16 who enrolls under this title during a special enroll-
17 ment period described in section 2202(c)(1), the pe-
18 riod during which the individual is entitled to bene-
19 fits under the program under this title shall begin
20 as of the date of birth.

21 “(2) OBTAINING LAWFUL RESIDENT STATUS.—
22 In the case of an eligible child who enrolls under this
23 title during a special enrollment period described in
24 section 2202(c)(2), the period during which the indi-
25 vidual is entitled to benefits under the program

1 under this title shall begin as of the first day of the
2 month in which the individual enrolls.

3 “(3) CONTINUATION OF COVERAGE.—In the
4 case of an eligible child who enrolls under this title
5 during a special enrollment period described in sec-
6 tion 2202(d), the period during which the individual
7 is entitled to benefits under the program under this
8 title shall begin as of the first day of the month in
9 which the individual enrolls (or, if later, the first day
10 of the month in which coverage under the group
11 health plan, including continuation coverage under
12 such a plan, terminates).

13 “(d) TERMINATION OF ENROLLMENT.—

14 “(1) INITIAL MINIMUM 1-YEAR PERIOD.—Ex-
15 cept as provided in paragraph (5), an individual’s
16 coverage period shall continue until terminated
17 under paragraph (2), (3), or (4), and termination
18 under such paragraph may not occur before the end
19 of the 12-month period beginning with the first
20 month in which the coverage period begins.

21 “(2) TERMINATION.—

22 “(A) INDIVIDUAL NOTICE.—With respect
23 to coverage after the minimum coverage period
24 required under paragraph (1), an individual
25 may terminate coverage under this title by the

1 filing of notice that the individual no longer
2 wishes to participate in the program under this
3 title. The termination of coverage under this
4 subparagraph shall take effect at the close of
5 the month following the month in which the no-
6 tice is filed.

7 “(B) FAILURE TO PAY PREMIUMS.—The
8 Secretary shall terminate coverage under this
9 title in the case of an individual for
10 nonpayment of premiums, but such termination
11 shall not be effective for coverage before the
12 end of the minimum coverage required under
13 paragraph (1). The Secretary may provide by
14 regulation for a grace period before coverage is
15 terminated under this subparagraph.

16 “(3) AGE.—An individual’s coverage period
17 shall in no case continue beyond the end of the
18 month in which the individual attains 19 years of
19 age or in which the individual dies.

20 “(4) MEDICARE COVERAGE.—An individual’s
21 coverage period shall be terminated in the month in
22 which the individual becomes entitled to benefits
23 under part A of title XVIII.

24 “(5) COVERAGE UNDER GROUP HEALTH
25 PLAN.—The 12-month minimum enrollment period

1 under paragraph (1) shall not apply in the case of
2 an eligible child if it is demonstrated (to the satis-
3 faction of the Secretary) that at the time of termi-
4 nation of enrollment under this title the child will be
5 covered under a group health plan.

6 “PART B—BENEFITS; PAYMENTS FOR BENEFITS

7 “**SEC. 2211. SCOPE OF BENEFITS.**

8 “(a) IN GENERAL.—Except as provided in the suc-
9 ceeding provisions of this section, the benefits provided to
10 an individual by the program established by this title shall
11 consist of the same benefits that are available under title
12 XVIII (including benefits for well-child services under sec-
13 tion 1861(ll)) to individuals entitled to benefits under part
14 A of that title and enrolled under part B of that title.

15 “(b) NEWBORN AND WELL-BABY CARE; WAIVER OF
16 COST-SHARING FOR WELL-CHILD SERVICES AND OF DE-
17 DUCTIBLE FOR COVERED OUTPATIENT SERVICES.—

18 “(1) IN GENERAL.—In addition to the benefits
19 described in subsection (a), the benefits under this
20 title shall include entitlement to have payment made
21 (in the same manner as for physicians’ services
22 under part B of title XVIII) for newborn and well-
23 baby care, including normal newborn care and pedia-
24 trician services for high-risk deliveries, without the
25 application of deductibles, coinsurance, or

1 copayments, subject to the periodicity schedule es-
2 tablished with respect to the services under para-
3 graph (2).

