

103^D CONGRESS
1ST SESSION

H. R. 3115

To improve access, affordability, and competition in health care, through the implementation of flexible savings accounts and malpractice reform, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 22, 1993

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

A BILL

To improve access, affordability, and competition in health care, through the implementation of flexible savings accounts and malpractice reform, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Competitive Affordable Health Care Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—TAX PROVISIONS ENCOURAGING LOW-COST HEALTH
PLANS AND HEALTH CARE SAVINGS ACCOUNTS

- Sec. 101. Refundable tax credit for individuals not covered under employer-provided health plan.
- Sec. 102. Limitation on exclusion for employer-provided health coverage.
- Sec. 103. Health care savings accounts.

TITLE II—HEALTH CARE COST CONTAINMENT

Subtitle A—Health Care Liability Reform

- Sec. 201. Federal reform of health care liability actions.
- Sec. 202. Statute of limitations.
- Sec. 203. Requirement for initial resolution of actions in Federal court through alternative dispute resolution.
- Sec. 204. Calculation and payment of damages.
- Sec. 205. Treatment of attorney's fees.
- Sec. 206. Joint and several liability.
- Sec. 207. Mandatory offsets for damages paid by a collateral source.
- Sec. 208. Preemption.
- Sec. 209. Definitions.
- Sec. 210. Effective date.

Subtitle B—Limit on Self-Referrals by Health Care Provider

- Sec. 221. Limitation on self-referrals by health care providers.

Subtitle C—Administrative Cost Savings

- Sec. 230. Definitions.

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

- Sec. 231. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 232. Application of standards.
- Sec. 233. Periodic review and revision of standards.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

- Sec. 241. Medical data standards for hospitals and other providers.
- Sec. 242. Application of electronic data standards to certain hospitals.
- Sec. 243. Electronic transmission to Federal agencies.
- Sec. 244. Advisory commission.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

- Sec. 251. State comparative value information programs for health care purchasing.
- Sec. 252. Comparative value information concerning Federal programs.
- Sec. 253. Development of model systems.

PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS

- Sec. 261. Standards relating to use of medicare and medicaid magnetized health benefit cards; secondary payer data bank.
- Sec. 262. Preemption of State quill pen laws.
- Sec. 263. Use of standard identification numbers.

Subtitle D—Limitation of Antitrust Recovery for Certain Hospital Joint Ventures

- Sec. 271. Purpose.
 Sec. 272. Definitions.
 Sec. 273. Limitation on damages for antitrust violations.
 Sec. 274. Disclosure of hospital joint venture.

Subtitle E—Medicaid Program Flexibility

- Sec. 281. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.
 Sec. 282. Period of certain waivers.

TITLE III—REFUNDABLE CREDIT FOR COSTS OF PROVIDING EMERGENCY INDIGENT CARE

- Sec. 301. Refundable credit for costs of providing emergency indigent care.

1 **TITLE I—TAX PROVISIONS EN-**
 2 **COURAGING LOW-COST**
 3 **HEALTH PLANS AND HEALTH**
 4 **CARE SAVINGS ACCOUNTS**

5 **SEC. 101. REFUNDABLE TAX CREDIT FOR INDIVIDUALS NOT**
 6 **COVERED UNDER EMPLOYER-PROVIDED**
 7 **HEALTH PLAN.**

8 (a) REFUNDABLE CREDIT.—Subpart C of part IV of
 9 subchapter A of chapter 1 of the Internal Revenue Code
 10 of 1986 (relating to refundable credits) is amended by re-
 11 designating section 35 as section 37 and by inserting after
 12 section 34 the following new section:

13 **“SEC. 35. QUALIFIED HEALTH CARE COSTS.**

14 “(a) ALLOWANCE OF CREDIT.—In the case of an eli-
 15 gible individual, there shall be allowed as a credit against
 16 the tax imposed by this subtitle an amount equal to 15
 17 percent of the lesser of—

1 “(1) the health care expenses of the taxpayer,
2 or

3 “(2) the maximum health care expense amount.

4 “(b) MAXIMUM HEALTH CARE EXPENSE AMOUNT.—
5 The maximum health care expense amount for any taxable
6 year is—

7 “(1) \$1,250 in the case of a taxpayer who is al-
8 lowed only 1 exemption amount under section 151,

9 “(2) \$2,500 in the case of a taxpayer who is al-
10 lowed only 2 exemption amounts under section 151,
11 and

12 “(3) \$4,750 in the case of a taxpayer who is al-
13 lowed 3 or more exemption amounts under section
14 151.

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

16 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
17 individual’ means any individual who is not covered
18 under any employer-provided health plan. Such term
19 shall not include an individual for whom an election
20 under section 220 is in effect for the taxable year.

21 “(2) HEALTH CARE EXPENSES.—The term
22 ‘health care expenses’ means the amount paid dur-
23 ing the taxable year which would be allowable as a
24 deduction for the taxable year under section 213 but

1 for the threshold based on adjusted gross income
2 and subsection (e) of this section.

3 “(d) DOLLAR AMOUNTS ADJUSTED FOR INFLA-
4 TION.—

5 “(1) IN GENERAL.—In the case of any taxable
6 year beginning in a calendar year beginning after
7 the date of the enactment of this section, each dollar
8 amount in subsection (b) shall be increased by an
9 amount equal to—

10 “(A) such dollar amount, multiplied by

11 “(B) the cost-of-living adjustment deter-
12 mined under section 1(f)(3) for the calendar
13 year in the taxable year begins, by substituting
14 the calendar year which includes the date of the
15 enactment of this section for the calendar year
16 referred to in subparagraph (B) thereof.

17 “(2) ROUNDING.—If any dollar amount as in-
18 creased under paragraph (1) is not a multiple of
19 \$10, such dollar amount shall be rounded to the
20 nearest multiple of \$10 (or, if such dollar amount is
21 a multiple of \$5 and not of \$10, such dollar amount
22 shall be increased to the nearest multiple of \$10).

23 “(e) DENIAL OF MEDICAL EXPENSE DEDUCTION
24 FOR CREDITED AMOUNTS.—Any amount for which a cred-
25 it is allowed under this section shall not be taken into ac-

1 count in computing the amount allowable as a deduction
2 under section 213(a).”

3 (b) ALTERNATIVE DEDUCTION.—

4 (1) IN GENERAL.—Part VII of subchapter B of
5 chapter 1 of such Code is amended by redesignating
6 section 220 as section 221 and by inserting after
7 section 219 the following new section:

8 **“SEC. 220. QUALIFIED HEALTH CARE COSTS.**

9 “(a) ALLOWANCE OF DEDUCTION.—At the election
10 of an eligible individual for the taxable year, there shall
11 be allowed as a deduction for the taxable year an amount
12 equal to the lesser of—

13 “(1) the health care expenses of the taxpayer,
14 or

15 “(2) the maximum health care expense amount.

16 “(b) DEFINITIONS.—For purposes of this section,
17 terms used in this section which are also used in section
18 35 shall have the respective meanings given such terms
19 in section 35.

20 “(c) DENIAL OF MEDICAL EXPENSE DEDUCTION
21 FOR DEDUCTED AMOUNTS.—Any amount for which a de-
22 duction is allowed under this section shall not be taken
23 into account in computing the amount allowable as a de-
24 duction under section 213(a).”

1 (2) DEDUCTION ALLOWABLE WHETHER OR NOT
2 INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Sub-
3 section (a) of section 62 of such Code is amended
4 by adding after paragraph (15) the following new
5 paragraph:

6 “(16) HEALTH INSURANCE COSTS.—The deduc-
7 tion allowed by section 220.”

8 (c) REPEAL OF SEPARATE DEDUCTION FOR SELF-
9 EMPLOYED INDIVIDUALS.—Subsection (l) of section 162
10 of such Code is hereby repealed.

11 (d) CLERICAL AMENDMENTS.—

12 (1) Subpart C of part IV of subchapter A of
13 chapter 1 of such Code is amended by striking the
14 last item and inserting the following new item:

“Sec. 35. Qualified health care costs.

“Sec. 36. Overpayments of tax.”

15 (2) Part VII of subchapter B of chapter 1 of
16 such Code is amended by striking the last item and
17 inserting the following new items:

“Sec. 220. Qualified health care costs.

“Sec. 221. Cross reference.”

18 **SEC. 102. LIMITATION ON EXCLUSION FOR EMPLOYER-PRO-**
19 **VIDED HEALTH COVERAGE.**

20 (a) IN GENERAL.—The text of section 106 of the In-
21 ternal Revenue Code of 1986 (relating to contributions by
22 employer to accident and health plans) is amended to read
23 as follows:

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

4 “(b) LIMITATION.—The amount excludable from
5 gross income under subsection (a) shall not exceed the
6 value of the coverage under the lowest-cost available mar-
7 ket health plan (as defined in section 137(c)(4)) available
8 to the employer.”

9 (b) EFFECTIVE DATE.—The amendment made by
10 this section shall apply to taxable years beginning after
11 the date of the enactment of this Act.

12 **SEC. 103. HEALTH CARE SAVINGS ACCOUNTS.**

13 (a) IN GENERAL.—Part III of subchapter B of chap-
14 ter 1 of the Internal Revenue Code of 1986 is amended
15 by redesignating section 137 as section 138 and by insert-
16 ing after section 136 the following new section:

17 **“SEC. 137. HEALTH CARE SAVINGS ACCOUNTS.**

18 “(a) EXCLUSION.—Gross income of an employee
19 shall not include any amount contributed during the tax-
20 able year by the employer to a health care savings account
21 of such employee.

22 “(b) LIMITATIONS.—

23 “(1) MAXIMUM EXCLUSION.—Subsection (a)
24 shall not apply to the extent that the amount con-
25 tributed to a health care savings account for the tax-

1 able year exceeds the cost of the lowest cost avail-
2 able market health plan.

3 “(2) EMPLOYEE MUST HAVE CATASTROPHIC
4 COVERAGE.—

5 “(A) IN GENERAL.—Subsection (a) shall
6 not apply to any employee unless such employee
7 has minimum catastrophic coverage throughout
8 such taxable year for such employee, such em-
9 ployee’s spouse, and each dependent (as defined
10 in section 152) of such employee.

11 “(B) MINIMUM CATASTROPHIC COV-
12 ERAGE.—For purposes of subparagraph (A),
13 the term ‘minimum catastrophic coverage’
14 means an insurance plan which pay a minimum
15 of 80 percent of all emergency care expenses
16 per year to the extent such expenses incurred
17 during such year exceed \$4,000.

18 “(3) EXCLUSION LIMITED TO EMPLOYEES
19 WITHOUT OTHER EMPLOYER-PROVIDED HEALTH
20 BENEFITS.—This section shall not apply to any em-
21 ployee for the taxable year if any amount is exclud-
22 able from the gross income of such employee under
23 section 106 for such taxable year.

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

1 “(1) HEALTH CARE SAVINGS ACCOUNT.—The
2 term ‘health care savings account’ means a trust
3 created or organized in the United States exclusively
4 for the purpose of paying the health care expenses
5 of the account beneficiary, but only if the written
6 governing instrument creating the trust meets the
7 following requirements:

8 “(A) No contribution will be accepted un-
9 less it is in cash.

10 “(B) The trustee is a bank (as defined in
11 section 408(n)) or another person who dem-
12 onstrates to the satisfaction of the Secretary
13 that the manner in which such person will ad-
14 minister the trust will be consistent with the re-
15 quirements of this section.

16 “(C) The assets of the trust will not be
17 commingled with other property except in a
18 common trust fund or common investment
19 fund.

20 “(2) HEALTH CARE EXPENSES.—The term
21 ‘health care expenses’ means, with respect to the ac-
22 count beneficiary, the amount paid by such bene-
23 ficiary during the taxable year which would be allow-
24 able as a deduction for the taxable year under sec-

1 tion 213 but for the threshold based on adjusted
2 gross income.

3 “(3) ACCOUNT BENEFICIARY.—The term ‘ac-
4 count beneficiary’ means the employee for whose
5 benefit the health care savings account is estab-
6 lished.

7 “(4) LOWEST COST AVAILABLE MARKET
8 HEALTH PLAN.—The term ‘lowest cost available
9 market health plan’ means the regional price of the
10 lowest cost health insurance plan containing a mini-
11 mum level of health care benefits (as determined by
12 the Secretary of Health and Human Services).

13 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

14 “(1) IN GENERAL.—Any amount paid or dis-
15 tributed out of a health care savings account shall
16 be included in the gross income of the individual for
17 whose benefit such account was established unless
18 such amount is used exclusively to pay the health
19 care expenses of such individual.

20 “(2) PENALTY FOR AMOUNTS INCLUDED IN IN-
21 COME BEFORE THE CLOSE OF CALENDAR YEAR.—If
22 any amount is includible in the gross income of the
23 account beneficiary before the last business day dur-
24 ing the taxable year, such beneficiary’s tax imposed

1 by this chapter shall be increased by 10 percent of
2 the amount so includible.

3 “(3) EXCESS CONTRIBUTIONS RETURNED BE-
4 FORE DUE DATE OF RETURN.—Paragraph (1) shall
5 not apply to the distribution of any contribution paid
6 during a taxable year to a health care savings ac-
7 count to the extent that such contribution exceeds
8 the amount excludable under subsection (a) if—

9 “(A) such distribution is received by the
10 individual on or before the last day prescribed
11 by law (including extensions of time) for filing
12 such individual’s return for such taxable year,
13 and

14 “(B) such distribution is accompanied by
15 the amount of net income attributable to such
16 excess contribution.

17 Any net income described in subparagraph (B) shall
18 be included in the gross income of the individual for
19 the taxable year in which it is received.

20 “(e) TAX TREATMENT OF ACCOUNTS.—

21 “(1) ACCOUNT TAXED AS GRANTOR TRUST.—
22 The individual for whose benefit a health care sav-
23 ings account is established shall be treated for pur-
24 poses of this title as the owner thereof and shall be
25 subject to tax thereon in accordance with subpart E

1 of part I of subchapter J of this chapter (relating
2 to grantors and others treated as substantial own-
3 ers).

4 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
5 GAGES IN PROHIBITED TRANSACTION.—

6 “(A) IN GENERAL.—If, during any taxable
7 year of the individual for whose benefit the
8 health care savings account was established,
9 such individual engages in any transaction pro-
10 hibited by section 4975 with respect to the ac-
11 count, the account ceases to be a health care
12 savings account as of the first day of that tax-
13 able year.

14 “(B) ACCOUNT TREATED AS DISTRIBUTING
15 ALL ITS ASSETS.—In any case in which any ac-
16 count ceases to be a health care savings account
17 by reason of subparagraph (A) on the first day
18 of any taxable year, paragraph (1) of subsection
19 (h) shall be applied as if there were a distribu-
20 tion on such first day in an amount equal to
21 the fair market value (on such first day) of all
22 assets in the account (on such first day) and no
23 portion of such distribution were used to pay
24 health care expenses.

1 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
2 RITY.—If, during any taxable year, the individual for
3 whose benefit a health care savings account was es-
4 tablished uses the account or any portion thereof as
5 security for a loan, the portion so used is treated as
6 distributed to that individual and not used to pay
7 health care expenses.

8 “(f) CUSTODIAL ACCOUNTS.—For purposes of this
9 section, a custodial account shall be treated as a trust if—

10 “(1) the assets of such account are held by a
11 bank (as defined in section 408(n)) or another per-
12 son who demonstrates to the satisfaction of the Sec-
13 retary that the manner in which he will administer
14 the account will be consistent with the requirements
15 of this section, and

16 “(2) the custodial account would, except for the
17 fact that it is not a trust, constitute a health care
18 savings account described in subsection (g).

19 For purposes of this title, in the case of a custodial ac-
20 count treated as a trust by reason of the preceding sen-
21 tence, the custodian of such account shall be treated as
22 the trustee thereof.

23 “(g) REPORTS.—The trustee of a health care savings
24 account shall make such reports regarding such account
25 to the Secretary and to the individual for whose benefit

1 the account is maintained with respect to contributions,
2 distributions, and such other matters as the Secretary
3 may require under regulations. The reports required by
4 this subsection shall be filed at such time and in such
5 manner and furnished to such individuals at such time and
6 in such manner as may be required by those regulations.

7 “(h) OTHER DEFINITIONS.—For purposes of this
8 section—

9 “(1) EMPLOYER.—The term ‘employer’ includes
10 persons treated as an employer under section
11 401(c)(4).

12 “(2) EMPLOYEE.—The term ‘employee’ in-
13 cludes—

14 “(A) an individual who is an employee
15 within the meaning of section 401(c)(1), and

16 “(B) former employees.

17 “(3) TYPE OF COVERAGE.—The types of cov-
18 erage are—

19 “(A) self-only coverage, and

20 “(B) coverage other than self-only cov-
21 erage.

22 “(4) HEALTH INSURANCE PLAN.—The term
23 ‘health insurance plan’ means any contract or ar-
24 rangement under which an insurer bears all or part
25 of the cost or risk of providing health care items and

1 services, including a hospital or medical expense in-
2 curred policy or certificate, hospital or medical serv-
3 ice plan contract, or health maintenance subscriber
4 contract (including any self-insured health insurance
5 plan), but does not include—

6 “(A) coverage only for accident, dental, vi-
7 sion, disability, or long term care, medicare
8 supplemental health insurance, or any combina-
9 tion thereof,

10 “(B) coverage issued as a supplement to li-
11 ability insurance,

12 “(C) workers’ compensation or similar in-
13 surance, or

14 “(D) automobile medical-payment insur-
15 ance.”

16 (b) EXCLUSION APPLIES FOR EMPLOYMENT TAX
17 PURPOSES.—

18 (1) SOCIAL SECURITY TAXES.—

19 (A) Paragraph (20) of section 3121(a) of
20 such Code is amended by striking “or 132” and
21 inserting “132, or 137”.

22 (B) Paragraph (17) of section 209(a) of
23 the Social Security Act is amended by striking
24 “or 132” and inserting “132, or 137”.

1 (2) RAILROAD RETIREMENT TAX.—Paragraph
2 (5) of section 3231(e) of such Code is amended by
3 striking “or 132” and inserting “132, or 137”.

4 (3) UNEMPLOYMENT TAX.—Paragraph (16) of
5 section 3306(b) of such Code is amended by striking
6 “or 132” and inserting “132, or 137”.

7 (4) WITHHOLDING TAX.—Paragraph (19) of
8 section 3401(a) of such Code is amended by striking
9 “or 132” and inserting “, 132, or 137”.

10 (c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
11 of such Code (relating to tax on excess contributions to
12 individual retirement accounts, certain section 403(b) con-
13 tracts, and certain individual retirement annuities) is
14 amended—

15 (1) by inserting “**HEALTH CARE SAVINGS**
16 **ACCOUNTS,**” after “**ACCOUNTS,**” in the heading
17 of such section,

18 (2) by redesignating paragraph (2) of sub-
19 section (a) as paragraph (3) and by inserting after
20 paragraph (1) the following:

21 “(2) a health care savings account (within the
22 meaning of section 137(g)),”

23 (3) by striking “or” at the end of paragraph
24 (1) of subsection (a), and

1 (4) by adding at the end thereof the following
2 new subsection:

3 “(d) EXCESS CONTRIBUTIONS TO HEALTH CARE
4 SAVINGS ACCOUNTS.—For purposes of this section, in the
5 case of a health care savings account (within the meaning
6 of section 137(g)), the term ‘excess contributions’ means
7 the amount by which the amount contributed for the tax-
8 able year to the account exceeds the amount excludable
9 from gross income under section 137 for such taxable
10 year. For purposes of this subsection, any contribution
11 which is distributed out of the health care savings account
12 in a distribution to which section 137(h)(2) applies shall
13 be treated as an amount not contributed.”

14 (d) TAX ON PROHIBITED TRANSACTIONS.—Section
15 4975 of such Code (relating to prohibited transactions)
16 is amended—

17 (1) by adding at the end of subsection (c) the
18 following new paragraph:

19 “(4) SPECIAL RULE FOR HEALTH CARE SAV-
20 INGS ACCOUNTS.—An individual for whose benefit a
21 health care savings account (within the meaning of
22 section 137(g)) is established shall be exempt from
23 the tax imposed by this section with respect to any
24 transaction concerning such account (which would
25 otherwise be taxable under this section) if, with re-

1 spect to such transaction, the account ceases to be
2 a health care savings account by reason of the appli-
3 cation of section 137(h)(2)(A) to such account.”,
4 and

5 (2) by inserting “or a health care savings ac-
6 count described in section 137(g)” in subsection
7 (e)(1) after “described in section 408(a)”.

8 (e) FAILURE TO PROVIDE REPORTS ON HEALTH
9 CARE SAVINGS ACCOUNTS.—Section 6693 of such Code
10 (relating to failure to provide reports on individual retire-
11 ment account or annuities) is amended—

12 (1) by inserting “**OR ON HEALTH CARE SAV-**
13 **INGS ACCOUNTS**” after “**ANNUITIES**” in the
14 heading of such section, and

15 (2) by adding at the end of subsection (a) the
16 following: “The person required by section 137(g) to
17 file a report regarding a health care savings account
18 at the time and in the manner required by such sec-
19 tion shall pay a penalty of \$50 for each failure un-
20 less it is shown that such failure is due to reasonable
21 cause.”