4 “(2) PERIODICITY SCHEDULE.—The Secretary,
5 in consultation with the American Academy of Pedi-
6 atrics, shall establish a schedule of periodicity which
7 reflects the general, appropriate frequency with
8 which services described in paragraph (1) should be
9 provided to healthy newborns and babies.

10 “(c) WAIVER OF COST-SHARING FOR WELL-CHILD
11 SERVICES.—For purposes of this title, payment shall be
12 made under this title for well-child services (as defined in
13 section 1861(ll)) without regard to any deductible or coin-
14 surance.

15 “(d) SPECIAL RULE FOR DEDUCTIBLE FOR COV-
16 ERED OUTPATIENT DRUGS.—For purposes of this title,
17 payment shall be made under this title for covered out-
18 patient drugs without regard to the deductible specified
19 under section 1834(e)(1).

20 **“SEC. 2212. EXCLUSIONS.**

21 “(a) IN GENERAL.—Except as provided in sub-
22 sections (b) and (c), section 1862 shall apply to expenses
23 incurred for items and services provided under this title
24 the same manner as such section applies to items and
25 services provided under title XVIII.

1 “(b) BENEFITS EXCEPTION.—In applying section
2 1862(a) with respect to services described in section
3 2211(b)(1) (relating to newborn and well-baby care), pay-
4 ment shall not be denied under paragraph (1), (7), or (12)
5 of such section 1862(a) if the services are provided in ac-
6 cordance with the periodicity schedule described in section
7 2211(b)(2).

8 **“SEC. 2213. PAYMENTS FOR BENEFITS.**

9 “(a) IN GENERAL.—Except as otherwise provided in
10 this section—

11 “(1) payment of benefits under this title with
12 respect to benefits shall be made in the same
13 amounts and on the same basis as payment may be
14 made with respect to such benefits under title
15 XVIII, and

16 “(2) the provisions of sections 1814, 1833,
17 1842, 1848, and 1886 shall apply to payment of
18 benefits under this title in the same manner as they
19 apply to benefits under title XVIII.

20 “(b) NO COST-SHARING FOR CERTAIN SERVICES.—
21 No deductibles, coinsurance, copayments, or other cost-
22 sharing shall be imposed with respect to newborn and well-
23 baby care described in section 2211(b)(1) and no deduct-
24 ible shall be imposed with respect to covered outpatient
25 drugs.

1 “(c) ESTABLISHMENT OF NEW DRGs AND
2 WEIGHTS.—In making payment under this title with re-
3 spect to inpatient hospital services, the Secretary shall
4 make such adjustments in the diagnosis-related groups
5 and weighting factors with respect to discharges within
6 such groups, otherwise established under section
7 1886(d)(4) as may be necessary to reflect the types of dis-
8 charges occurring under this title which are not occurring
9 under title XVIII.

10 “(d) CONDITIONS OF AND LIMITATIONS ON PAY-
11 MENTS.—The provisions of sections 1814 and 1835 shall
12 apply to payment for services under this title in the same
13 manner as they apply to payment for services under parts
14 A and B, respectively, of title XVIII.

15 “(e) USE OF TRUST FUND.—In carrying out this sec-
16 tion, any reference in title XVIII to a trust fund shall be
17 treated as a reference to the Children’s Health Insurance
18 Trust Fund established under section 2233.

19 “PART C—PREMIUMS; TRUST FUND

20 “**SEC. 2231. AMOUNT OF PREMIUMS.**

21 “(a) PREMIUM CLASSES.—There are 2 monthly pre-
22 mium rate classes under this section as follows:

23 “(1) SINGLE CHILD MONTHLY PREMIUM
24 RATE.—A premium rate for a single eligible child in
25 a family (in this section referred to as the ‘single

1 child monthly premium rate’), which shall be the
 2 rate paid under section 2232 with respect to a child
 3 who has no other eligible children in the same fam-
 4 ily.

5 “(2) FAMILY MONTHLY PREMIUM RATE.—A
 6 premium rate for two or more eligible children in a
 7 family (in this section referred to as the ‘family
 8 monthly premium rate’), which shall be the rate paid
 9 under section 2232 with respect to all eligible chil-
 10 dren in the same family.