22 (f) HEALTH CARE SAVINGS ACCOUNT CONTRIBU-
23 TIONS NOT SUBJECT TO WELFARE BENEFIT FUND
24 RULES.—Paragraph (2) of section 419(e) of such Code
25 (defining welfare benefit) is amended by striking “or” at

1 the end of subparagraph (B), by striking the period at
2 the end of subparagraph (C) and inserting “, or”, and by
3 adding at the end thereof the following new subparagraph:

4 “(D) section 137 applies.”

5 (g) CLERICAL AMENDMENTS.—

6 (1) The table of sections for part III of sub-
7 chapter B of chapter 1 of such Code is amended by
8 striking the last item and inserting the following:

“Sec. 137. Health care savings accounts.
“Sec. 138. Cross references to other Acts.”

9 (2) The table of sections for chapter 43 of such
10 Code is amended by striking the item relating to sec-
11 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement
accounts, health care savings accounts, certain
403(b) contracts, and certain individual retirement
annuities.”

12 (3) The table of sections for subchapter B of
13 chapter 68 of such Code is amended by inserting “or
14 on health care savings accounts” after “annuities”
15 in the item relating to section 6693.

16 (h) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 the close of the calendar year which includes the date of
19 the enactment of this Act.

1 **TITLE II—HEALTH CARE COST**
2 **CONTAINMENT**
3 **Subtitle A—Health Care Liability**
4 **Reform**

5 **SEC. 201. FEDERAL REFORM OF HEALTH CARE LIABILITY**
6 **ACTIONS.**

7 (a) **APPLICABILITY.**—This subtitle shall apply with
8 respect to any health care liability claim and to any health
9 care liability action brought in any State or Federal court
10 (except as provided in section 203), except that this sub-
11 title shall not apply to a claim or action for damages aris-
12 ing from a vaccine-related injury or death to the extent
13 that title XXI of the Public Health Service Act applies
14 to the action.

15 (b) **PREEMPTION OF STATE LAW.**—Subject to section
16 208, this subtitle supersedes State law only to the extent
17 that State law differs from any provision of law estab-
18 lished by or under this subtitle. Any issue that is not gov-
19 erned by any provision of law established by or under this
20 subtitle shall be governed by otherwise applicable State or
21 Federal law.

22 (c) **FEDERAL COURT JURISDICTION NOT ESTAB-**
23 **LISHED ON FEDERAL QUESTION GROUNDS.**—Nothing in
24 this subtitle shall be construed to establish any jurisdiction
25 in the district courts of the United States over health care

1 liability actions on the basis of sections 1331 or 1337 of
2 title 28, United States Code.

3 **SEC. 202. STATUTE OF LIMITATIONS.**

4 (a) IN GENERAL.—No health care liability claim may
5 be brought against any party after the expiration of the
6 10-year period that begins on the date the party commit-
7 ted the action which caused the alleged injury that is the
8 subject of the claim.

9 (b) EXCEPTION FOR CLAIMS BASED ON INTEN-
10 TIONAL ACTION.—Subsection (a) shall not apply to a
11 claim brought against a party if the claimant’s sole allega-
12 tion is an allegation of an intentional tort.

13 **SEC. 203. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
14 **TIONS IN FEDERAL COURT THROUGH ALTER-**
15 **NATIVE DISPUTE RESOLUTION.**

16 (a) REQUIREMENT.—

17 (1) IN GENERAL.—No health care liability ac-
18 tion may be brought in any Federal court during a
19 calendar year unless the health care liability claim
20 that is the subject of the action has been initially re-
21 solved under the alternative dispute resolution sys-
22 tem established by the Secretary under subsection
23 (b).

24 (2) INITIAL RESOLUTION OF CLAIMS UNDER
25 ADR.—For purposes of paragraph (1), an action is

1 “initially resolved” under an alternative dispute res-
2 olution system if—

3 (A) the ADR reaches a decision on wheth-
4 er the defendant is liable to the plaintiff for
5 damages; and

6 (B) if the ADR determines that the de-
7 fendant is liable, the ADR reaches a decision on
8 the amount of damages assessed against the de-
9 fendant.

10 (3) EXCLUSION OF COURTS OF DISTRICT OF
11 COLUMBIA.—For purposes of paragraph (1), the
12 term “Federal court” does not include the Superior
13 Court of the District of Columbia or the District of
14 Columbia Court of Appeals.

15 (b) ESTABLISHMENT OF SYSTEM.—

16 (1) IN GENERAL.—The Attorney General shall
17 establish an alternative dispute resolution system
18 that meets the requirements of paragraph (2) for
19 the resolution of health care liability claims under
20 the jurisdiction of the Federal courts.

21 (2) REQUIREMENTS DESCRIBED.—The ADR
22 system established by the Attorney General under
23 paragraph (1) meets the requirements of this para-
24 graph if the system—

1 (A) applies to all health care liability
2 claims under the jurisdiction of the Federal
3 courts;

4 (B) requires that a written opinion resolv-
5 ing the dispute be issued not later than 6
6 months after the date by which each party
7 against whom the claim is filed has received no-
8 tice of the claim (other than in exceptional
9 cases for which a longer period is required for
10 the issuance of such an opinion), and that the
11 opinion contain—

12 (i) findings of fact relating to the dis-
13 pute, and

14 (ii) a description of the costs incurred
15 in resolving the dispute under the system
16 (including any fees paid to the individuals
17 hearing and resolving the claim), together
18 with an appropriate assessment of the
19 costs against any of the parties;

20 (C) provides that claims brought under the
21 system shall be heard and resolved by arbitra-
22 tors appointed by the Secretary in consultation
23 with the Attorney General;

24 (D) requires all parties to present (or to
25 make all reasonable efforts to present) all rel-

1 evant information relating to the claim to the
2 arbitrator, and permits the arbitrator to request
3 the court of relevant jurisdiction to impose
4 criminal penalties against any party that know-
5 ingly or intentionally fails to present (or to
6 make all reasonable efforts to present) such in-
7 formation;

8 (E) provides for the transmittal to the
9 State agency responsible for monitoring or dis-
10 ciplining health care professionals and health
11 care providers of any findings made under the
12 system that such a professional or provider
13 committed malpractice, unless, during the 90-
14 day period beginning on the date the system re-
15 solves the claim against the professional or pro-
16 vider, the professional or provider brings a
17 health care liability action contesting the deci-
18 sion made under the system; and

19 (F) provides for the regular transmittal to
20 the Administrator for Health Care Policy and
21 Research of information on disputes resolved
22 under the system, in a manner that assures
23 that the identity of the parties to a dispute
24 shall not be revealed.

1 (c) APPLICATION OF HEALTH CARE LIABILITY
2 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
3 The provisions of this subtitle shall apply with respect to
4 claims brought under the alternative dispute resolution
5 system established under this section in the same manner
6 as such provisions apply with respect to health care liabil-
7 ity actions.

8 (d) RULES FOR HEALTH CARE LIABILITY ACTIONS
9 CONTESTING ADR RULING.—

10 (1) REQUIRING PARTY CONTESTING ADR RUL-
11 ING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

12 (A) IN GENERAL.—In each health care li-
13 ability action brought in a Federal court, the
14 court shall require the party that contested the
15 ruling of the alternative dispute resolution sys-
16 tem with respect to the health care liability
17 claim that is the subject of the action to pay to
18 the opposing party the costs incurred by the op-
19 posing party under the action, including attor-
20 ney's fees, fees paid to expert witnesses, and
21 other litigation expenses (but not including any
22 fees or costs associated with the resolution of
23 the claim under the alternative dispute resolu-
24 tion system).

1 (B) EXCEPTIONS.—Subparagraph (A)
2 shall not apply if—

3 (i) the party contesting the ruling
4 made under the previous alternative dis-
5 pute resolution system shows that—

6 (I) the ruling was procured by
7 corruption, fraud, or undue means,

8 (II) there was partiality or cor-
9 ruption under the system,

10 (III) there was other misconduct
11 under the system that materially prej-
12 udiced the party's rights, or

13 (IV) the ruling was based on an
14 error of law;

15 (ii) the party contesting the ruling
16 made under the previous alternative dis-
17 pute resolution system presents new evi-
18 dence before the trier of fact that was not
19 available for presentation under the ADR
20 system; or

21 (iii) the court finds that the applica-
22 tion of such paragraph to a party would
23 constitute an undue hardship, and issues
24 an order waiving or modifying the applica-

1 tion of such paragraph that specifies the
2 grounds for the court's decision.

3 (2) RESTRICTIONS ON EVIDENCE PRE-
4 SENTED.—In any health care liability action brought
5 in a Federal court, no party may present any evi-
6 dence to the court that the party did not present
7 during the previous proceeding under the alternative
8 dispute resolution system unless the court finds
9 that—

10 (A) the party could not reasonably have
11 been aware of the existence of such evidence or
12 its availability for presentation at the time of
13 the ADR proceeding; or

14 (B) the restriction against the ability of
15 the party to present such evidence would con-
16 stitute an undue hardship against the party.

17 (e) ESTABLISHMENT OF MODEL STATE SYSTEM.—
18 Not later than 4 years after the date of the enactment
19 of this Act, the Secretary (in consultation with the Attor-
20 ney General) shall establish a model alternative dispute
21 resolution system that a State may (at its option) apply
22 to health care liability claims under the jurisdiction of its
23 courts.

24 **SEC. 204. CALCULATION AND PAYMENT OF DAMAGES.**

25 (a) LIMITATION ON NONECONOMIC DAMAGES.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 the total amount of noneconomic damages that may
3 be awarded to a plaintiff and the members of the
4 plaintiff’s family for losses resulting from the injury
5 which is the subject of a health care liability action
6 may not exceed \$250,000, regardless of the number
7 of parties against whom the action is brought or the
8 number of actions brought with respect to the in-
9 jury.

10 (2) MAXIMUM LIABILITY.—The maximum
11 amount of the liability of any defendant for any
12 event, action, or product with respect to all plaintiffs
13 (and potential plaintiffs) in a health care liability ac-
14 tion for noneconomic damages may not exceed
15 \$1,000,000.

16 (b) ALLOCATION OF PUNITIVE DAMAGES TO UNIN-
17 SURED RISK POOL.—Of the total amount of punitive dam-
18 ages imposed under a health care liability action—

19 (1) 15 percent shall be paid to the plaintiff; and

20 (2) 85 percent shall be paid to the United
21 States for the deposit into the Treasury as mis-
22 cellaneous revenues (for the purpose of financing of
23 tax credits provided under section 35 of the Internal
24 Revenue Code of 1986).

1 **SEC. 205. TREATMENT OF ATTORNEY'S FEES.**

2 If the plaintiff in a health care liability action has
3 entered into an agreement with the plaintiff's attorney to
4 pay the attorney's fees on a contingency basis, the attor-
5 ney's fees for the action may not exceed—

6 (1) 30 percent of the first \$100,000 of any
7 award or settlement paid to the plaintiff;

8 (2) 20 percent of the next \$100,000 of such
9 award or settlement paid to the plaintiff; or

10 (3) 10 percent of any additional amounts paid
11 to the plaintiff.

12 **SEC. 206. JOINT AND SEVERAL LIABILITY.**

13 The liability of each defendant in a health care liabil-
14 ity action shall be several only and shall not be joint, and
15 each defendant shall be liable only for the amount of dam-
16 ages allocated to the defendant in direct proportion to the
17 defendant's percentage of responsibility (as determined by
18 the trier of fact).

19 **SEC. 207. MANDATORY OFFSETS FOR DAMAGES PAID BY A**
20 **COLLATERAL SOURCE.**

21 (a) IN GENERAL.—The total amount of damages re-
22 ceived by a plaintiff in a health care liability action shall
23 be reduced (in accordance with subsection (b)) by any
24 other payment that has been or will be made to the indi-
25 vidual to compensate the plaintiff for the injury that was
26 the subject of the action, including payment under—

1 (1) Federal or State disability or sickness pro-
2 grams;

3 (2) Federal, State, or private health insurance
4 programs;

5 (3) private disability insurance programs;

6 (4) employer wage continuation programs; and

7 (5) any other source of payment intended to
8 compensate the plaintiff for such injury.

9 (b) AMOUNT OF REDUCTION.—The amount by which
10 an award of damages to a plaintiff shall be reduced under
11 subsection (a) shall be—

12 (1) the total amount of any payments (other
13 than such award) that have been made or that will
14 be made to the plaintiff to compensate the plaintiff
15 for the injury that was the subject of the action;
16 minus

17 (2) the amount paid by the plaintiff (or by the
18 spouse, parent, or legal guardian of the plaintiff) to
19 secure the payments described in paragraph (1).

20 **SEC. 208. PREEMPTION.**

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

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

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

3 (3) establishes a longer period during which a
4 health care liability claim may be initiated.

5 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
6 OF LAW OR VENUE.—Nothing in subsection (a) shall be
7 construed to—

8 (1) waive or affect any defense of sovereign im-
9 munity asserted by any State under any provision of
10 law;

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

13 (3) affect the applicability of any provision of
14 the Foreign Sovereign Immunities Act of 1976;

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

18 (5) affect the right of any court to transfer
19 venue or to apply the law of a foreign nation or to
20 dismiss a claim of a foreign nation or of a citizen
21 of a foreign nation on the ground of inconvenient
22 forum.

23 **SEC. 209. DEFINITIONS.**

24 As used in this subtitle:

1 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
2 TEM; ADR.—The term “alternative dispute resolution
3 system” or “ADR” means the system established by
4 the Attorney General under section 203 that pro-
5 vides for the resolution of health care liability claims
6 under the jurisdiction of the Federal courts in a
7 manner other than through health care liability ac-
8 tions.

9 (2) CLAIMANT.—The term “claimant” means
10 any person who alleges a health care liability claim,
11 or, in the case of an individual who is deceased, in-
12 competent, or a minor, the person on whose behalf
13 such a claim is alleged.

14 (3) ECONOMIC DAMAGES.—The term “economic
15 damages” means damages paid to compensate an in-
16 dividual for losses for hospital and other medical ex-
17 penses, lost wages, lost employment, and other pecu-
18 niary losses.

19 (4) HEALTH CARE LIABILITY ACTION.—The
20 term “health care liability action” means a civil ac-
21 tion (other than an action in which the plaintiff’s
22 sole allegation is an allegation of an intentional tort)
23 brought in a State or Federal court against a health
24 care provider or health care professional (regardless
25 of the theory of liability on which the action is

1 based) in which the plaintiff alleges a health care li-
2 ability claim, and includes an action in which the
3 plaintiff alleges harm arising from the use of a med-
4 ical product.

5 (5) HEALTH CARE LIABILITY CLAIM.—The
6 term “health care liability claim” means a claim in
7 which the claimant alleges that injury was caused by
8 the provision of (or the failure to provide) health
9 care services or the use of a medical product.

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

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

23 (8) INJURY.—The term “injury” means any ill-
24 ness, disease, or other harm that is the subject of
25 a health care liability action or claim.

1 (9) MEDICAL PRODUCT.—The term “medical
2 product” means a device (as defined in section
3 201(h) of the Federal Food, Drug, and Cosmetic
4 Act) or a drug (as defined in section 201(g)(1) of
5 the Federal Food, Drug, and Cosmetic Act).

6 (10) NONECONOMIC DAMAGES.—The term
7 “noneconomic damages” means damages paid to
8 compensate an individual for losses for physical and
9 emotional pain, suffering, inconvenience, physical
10 impairment, mental anguish, disfigurement, loss of
11 enjoyment of life, loss of consortium, and other
12 nonpecuniary losses, but does not include punitive
13 damages.

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

16 (12) STATE.—The term “State” means each of
17 the several States, the District of Columbia, the
18 Commonwealth of Puerto Rico, the Virgin Islands,
19 Guam, and American Samoa.

20 **SEC. 210. EFFECTIVE DATE.**

21 This subtitle shall apply with respect to claims accu-
22 ing or actions brought on or after the expiration of the
23 1-year period that begins on the date of the enactment
24 of this Act.

1 **Subtitle B—Limit on Self-Referrals**
2 **by Health Care Provider**

3 **SEC. 221. LIMITATION ON SELF-REFERRALS BY HEALTH**
4 **CARE PROVIDERS.**

5 (a) IN GENERAL.—If a health care provider refers
6 a patient to any facility in which the provider (or a family
7 member) has a financial interest for the performance of
8 any health care service, the provider—

9 (1) must disclose to the patient the nature of
10 such interest;

11 (2) must present the patient with a list of the
12 3 closest reasonably known available facilities which
13 perform the service; and

14 (3) may not place undue pressure on the pa-
15 tient to obtain the service from the facility in which
16 the provider (or a family member) has a financial in-
17 terest.

18 (b) ENFORCEMENT.—

19 (1) INITIAL VIOLATION.—If a health care pro-
20 vider violates a requirement of subsection (a) and
21 has not previously been subject to a sanction under
22 this subsection, the provider is subject to a civil
23 money penalty in an amount specified under sub-
24 section (c).

1 (2) SECOND VIOLATION.—If a health care pro-
2 vider violates a requirement of subsection (a) and
3 has previously been subject to a sanction under this
4 subsection, the provider is subject to—

5 (A) a civil money penalty in an amount
6 specified under subsection (c), and

7 (B) a suspension of the right of the pro-
8 vider to provide health care services for a period
9 of time specified under subsection (c).

10 (3) THIRD VIOLATION.—If a health care pro-
11 vider violates a requirement of subsection (a), and
12 has previously been subject to a suspension under
13 this subsection—

14 (A) the provider is subject to a civil money
15 penalty in an amount specified under subsection
16 (c), and

17 (B) the provider’s right to provide health
18 care services is permanently revoked.

19 (c) AMOUNT OF CIVIL MONEY PENALTY AND PERIOD
20 OF SUSPENSION.—The amount of a civil money penalty
21 under subsection (b) and the period of any suspension of
22 the right to provide health care services under subsection
23 (b) shall be established by the Secretary of Health and
24 Human Services based upon the recommendations of the

1 National Association of Insurance Commissioners and
2 other health care representatives.

3 (d) ENFORCEMENT PROCESS.—The Secretary of
4 Health and Human Services shall establish a process for
5 the imposition of sanctions under subsection (b).

6 (e) DEFINITIONS.—In this section:

7 (1) The term “Secretary” means the Secretary
8 of Health and Human Services.

9 (2) The term “financial interest” includes any
10 ownership, income rights, or other pecuniary inter-
11 est.

12 (3) The term “family member” includes the
13 spouse, child, grandchild, parent, or sibling, or
14 spouse of such a child, grandchild, parent, or sibling.

15 (f) EFFECTIVE DATE.—This section shall apply to
16 referrals made later than 1 year after the date of the en-
17 actment of this Act.

18 **Subtitle C—Administrative Cost** 19 **Savings**

20 **SEC. 230. DEFINITIONS.**

21 For purposes of this subtitle:

22 (1) HEALTH BENEFIT PLAN.—The term
23 “health benefit plan” means any hospital or medical
24 expense incurred policy or certificate, hospital or
25 medical service plan contract, or health maintenance

1 subscriber contract, or a multiple employer welfare
2 arrangement or employee benefit plan (as defined
3 under the Employee Retirement Income Security Act
4 of 1974) which provides benefits with respect to
5 health care services. The term includes the medicare
6 program (under title XVIII of the Social Security
7 Act), medicare supplemental health insurance, and a
8 State medicaid plan (approved under title XIX of
9 such Act). The term does not include—

10 (A) coverage only for accident, dental, vi-
11 sion, disability income, or long-term care insur-
12 ance, or any combination thereof,

13 (B) coverage issued as a supplement to li-
14 ability insurance,

15 (C) worker's compensation or similar in-
16 surance, or

17 (D) automobile medical-payment insur-
18 ance,

19 or any combination thereof.

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

22 (3) STATE.—The term “State” means any of
23 the several States, the District of Columbia, the
24 Commonwealth of Puerto Rico, the Virgin Islands,
25 Guam, and American Samoa.

1 PART 1—STANDARDIZATION OF CLAIMS PROCESSING

2 **SEC. 231. ADOPTION OF DATA ELEMENTS, UNIFORM**
3 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
4 **MISSION STANDARDS.**

5 (a) IN GENERAL.—The Secretary shall adopt stand-
6 ards relating to each of the following:

7 (1) Data elements for use in paper and elec-
8 tronic claims processing under health benefit plans,
9 as well as for use in utilization review and manage-
10 ment of care (including data fields, formats, and
11 medical nomenclature, and including plan benefit
12 and insurance information).

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

17 (3) Uniform electronic transmission of the data
18 elements (for purposes of billing and utilization re-
19 view).

20 Standards under paragraph (3) relating to electronic
21 transmission of data elements for claims for services shall
22 supersede (to the extent specified in such standards) the
23 standards adopted under paragraph (2) relating to the
24 submission of paper claims for such services. Standards
25 under paragraph (3) shall include protections to assure

1 the confidentiality of patient-specific information and to
2 protect against the unauthorized use and disclosure of in-
3 formation.