11 “(3) FAMILY.—The Secretary shall specify, in
 12 regulations, those children who shall be considered
 13 to be in the same family for purposes of this section.

14 “(b) MONTHLY PREMIUM RATES.—

15 “(1) 1996 and 1997.—Subject to subsection
 16 (c), the single child monthly premium rate and the
 17 family monthly premium rate, for months in 1996
 18 and 1997, are determined as follows:

For months in	The single child monthly premium rate	The family monthly premium rate
1996	\$156	\$299
1997	\$167	\$321

19 “(2) AFTER 1997.—Subject to subsection (d),
 20 for months in years after 1997, the single child
 21 monthly premium rate and the family monthly pre-
 22 mium rate are equal to such respective rates estab-

1 lished under this subsection for the previous year
2 multiplied by the applicable adjustment factor (spec-
3 ified under section 101(c) of the Health Care Cost
4 Containment and Reform Act of 1993) for the year
5 involved.

6 “(c) GEOGRAPHIC AREA ADJUSTMENT.—

7 “(1) FORMULA.—The Secretary shall compute,
8 for each geographic locality, the ratio of the average
9 per capita costs of coverage under this title in local-
10 ity to the national average per capita costs.

11 “(2) ADJUSTMENT.—The premium rates other-
12 wise established under this section and applied to a
13 geographic locality shall be multiplied by such ratio
14 and by such factor as the Secretary determines to be
15 necessary so that, if all eligible children were en-
16 rolled in the program under this title for all months
17 in the year and paid premiums based on the rates
18 specified in subsection (c) as adjusted under this
19 subsection, the total amount of such premiums
20 would equal the total amount of payments that
21 would be made under this title in the year.

22 “(3) SELECTION OF GEOGRAPHIC LOCAL-
23 ITIES.—For purposes of this subsection, the Sec-
24 retary shall use contiguous geographic localities that
25 are not smaller than metropolitan statistical areas.

1 “(d) PUBLICATION OF RATES.—The Secretary shall
2 during July of each year (beginning in 1996) publish the
3 applicable premiums under this section for months in the
4 succeeding year for the different localities used under sub-
5 section (c).

6 **“SEC. 2232. PAYMENT OF PREMIUMS.**

7 “(a) IN GENERAL.—Subject to subsection (c), pre-
8 miums under this title shall be paid at the rates specified
9 under section 2231 to the Secretary at such times, and
10 in such manner, as the Secretary shall prescribe by regula-
11 tions.

12 “(b) INTEREST FOR LATE PAYMENT.—In the case
13 premiums are not paid on a timely basis, the Secretary
14 may impose a reasonable late charge and interest at a rate
15 (estimated by the Secretary) not to exceed 125 percent
16 of the average market yield described in the third sentence
17 of section 1817(c).

18 “(c) SUSPENSION OF PREMIUMS.—Payment of pre-
19 miums under this section shall be suspended for any
20 month for which the eligible individual establishes that the
21 individual—

22 “(1) is entitled to medical assistance under a
23 State plan approved under title XIX, or

24 “(2) is entitled to benefits under a group health
25 plan (as defined in section 5000(b)(1) of the Inter-

1 nal Revenue Code of 1986), including benefits under
2 continuation coverage.

3 “(d) DEPOSIT INTO TRUST FUND.—Premiums col-
4 lected under this section shall be deposited in the Chil-
5 dren’s Health Insurance Trust Fund.

6 **“SEC. 2233. CHILDREN’S HEALTH INSURANCE TRUST FUND.**

7 “(a) ESTABLISHMENT.—(1) There is hereby created
8 on the books of the Treasury of the United States a trust
9 fund to be known as the ‘Children’s Health Insurance
10 Trust Fund’ (in this section referred to as the ‘Trust
11 Fund’). The Trust Fund shall consist of such gifts and
12 bequests as may be made as provided in section 201(i)(1)
13 and amounts appropriated under paragraph (2).

14 “(2) There are authorized to be appropriated for each
15 fiscal year out of any moneys in the Treasury not other-
16 wise appropriated to the Trust Fund a Government con-
17 tribution equal to the amount of expenditures made under
18 this title in the fiscal year, reduced by the amount of the
19 premiums deposited in the Trust Fund under section
20 2232(d).