4 (b) USE OF TASK FORCES.—In adopting standards
5 under this section—

6 (1) the Secretary shall take into account the
7 recommendations of current taskforces, including at
8 least the Workgroup on Electronic Data Inter-
9 change, National Uniform Billing Committee, the
10 Uniform Claim Task Force, and the Computer-based
11 Patient Record Institute;

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

16 (3) the Secretary shall, to the maximum extent
17 practicable, seek to make the standards consistent
18 with any uniform clinical data sets which have been
19 adopted and are widely recognized.

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

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

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

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

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

11 (d) REPORT TO CONGRESS.—Not later than 3 years
12 after the date of the enactment of this Act, the Secretary
13 shall report to Congress recommendations regarding re-
14 structuring the medicare peer review quality assurance
15 program given the availability of hospital data in elec-
16 tronic form.

17 **SEC. 232. APPLICATION OF STANDARDS.**

18 (a) IN GENERAL.—If the Secretary determines, at
19 the end of the 2-year period beginning on the date that
20 standards are adopted under section 231 with respect to
21 classes of services, that a significant number of claims for
22 benefits for such services under health benefit plans are
23 not being submitted in accordance with such standards,
24 the Secretary may require, after notice in the Federal
25 Register of not less than 6 months, that all providers of

1 such services must submit claims to health benefit plans
2 in accordance with such standards. The Secretary may
3 waive the application of such a requirement in such cases
4 as the Secretary finds that the imposition of the require-
5 ment would not be economically practicable.

6 (b) SIGNIFICANT NUMBER.—The Secretary shall
7 make an affirmative determination described in subsection
8 (a) for a class of services only if the Secretary finds that
9 there would be a significant, measurable additional gain
10 in efficiencies in the health care system that would be ob-
11 tained by imposing the requirement described in such
12 paragraph with respect to such services.

13 (c) APPLICATION OF REQUIREMENT.—

14 (1) IN GENERAL.—If the Secretary imposes the
15 requirement under subsection (a)—

16 (A) in the case of a requirement that im-
17 poses the standards relating to electronic trans-
18 mission of claims for a class of services, each
19 health care provider that furnishes such services
20 for which benefits are payable under a health
21 benefit plan shall transmit electronically and di-
22 rectly to the plan on behalf of the beneficiary
23 involved a claim for such services in accordance
24 with such standards;

1 (B) any health benefit plan may reject any
2 claim subject to the standards adopted under
3 section 231 but which is not submitted in ac-
4 cordance with such standards;

5 (C) it is unlawful for a health benefit plan
6 (i) to reject any such claim on the basis of the
7 form in which it is submitted if it is submitted
8 in accordance with such standards or (ii) to re-
9 quire, for the purpose of utilization review or as
10 a condition of providing benefits under the plan,
11 a provider to transmit medical data elements
12 that are inconsistent with the standards estab-
13 lished under section 231(a)(1); and

14 (D) the Secretary may impose a civil
15 money penalty on any provider that knowingly
16 and repeatedly submits claims in violation of
17 such standards or on any health benefit plan
18 (other than a health benefit plan described in
19 paragraph (2)) that knowingly and repeatedly
20 rejects claims in violation of subparagraph (B),
21 in an amount not to exceed \$100 for each such
22 claim.

23 The provisions of section 1128A of the Social Secu-
24 rity Act (other than the first sentence of subsection
25 (a) and other than subsection (b)) shall apply to a

1 civil money penalty under subparagraph (D) in the
2 same manner as such provisions apply to a penalty
3 or proceeding under section 1128A(a) of such Act.

4 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
5 ULATION.—A plan described in this paragraph is a
6 health benefit plan—

7 (A) that is subject to regulation by a
8 State; and

9 (B) with respect to which the Secretary
10 finds that—

11 (i) the State provides for application
12 of the standards established under section
13 231, and

14 (ii) the State regulatory program pro-
15 vides for the appropriate and effective en-
16 forcement of such standards.

17 (d) TREATMENT OF REJECTIONS.—If a plan rejects
18 a claim pursuant to subsection (c)(1), the plan shall per-
19 mit the person submitting the claim a reasonable oppor-
20 tunity to resubmit the claim on a form or in an electronic
21 manner that meets the requirements for acceptance of the
22 claim under such subsection.

23 **SEC. 233. PERIODIC REVIEW AND REVISION OF STAND-**
24 **ARDS.**

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

1 standards described in subsection (b) for hospitals
2 concerning electronic medical data.

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

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

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

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

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

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

23 (5) Standards concerning the transmission of
24 electronic medical data.

1 (6) Standards relating to confidentiality of pa-
2 tient-specific information.

3 The standards under this section shall be consistent with
4 standards for data elements established under section 231.

5 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
6 VIDERS.—

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

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

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

20 (1) consult with the American National Stand-
21 ards Institute, hospitals, with the advisory commis-
22 sion established under section 244, and with other
23 affected providers, health benefit plans, and other
24 interested parties, and

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

2 (1) The Secretary may waive the application of
3 the requirements of subsection (a) for a hospital
4 that is a small rural hospital, for such period as the
5 hospital demonstrates compliance with such require-
6 ments would constitute an undue financial hardship.

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

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

22 (c) APPLICATION TO HOSPITALS OF THE DEPART-
23 MENT OF VETERANS AFFAIRS.—

24 (1) IN GENERAL.—The Secretary of Veterans
25 Affairs shall provide that each hospital of the De-

1 partment of Veterans Affairs shall comply with the
2 requirements of subsection (a) in the same manner
3 as such requirements would apply to the hospital if
4 it were participating in the Medicare program.

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

10 **SEC. 243. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
11 **CIES.**

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

20 (b) PRESENTATION OR TRANSMISSION STANDARD
21 DEFINED.—In subsection (a), the term “presentation or
22 transmission standard” means a standard, promulgated
23 under subsection (b) or (c) of section 241, described in
24 paragraph (4) or (5) of section 241(b).

1 **SEC. 244. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for Dis-
11 ease Control.

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

14 (1) the standards established under this part,
15 and

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

18 (c) STAFF.—From the amounts appropriated under
19 subsection (d), the Secretary shall provide sufficient staff
20 to assist the advisory commission in its activities under
21 this section.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1994 through 1999 to carry out this section.

1 PART 3—DEVELOPMENT AND DISTRIBUTION OF
2 COMPARATIVE VALUE INFORMATION

3 **SEC. 251. STATE COMPARATIVE VALUE INFORMATION PRO-**
4 **GRAMS FOR HEALTH CARE PURCHASING.**

5 (a) PURPOSE.—In order to assure the availability of
6 comparative value information to purchasers of health
7 care in each State, the Secretary shall determine whether
8 each State is developing and implementing a health care
9 value information program that meets the criteria and
10 schedule set forth in subsection (b).

11 (b) CRITERIA AND SCHEDULE FOR STATE PRO-
12 GRAMS.—The criteria and schedule for a State health care
13 value information program in this subsection shall be spec-
14 ified by the Secretary as follows:

15 (1) The State begins promptly after enactment
16 of this Act to develop (directly or through contrac-
17 tual or other arrangements with one or more States,
18 coalitions of health insurance purchasers, other enti-
19 ties, or any combination of such arrangements) in-
20 formation systems regarding comparative health val-
21 ues.

22 (2) The information contained in such systems
23 covers at least the average prices of common health
24 care services (as defined in subsection (d)) and
25 health insurance plans, and, where available, meas-

1 ures of the variability of these prices within a State
2 or other market areas.

3 (3) The information described in paragraph (2)
4 is made available within the State beginning not
5 later than 1 year after the date of the enactment of
6 this Act, and is revised as frequently as reasonably
7 necessary, but at intervals of no greater than 1 year.

8 (4) Not later than 6 years after the date of the
9 enactment of this Act the State has developed infor-
10 mation systems that provide comparative costs, qual-
11 ity, and outcomes data with respect to health insur-
12 ance plans and hospitals and made the information
13 broadly available within the relevant market areas.

14 Nothing in this section shall preclude a State from provid-
15 ing additional information, such as information on prices
16 and benefits of different health benefit plans, available.

17 (c) GRANTS TO STATES FOR THE DEVELOPMENT OF
18 STATE PROGRAMS.—

19 (1) GRANT AUTHORITY.—The Secretary may
20 make grants to each State to enable such State to
21 plan the development of its health care value infor-
22 mation program and, if necessary, to initiate the im-
23 plementation of such program. Each State seeking
24 such a grant shall submit an application therefore,
25 containing such information as the Secretary finds

1 necessary to assure that the State is likely to de-
2 velop and implement a program in accordance with
3 the criteria and schedule in subsection (b).

4 (2) AUTHORIZATION OF APPROPRIATIONS.—

5 There are authorized to be appropriated such sums
6 as are necessary to make grants under this sub-
7 section, to remain available until expended.

8 (d) COMMON HEALTH CARE SERVICES DEFINED.—

9 In this section, the term “common health care services”
10 includes such procedures as the Secretary may specify and
11 any additional health care services which a State may wish
12 to include in its comparative value information program.

13 **SEC. 252. COMPARATIVE VALUE INFORMATION CONCERN-**
14 **ING FEDERAL PROGRAMS.**

15 (a) DEVELOPMENT.—The head of each Federal agen-
16 cy with responsibility for the provision of health insurance
17 or of health care services to individuals shall promptly de-
18 velop health care value information relating to each pro-
19 gram that such head administers and covering the same
20 types of data that a State program meeting the criteria
21 of section 251(b) would provide.

22 (b) DISSEMINATION OF INFORMATION.—Such infor-
23 mation shall be made generally available to States and to
24 providers and consumers of health care services.

1 **SEC. 253. DEVELOPMENT OF MODEL SYSTEMS.**

2 (a) IN GENERAL.—The Secretary shall, directly or
3 through grant or contract, develop model systems to facili-
4 tate—

5 (1) the gathering of data on health care cost,
6 quality, and outcome described in section 251(b)(4),
7 and

8 (2) analyzing such data in a manner that will
9 permit the valid comparison of such data among
10 providers and among health plans.

11 (b) EXPERIMENTATION.—The Secretary shall sup-
12 port experimentation with different approaches to achieve
13 the objectives of subsection (a) in the most cost effective
14 manner (relative to the accuracy and timeliness of the
15 data secured) and shall evaluate the various methods to
16 determine their relative success.

17 (c) STANDARDS.—When the Secretary considers it
18 appropriate, the Secretary may establish standards for the
19 collection and reporting of data on health care cost, qual-
20 ity and outcomes in order to facilitate analysis and com-
21 parisons among States and nationally.

22 (d) REPORT.—By not later than 3 years after the
23 date of the enactment of this Act, the Secretary shall re-
24 port to the Congress and the States on the models devel-
25 oped, and experiments conducted, under this section.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as are nec-
3 essary for each fiscal year beginning with fiscal year 1994
4 to enable the Secretary to carry out this section, including
5 evaluation of the different approaches tested under sub-
6 section (b) and their relative cost effectiveness.

7 PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS

8 **SEC. 261. STANDARDS RELATING TO USE OF MEDICARE**

9 **AND MEDICAID MAGNETIZED HEALTH BENE-**

10 **FIT CARDS; SECONDARY PAYER DATA BANK.**

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

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

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

20 Such cards shall be designed to be compatible with ma-
21 chines currently employed to transmit information on
22 credit cards. Such cards also shall be designed to be able
23 to be used with respect to the provision of benefits under
24 medicare supplemental policies.

25 (b) ADOPTION UNDER MEDICAID PLANS.—

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

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

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

20 (d) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated, in equal proportions
22 from the Federal Hospital Insurance Trust Fund and
23 from the Federal Supplementary Medical Insurance Trust
24 Fund, a total of \$25,000,000 to carry out subsections (a)

1 and (c), including the issuance of magnetized cards to
2 medicare beneficiaries.

3 **SEC. 262. PREEMPTION OF STATE QUILL PEN LAWS.**

4 (a) IN GENERAL.—Effective January 1, 1994, no ef-
5 fect shall be given to any provision of State law that re-
6 quires medical or health insurance records (including bill-
7 ing information) to be maintained in written, rather than
8 electronic form.

9 (b) SECRETARIAL AUTHORITY.—The Secretary may
10 issue regulations to carry out subsection (a). Such regula-
11 tions may provide for such exceptions to subsection (a)
12 as the Secretary determines to be necessary to prevent
13 fraud and abuse, with respect to controlled substances,
14 and in such other cases as the Secretary deems appro-
15 priate.

16 **SEC. 263. USE OF STANDARD IDENTIFICATION NUMBERS.**

17 (a) IN GENERAL.—Effective January 1, 1994, each
18 health benefit plan shall—

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

23 (2) for each provider that has a unique identi-
24 fier for purposes of title XVIII of the Social Security
25 Act and that furnishes health care items or services

1 to a beneficiary under the plan, use that identifier
2 as the identifier of that provider for claims process-
3 ing and related purposes.

4 (b) COMPLIANCE.—

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

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

21 (A) the State provides for application of
22 the requirement of subsection (a), and

23 (B) the State regulatory program provides
24 for the appropriate and effective enforcement of
25 such requirement with respect to such plans.

1 **Subtitle D—Limitation of Antitrust**
2 **Recovery for Certain Hospital**
3 **Joint Ventures**

4 **SEC. 271. PURPOSE.**

5 The purpose of this subtitle is to encourage coopera-
6 tion among hospitals in order to contain costs and achieve
7 a more efficient health care delivery system through the
8 elimination of unnecessary duplication and proliferation of
9 expensive high technology equipment, medical services, or
10 ancillary services.

11 **SEC. 272. DEFINITIONS.**

12 For the purposes of this subtitle:

13 (1) The term “antitrust laws” has the meaning
14 given it in subsection (a) of the first section of the
15 Clayton Act (15 U.S.C. 12(a)), except that such
16 term includes—

17 (A) section 5 of the Federal Trade Com-
18 mission Act (15 U.S.C. 45) to the extent such
19 section applies to unfair methods of competi-
20 tion, and

21 (B) any State law similar to the antitrust
22 laws.

23 (2) The term “high technology equipment”
24 means equipment and devices utilized in medical

1 care, and the technical support systems for them,
2 that—

3 (A) have acquisition costs greater than
4 \$1,000,000 or annual operating costs greater
5 than \$500,000, and

6 (B) use technologies with respect to which
7 there is a reasonable expectation that shared
8 ownership will avoid a significant degree of ac-
9 tual or anticipated excess capacity of service in
10 the geographical area to be served.

11 (3) The term “medical services” means services
12 that are involved in providing medical care to pa-
13 tients and that—

14 (A) have annual operating costs greater
15 than \$1,000,000, and

16 (B) with respect to which there is a rea-
17 sonable expectation that shared ownership will
18 avoid a significant degree of the actual or an-
19 ticipated excess capacity of such services in the
20 geographical area to be served,

21 and may include mobile services.

22 (4) The term “ancillary services” means sup-
23 port functions associated with operating a hospital
24 (laundry, billing, patient transportation, data proc-
25 essing, and other similar services) the predominant

1 function of which does not involve the provision of
2 medical treatment to patients.

3 (5) The term “hospital” means a hospital
4 that—

5 (A) has entered into, and has in effect a
6 participation agreement under section 1866(a)
7 of the Social Security Act (42 U.S.C.
8 1395cc(a)), or

9 (B) has in effect a participation agreement
10 under title XIX of such Act (42 U.S.C. 1396 et
11 seq.) with the State in which the hospital is lo-
12 cated.

13 (6) The term “hospital joint venture” means an
14 agreement between 2 or more hospitals that is en-
15 tered into solely for the purpose of sharing in the
16 purchase or operation of high technology equipment,
17 medical services, or ancillary services, and that in-
18 volves substantial integration or financial risk-shar-
19 ing between the parties. The term excludes—

20 (A) exchanging information among com-
21 petitors relating to costs, sales, profitability,
22 prices, marketing, or distribution of any prod-
23 uct, process, or service that is not reasonably
24 required to carry out such agreement,

1 (B) entering into any arrangement or en-
2 gaging in any other conduct to restrict, require,
3 or otherwise involve the marketing by any party
4 to such agreement of any product, process, or
5 service that is not reasonably required to carry
6 out such agreement, and

7 (C) entering into any arrangement or en-
8 gaging in any other conduct to restrict or re-
9 quire the participation by any party to such
10 agreement in conduct that is not reasonably re-
11 quired to carry out such agreement.

12 (7) The term “Attorney General” means the
13 Attorney General of the United States.

14 (8) The term “Secretary” means the Secretary
15 of Health and Human Services.

16 (9) The term “Commission” means the Federal
17 Trade Commission.

18 **SEC. 273. LIMITATION ON DAMAGES FOR ANTITRUST VIO-**
19 **LATIONS.**

20 Monetary recovery on a claim in any action brought
21 under the antitrust laws against a hospital that is a party
22 to a hospital joint venture shall be limited to actual dam-
23 ages if—

24 (1) the hospitals forming such venture meet the
25 notification requirements specified in section 274,

1 (2) the claim results from conduct that is with-
2 in the scope of the notification filed under section
3 274, and

4 (3) the action is filed after such notification be-
5 comes effective pursuant to section 274(c).

6 **SEC. 274. DISCLOSURE OF HOSPITAL JOINT VENTURE.**

7 (a) WRITTEN NOTIFICATIONS; FILING.—Any hos-
8 pital that is a party to a hospital joint venture, acting on
9 the venture’s behalf, not later than 90 days after entering
10 into a written agreement to form the venture, or not later
11 than 90 days after, the date of the enactment of this Act,
12 whichever is later, may file simultaneously with the Attor-
13 ney General, the Secretary, and the Commission, a written
14 notification disclosing—

15 (1) the identities of the parties to the venture,
16 and

17 (2) the nature, objectives, and planned activity
18 of the venture.

19 Any hospital that is a party to a hospital joint venture,
20 acting on the venture’s behalf, may file additional disclo-
21 sure notifications pursuant to this section as are appro-
22 priate to extend the protections of section 273. In order
23 to maintain the protections of section 273, the venture,
24 not later than 90 days after a change in its membership
25 or its planned activity, shall file simultaneously with the

1 Attorney General, the Secretary, and the Commission a
2 written notification disclosing such change.

3 (b) PUBLICATION; FEDERAL REGISTER; NOTICE.—

4 Not later than 30 days after receiving a notification filed
5 under subsection (a), the Secretary, after consultation
6 with the Attorney General and the Commission, shall pub-
7 lish in the Federal Register a notice with respect to the
8 hospital joint venture that identifies the parties to the ven-
9 ture and that describes the planned activity of the venture.
10 Prior to its publication, the contents of such notice shall
11 be made available to the parties to the venture.

12 (c) EFFECT OF THE NOTICE.—If with respect to a
13 notification filed under subsection (a) of this section, no-
14 tice is published in the Federal Register, then such notifi-
15 cation shall operate to convey the protections of section
16 273 as of the earlier of—

17 (1) the date of the publication of notice under
18 subsection (b), or

19 (2) if such notice is not so published within the
20 time required by subsection (b) of this section, after
21 the expiration of the 30-day period beginning on the
22 date that the Attorney General, the Secretary, or the
23 Commission receives the applicable information de-
24 scribed in subsection (a).

1 (d) EXEMPTION; DISCLOSURE; INFORMATION.—Ex-
2 cept with respect to the information published pursuant
3 to subsection (b)—

4 (1) all information and documentary material
5 submitted as part of a notification filed pursuant to
6 this section, and

7 (2) all other information obtained by the Attor-
8 ney General, the Secretary, or the Commission in
9 the course of any investigation, administrative pro-
10 ceeding, or case, with respect to a potential violation
11 of the antitrust laws by the joint venture with re-
12 spect to which such notification was filed,

13 shall be exempt from disclosure under section 552 of title
14 5, United States Code, and shall not be made publicly
15 available by any agency of the United States to which such
16 section applies, except as relevant to a law enforcement
17 investigation or in a judicial or administrative proceeding
18 in which such information and material is subject to any
19 protective order.

20 (e) WITHDRAWAL OF NOTIFICATION.—Any party
21 that files a notification pursuant to this section may with-
22 draw such notification before notice of the hospital joint
23 venture involved is published under subsection (b) of this
24 section. Any notification so withdrawn shall not be subject

1 to subsection (b) and shall not confer the protections of
2 section 273.

3 (f) JUDICIAL REVIEW: INAPPLICABLE WITH RE-
4 SPECT TO NOTIFICATIONS.—Any action taken or not
5 taken by the Attorney General, the Secretary, or the Com-
6 mission with respect to notifications filed pursuant to this
7 section shall not be subject to judicial review.

8 (g) ADMISSIBILITY INTO EVIDENCE: DISCLOSURE OF
9 CONDUCT; PUBLICATION OF NOTICE; SUPPORTING OR
10 ANSWERING CLAIMS UNDER ANTITRUST LAWS.—

11 (1) Except as provided in paragraph (2), the
12 fact of disclosure of conduct under subsection (a)
13 and the fact of publication of a notice under sub-
14 section (b) shall be admissible into evidence in any
15 judicial or administrative proceeding for the sole
16 purpose of establishing that a person is entitled to
17 the protections of section 273.