21 “(b) INCORPORATION OF PROVISIONS.—

22 “(1) IN GENERAL.—Subject to paragraph (2),
23 the provisions of subsections (b) through (j) of sec-
24 tion 1817 shall apply to the Trust Fund in the same

1 manner as they apply to the Federal Hospital Insur-
2 ance Trust Fund.

3 “(2) EXCEPTIONS.—In applying paragraph
4 (1)—

5 “(A) the Board of Trustees and Managing
6 Trustee of the Trust Fund shall be composed of
7 the members of the Board of Trustees and the
8 Managing Trustee, respectively, of the Federal
9 Hospital Insurance Trust Fund; and

10 “(B) any reference in section 1817 to the
11 Federal Hospital Insurance Trust Fund or to
12 title XVIII (or part A thereof) is deemed a ref-
13 erence to the Trust Fund under this section
14 and this title, respectively.

15 “PART D—GENERAL PROVISIONS

16 **“SEC. 2251. INCORPORATION OF CERTAIN MEDICARE PRO-**
17 **VISIONS.**

18 “(a) USE OF CARRIERS AND INTERMEDIARIES.—The
19 Secretary shall provide for the administration of this title
20 through the use of fiscal intermediaries and carriers in
21 the same manner as title XVIII is carried out through
22 the use of such fiscal intermediaries and carriers.

23 “(b) DEFINITIONS.—Except as otherwise provided in
24 this title, the definitions contained in section 1861 shall

1 apply for purposes of this title in the same manner as they
2 apply for purposes of title XVIII.

3 “(c) CERTIFICATION, PROVIDER QUALIFICATION,
4 ETC.—The provisions of sections 1863 through 1875, sec-
5 tions 1878 through 1880, section 1883, section 1885, and
6 sections 1887 through 1892 shall apply to this title in the
7 same manner as they apply to title XVIII.

8 “(d) HEALTH MAINTENANCE ORGANIZATIONS AND
9 COMPETITIVE MEDICAL PLANS.—

10 “(1) IN GENERAL.—Except as provided in this
11 subsection, section 1876 shall apply to individuals
12 entitled to benefits under this title in the same man-
13 ner as such section applies to individuals entitled to
14 benefits under part A, and enrolled under part B, of
15 title XVIII.

16 “(2) APPLICATION.—In applying section 1876
17 under this subsection—

18 “(A) the provisions of such section relating
19 only to individuals enrolled under part B of title
20 XVIII shall not apply;

21 “(B) any reference to a Trust Fund estab-
22 lished under title XVIII and to benefits under
23 such title is deemed a reference to the Chil-
24 dren’s Health Insurance Trust Fund and to
25 benefits under this title;

1 “(C) the adjusted average per capita cost
2 and the adjusted community rate shall be deter-
3 mined on the basis of benefits under this title;
4 and

5 “(D) subsection (f) shall not apply.

6 **“SEC. 2252. INCORPORATION OF PEER REVIEW PROVISIONS**
7 **AND FRAUD AND ABUSE PROVISIONS.**

8 “The provisions of sections 1121 through 1126, sec-
9 tions 1128 through 1128B, section 1134, section 1138,
10 and part B of title XI shall apply to this title in the same
11 manner as they apply to title XVIII.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Section 201(g)(1)(A) of the Social Security
14 Act (42 U.S.C. 401(g)(1)(A)) is amended by striking
15 “and the Federal Supplementary Medical Insurance
16 Trust Fund” and inserting “, Federal Supple-
17 mentary Medical Insurance Trust Fund, and the
18 Children’s Health Insurance Trust Fund”.

19 (2) Section 201(i)(1) of such Act (42 U.S.C.
20 401(i)(1)) is amended by striking “and the Federal
21 Supplementary Medical Insurance Trust Fund” and
22 inserting “, Federal Supplementary Medical Insur-
23 ance Trust Fund, and the Children’s Health Insur-
24 ance Trust Fund”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect on the date of the enactment
3 of this Act, except that no benefits shall be available under
4 title XXII of the Social Security Act for items or services
5 furnished before January 1, 1996.

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