18 (2) No action by the Attorney General, the Sec-
19 retary, or the Commission taken pursuant to this
20 section shall be admissible into evidence in any pro-
21 ceeding for the purpose of supporting or answering
22 any claim under the antitrust laws.

1 **Subtitle E—Medicaid Program**
2 **Flexibility**

3 **SEC. 281. MODIFICATION OF FEDERAL REQUIREMENTS TO**
4 **ALLOW STATES MORE FLEXIBILITY IN CON-**
5 **TRACTING FOR COORDINATED CARE SERV-**
6 **ICES UNDER MEDICAID.**

7 (a) IN GENERAL.—Section 1903(m) of the Social Se-
8 curity Act (42 U.S.C. 1396b(m)) is amended—

9 (1) by striking all that precedes paragraph (4)
10 and inserting the following:

11 “(m) COORDINATED CARE.—

12 “(1) PAYMENT CONDITIONED ON COMPLI-
13 ANCE.—

14 “(A) GENERAL RULE.—No payment shall
15 be made under this title to a State with respect
16 to expenditures incurred by it for payment to a
17 risk contracting entity or primary care case
18 management entity (as defined in subparagraph
19 (B)), or with respect to an undertaking de-
20 scribed in paragraph (6), unless the State and
21 the entity or undertaking meet the applicable
22 requirements of this subsection. For purposes
23 of determining whether payment may be made
24 under this section, the Secretary may reject a

1 State's determination of compliance with any
2 provision of this subsection.

3 “(B) GENERAL DEFINITIONS.—For pur-
4 poses of this title—

5 “(i) RISK CONTRACTING ENTITY.—
6 The term ‘risk contracting entity’ means
7 an entity that has a contract with the
8 State agency under which the entity—

9 “(I) provides or arranges for the
10 provision of health care items or serv-
11 ices to individuals eligible for medical
12 assistance under the State plan under
13 this title, and

14 “(II) is at risk (as defined in
15 clause (iv)) for part or all of the cost
16 of such items or services furnished to
17 such individuals.

18 “(ii) PRIMARY CARE CASE MANAGE-
19 MENT PROGRAM.—The term ‘primary care
20 case management program’ means a State
21 program under which individuals eligible
22 for medical assistance under the State plan
23 under this title are enrolled with primary
24 care case management entities, and are en-
25 titled to receive specified health care items

1 and services covered under such plan only
2 as arranged for and approved by such enti-
3 ties.

4 “(iii) AT RISK.—An entity is ‘at risk’,
5 for purposes of this subparagraph, if it has
6 a contract with the State agency under
7 which it is paid a fixed amount for provid-
8 ing or arranging for the provision of speci-
9 fied health care items or services to an in-
10 dividual eligible for medical assistance and
11 enrolled with the entity, regardless of
12 whether such items or services are fur-
13 nished to such individual, and is liable for
14 all or part of the cost of furnishing such
15 items or services, regardless of whether or
16 the extent to which such cost exceeds such
17 fixed payment.

18 “(iv) PRIMARY CARE CASE MANAGE-
19 MENT ENTITY.—The term ‘primary care
20 case management entity’ means a health
21 care provider (whether an individual or an
22 entity) that, under a State primary care
23 case management program meeting the re-
24 quirements of paragraph (7), has a con-
25 tract with the State agency under which

1 the entity arranges for or authorizes the
2 provision of health care items and services
3 to individuals eligible for medical assist-
4 ance under the State plan under this title,
5 but is not at risk (as defined in clause (iv))
6 for the cost of such items or services pro-
7 vided to such individuals.

8 “(2) GENERAL REQUIREMENTS FOR RISK CON-
9 TRACTING ENTITIES.—

10 “(A) FEDERAL OR STATE QUALIFICA-
11 TION.—Subject to paragraph (3), a risk con-
12 tracting entity meets the requirements of this
13 subsection only if it either—

14 “(i) is a qualified health maintenance
15 organization as defined in section 1310(d)
16 of the Public Health Service Act, as deter-
17 mined by the Secretary pursuant to section
18 1312 of that Act, or

19 “(ii) is an entity which the State
20 agency has determined—

21 “(I) affords, to individuals eligi-
22 ble for medical assistance under the
23 State plan and enrolled with the en-
24 tity, access to health care items and
25 services furnished by the entity, with-

1 in the area served by the entity, at
2 least equivalent to the access such in-
3 dividuals would have to such health
4 care items and services in such area if
5 not enrolled with the entity, and

6 “(II) has made adequate provi-
7 sion against the risk of insolvency,
8 and assures that individuals eligible
9 for medical assistance under this title
10 are not held liable for the entity’s
11 debts in case of the entity’s insol-
12 vency.

13 “(B) CONTRACT WITH STATE AGENCY.—
14 Subject to paragraph (3), a risk contracting en-
15 tity meets the requirements of this subsection
16 only if the entity has a written contract with
17 the State agency that provides—

18 “(i) that the entity will comply with
19 all applicable provisions of this subsection;

20 “(ii) for a payment methodology based
21 on experience rating or another actuarially
22 sound methodology approved by the Sec-
23 retary, which guarantees (as demonstrated
24 by such models or formulas as the Sec-
25 retary may approve) that payments to the

1 entity under the contract shall not exceed
2 100 percent of expenditures that would
3 have been made by the State agency in the
4 absence of the contract;

5 “(iii) that the Secretary and the State
6 (or any person or organization designated
7 by either) shall have the right to audit and
8 inspect any books and records of the entity
9 (and of any subcontractor) that pertain—

10 “(I) to the ability of the entity to
11 bear the risk of potential financial
12 losses, or

13 “(II) to services performed or de-
14 terminations of amounts payable
15 under the contract;

16 “(iv) that in the entity’s reenrollment
17 or disenrollment of individuals eligible for
18 medical assistance under this title and eli-
19 gible to reenroll or disenroll with the entity
20 pursuant to the contract, the entity will
21 not discriminate among such individuals on
22 the basis of their health status or require-
23 ments for health care services;

24 “(v)(I) that individuals eligible for
25 medical assistance under the State plan

1 who have enrolled with the entity are per-
2 mitted to terminate such enrollment with-
3 out cause as of the beginning of the first
4 calendar month following a full calendar
5 month after the request is made for such
6 termination (or at such times as required
7 pursuant to paragraph (8)), and

8 “(II) for notification of each such in-
9 dividual, at the time of the individual’s en-
10 rollment, of the right to terminate enroll-
11 ment;

12 “(vi) for reimbursement, either by the
13 entity or by the State agency, for medically
14 necessary services provided—

15 “(I) to an individual eligible for
16 medical assistance under the State
17 plan and enrolled with the entity, and

18 “(II) other than through the en-
19 tity because the services were imme-
20 diately required due to an unforeseen
21 illness, injury, or condition;

22 “(vii) for disclosure of information in
23 accordance with paragraph (4) and section
24 1124;

1 “(viii) in the case of an entity that
2 has entered into a contract with a Feder-
3 ally-qualified health center for the provi-
4 sion of services of such center—

5 “(I) that rates of prepayment
6 from the State are adjusted to reflect
7 fully the rates of payment specified in
8 section 1902(a)(13)(E), and

9 “(II) that, at the election of such
10 center, payments made by the entity
11 to such center for services described
12 in section 1905(a)(2)(C) are made at
13 the rates of payment specified in sec-
14 tion 1902(a)(13)(E);

15 “(ix) that any physician incentive plan
16 that the entity operates meets the require-
17 ments of section 1876(i)(8);

18 “(x) for maintenance of sufficient pa-
19 tient encounter data to identify the physi-
20 cian who delivers services to patients; and

21 “(xi) that the entity complies with the
22 requirement of section 1902(w) with re-
23 spect to each enrollee.

24 “(3) EXCEPTIONS TO REQUIREMENTS FOR RISK
25 CONTRACTING ENTITIES.—The requirements of

1 paragraph (2) (other than subparagraph (B)(viii))
2 do not apply to an entity that—

3 “(A)(i) received a grant of at least
4 \$100,000 in the fiscal year ending June 30,
5 1976, under section 329(d)(1)(A) or 330(d)(1)
6 of the Public Health Service Act, and for the
7 period beginning July 1, 1976, and ending on
8 the expiration of the period for which payments
9 are to be made under this title, has been the re-
10 cipient of a grant under either such section;
11 and

12 “(ii) provides to its enrollees, on a prepaid
13 capitation or other risk basis, all of the services
14 described in paragraphs (1), (2), (3), (4)(C),
15 and (5) of section 1905(a) and, to the extent
16 required by section 1902(a)(10)(D) to be pro-
17 vided under the State plan, the services de-
18 scribed in section 1905(a)(7);

19 “(B) is a nonprofit primary health care en-
20 tity located in a rural area (as defined by the
21 Appalachian Regional Commission)—

22 “(i) which received in the fiscal year
23 ending June 30, 1976, at least \$100,000
24 (by grant, subgrant, or subcontract) under

1 the Appalachian Regional Development Act
2 of 1965), and

3 “(ii) for the period beginning July 1,
4 1976, and ending on the expiration of the
5 period for which payments are to be made
6 under this title either has been the recipi-
7 ent of a grant, subgrant, or subcontract
8 under such Act or has provided services
9 under a contract (initially entered into dur-
10 ing a year in which the entity was the re-
11 cipient of such a grant, subgrant, or sub-
12 contract) with a State agency under this
13 title on a prepaid capitation or other risk
14 basis; or

15 “(C) which has contracted with the State
16 agency for the provision of services (but not in-
17 cluding inpatient hospital services) to persons
18 eligible for medical assistance under this title
19 on a prepaid risk basis prior to 1970.”; and

20 (2) by adding after paragraph (6) the following
21 new paragraphs:

22 “(7) GENERAL REQUIREMENTS FOR PRIMARY
23 CARE CASE MANAGEMENT.—A State that elects in
24 its State plan under this title to implement a pri-
25 mary care case management program under this

1 subsection shall include in the plan methods for the
2 selection and monitoring of participating primary
3 care case management entities to ensure that—

4 “(A) the numbers, geographic locations,
5 hours of operation, and other relevant charac-
6 teristics of such entities are sufficient to afford
7 individuals eligible for medical assistance rea-
8 sonable access to and choice among such enti-
9 ties;

10 “(B) such entities and their professional
11 personnel are qualified to provide health care
12 case management services, through methods in-
13 cluding ongoing monitoring of compliance with
14 applicable requirements for licensing of health
15 care providers, providing training and certifi-
16 cation of primary care case managers, and pro-
17 viding information and technical assistance; and

18 “(C) such entities are making timely and
19 appropriate decisions with respect to enrollees’
20 need for health care items and services, and are
21 giving timely approval and referral to providers
22 of adequate quality where such items and serv-
23 ices are determined to be medically necessary.

24 “(8) STATE OPTIONS WITH RESPECT TO EN-
25 ROLLMENT AND DISENROLLMENT.—

1 “(A) MANDATORY ENROLLMENT OP-
2 TION.—A State plan may require an individual
3 eligible for medical assistance under the State
4 plan (other than a medicare qualified bene-
5 ficiary) to enroll with a risk contracting entity
6 or primary care case management entity, with-
7 out regard to the requirement of section
8 1902(a)(1) (concerning Statewideness), the re-
9 quirements of section 1902(a)(10)(B) (concern-
10 ing comparability of benefits), or the require-
11 ments of section 1902(a)(23) (concerning free-
12 dom of choice of provider), if the individual is
13 permitted a choice—

14 “(i) between or among two or more
15 risk contracting entities,

16 “(ii) between a risk contracting entity
17 and a primary care case management en-
18 tity, or

19 “(iii) between or among two or more
20 primary care case management entities.

21 “(B)(i) RESTRICTIONS ON
22 DISENROLLMENT WITHOUT CAUSE.—A State
23 plan may restrict the period in which individ-
24 uals enrolled with a qualifying risk contracting
25 entity (as defined in clause (ii)) may terminate

1 such enrollment without cause to the first
2 month of each period of enrollment (as defined
3 in clause (iii)), but only if the State provides
4 notification, at least once during each such en-
5 rollment period, to individuals enrolled with
6 such entity of the right to terminate such en-
7 rollment and the restriction on the exercise of
8 this right. Such restriction shall not apply to
9 requests for termination of enrollment for
10 cause.

11 “(ii) For purposes of this subparagraph,
12 the term ‘qualifying risk contracting entity’
13 means a risk contracting entity that is—

14 “(I) a qualified health maintenance
15 organization as defined in section 1310(d)
16 of the Public Health Service Act;

17 “(II) an eligible organization with a
18 contract under section 1876;

19 “(III) an entity that is receiving (and
20 has received during the previous 2 years)
21 a grant of at least \$100,000 under section
22 329(d)(1)(A) or 330(d)(1) of the Public
23 Health Service Act;

24 “(IV) an entity that is receiving (and
25 has received during the previous 2 years)

1 at least \$100,000 (by grant, subgrant, or
2 subcontract) under the Appalachian Re-
3 gional Development Act of 1965;

4 “(V) a program pursuant to an under-
5 taking described in paragraph (6) in which
6 at least 25 percent of the membership en-
7 rolled on a prepaid basis are individuals
8 who (I) are not insured for benefits under
9 part B of title XVIII or eligible for medical
10 assistance under this title, and (II) (in the
11 case of such individuals whose prepay-
12 ments are made in whole or in part by any
13 government entity) had the opportunity at
14 the time of enrollment in the program to
15 elect other coverage of health care costs
16 that would have been paid in whole or in
17 part by any governmental entity; or

18 “(VI) an entity that, on the date of
19 enactment of this provision, had a contract
20 with the State agency under a waiver
21 under section 1115 or 1915(b) and was
22 not subject to a requirement under this
23 subsection to permit disenrollment without
24 cause.

1 “(iii) For purposes of this subparagraph,
2 the term ‘period of enrollment’ means—

3 “(I) a period not to exceed 6 months
4 in duration, or

5 “(II) a period not to exceed one year
6 in duration, in the case of a State that, on
7 the effective date of this subparagraph,
8 had in effect a waiver under section 1115
9 of requirements under this title under
10 which the State could establish a 1-year
11 minimum period of enrollment with risk
12 contracting entities.

13 “(C) REENROLLMENT OF INDIVIDUALS
14 WHO REGAIN ELIGIBILITY.—In the case of an
15 individual who—

16 “(i) in a month is eligible for medical
17 assistance under the State plan and en-
18 rolled with a risk contracting entity with a
19 contract under this subsection,

20 “(ii) in the next month (or next 2
21 months) is not eligible for such medical as-
22 sistance, but

23 “(iii) in the succeeding month is again
24 eligible for such benefits,

1 the State plan may enroll the individual for
2 that succeeding month with such entity, if the
3 entity continues to have a contract with the
4 State agency under this subsection.”.

5 (b) STATE OPTION TO GUARANTEE MEDICAID ELIGI-
6 BILITY.—Section 1902(e)(2) of such Act (42 U.S.C.
7 1396a(e)(2)) is amended—

8 (A) in subparagraph (A), by striking all
9 that precedes “(but for this paragraph)” and
10 inserting “In the case of an individual who is
11 enrolled—

12 “(i) with a risk contracting entity (as
13 defined in section 1903(m)(1)(B)(i)) re-
14 sponsible for the provision of inpatient hos-
15 pital services and any other service de-
16 scribed in paragraphs (2), (3), (4), (5),
17 and (7) of section 1905(a),

18 “(ii) with any risk contracting entity
19 (as so defined) in a State that, on the ef-
20 fective date of this provision, had in effect
21 a waiver under section 1115 of require-
22 ments under this title under which the
23 State could extend eligibility for medical
24 assistance for enrollees of such entity, or

1 “(iii) with an eligible organization
2 with a contract under section 1876 and
3 who would”, and

4 (B) in subparagraph (B), by striking “or-
5 ganization or” each place it appears.

6 (c) CONFORMING AMENDMENTS.—

7 (1) Section 1128(b)(6)(C)(i) of such Act (42
8 U.S.C. 1320a-7(b)(6)(C)(i)) is amended by striking
9 “health maintenance organization” and inserting
10 “risk contracting entity”.

11 (2) Section 1902(a)(57) of such Act (42 U.S.C.
12 1396a(a)(57)) is amended by striking “or health
13 maintenance organization” and inserting “or risk
14 contracting entity”.

15 (3) Section 1902(a) of such Act (42 U.S.C.
16 1396a(a)) is amended—

17 (A) by striking “and” at the end of para-
18 graph (54);

19 (B) in the paragraph (55) inserted by sec-
20 tion 4602(a)(3) of Public Law 101-508, by
21 striking the period at the end and inserting a
22 semicolon;

23 (C) by redesignating the paragraph (55)
24 inserted by section 4604(b)(3) of Public Law
25 101-508 as paragraph (56), by transferring

1 and inserting it after the paragraph (55) in-
2 serted by section 4602(a)(3) of such Act, and
3 by striking the period at the end and inserting
4 a semicolon;

5 (D) by placing paragraphs (57) and (58),
6 inserted by section 4751(a)(1)(C) of Public
7 Law 101–508, immediately after paragraph
8 (56), as redesignated by paragraph (3);

9 (E) in the paragraph (58) inserted by sec-
10 tion 4751(a)(1)(C) of Public Law 101–508, by
11 striking the period at the end and inserting a
12 semicolon;

13 (F) by redesignating the paragraph (58)
14 inserted by section 4752(c)(1)(C) of Public Law
15 101–508 as paragraph (59), by transferring
16 and inserting it after the paragraph (58) in-
17 serted by section 4751(a)(1)(C) of such Act,
18 and by striking the period at the end and in-
19 serting “; and”; and

20 (G) by inserting after such paragraph (59)
21 the following new paragraph:

22 “(60) at State option, provide for a primary
23 care case management program in accordance with
24 section 1903(m)(7).”.

1 (4) Section 1902(p)(2) of such Act (42 U.S.C.
2 1396a(p)(2)) is amended by striking “health mainte-
3 nance organization” and inserting “risk contracting
4 entity”.

5 (5) Section 1902(w) of such Act (42 U.S.C.
6 1396a(w)) is amended—

7 (A) in paragraph (1), by striking “section
8 1903(m)(1)(A)” and inserting “section
9 1903(m)(2)(C)(xi)”, and

10 (B) in paragraph (2)(E), by striking
11 “health maintenance organization” and “the or-
12 ganization” and inserting “risk contracting en-
13 tity” and “the entity”, respectively.

14 (6) Section 1903(k) of such Act (42 U.S.C.
15 1396b(k)) is amended by striking “health mainte-
16 nance organization” and inserting “risk contracting
17 entity”.

18 (7) Section 1903(m)(4)(A) of such Act (42
19 U.S.C. 1396b(m)(4)(A)) is amended—

20 (A) in the first sentence, by striking “Each
21 health maintenance organization” and inserting
22 “Each risk contracting entity”,

23 (B) in the first sentence, by striking “the
24 organization” each place it appears and insert-
25 ing “the entity”, and

1 (C) in the second sentence, by striking “an
2 organization” and “the organization” and in-
3 serting “a risk contracting entity” and “the
4 risk contracting entity”, respectively.

5 (8) Section 1903(m)(4)(B) of such Act (42
6 U.S.C. 1396b(m)(4)(B)) is amended by striking “or-
7 ganization” and inserting “risk contracting entity”.

8 (9) Section 1903(m)(5) of such Act (42 U.S.C.
9 1396b(m)(5)) is amended in paragraphs (A)(iii) and
10 (B)(ii) by striking “organization” and inserting “en-
11 tity”.

12 (10) Section 1903(w)(7)(A)(viii) of such Act
13 (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by
14 striking “health maintenance organizations (and
15 other organizations with contracts under section
16 1903(m))” and inserting “risk contracting entities
17 with contracts under section 1903(m)”.

18 (11) Section 1905(a) of such Act (42 U.S.C.
19 1396d(a)) is amended, in the matter preceding
20 clause (i), by inserting “(which may be on a prepaid
21 capitation or other risk basis)” after “payment” the
22 first place it appears.

23 (12) Section 1916(b)(2)(D) of such Act (42
24 U.S.C. 1396o(b)(2)(D)) is amended by striking

1 “health maintenance organization” and inserting
2 “risk contracting entity”.

3 (13) Section 1925(b)(4)(D)(iv) of such Act (42
4 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

5 (A) in the heading, by striking “HMO” and
6 inserting “RISK CONTRACTING ENTITY”,

7 (B) by striking “health maintenance orga-
8 nization” and inserting “risk contracting en-
9 tity” each place it appears, and

10 (C) by striking “section 1903(m)(1)(A)”
11 and inserting “section 1903(m)(1)(B)(i)”.

12 (14) Paragraphs (1) and (2) of section 1926(a)
13 of such Act (42 U.S.C. 1396r-7(a)) are each amend-
14 ed by striking “health maintenance organizations”
15 and inserting “risk contracting entities”.

16 (15) Section 1927(j)(1) of such Act (42 U.S.C.
17 1396s(j)(1)) is amended by striking “*** Health
18 Maintenance Organizations, including those organi-
19 zations” and inserting “risk contracting entities”.

20 (d) EFFECTIVE DATE.—The amendments made by
21 this section shall become effective with respect to calendar
22 quarters beginning on or after January 1, 1994.

23 **SEC. 282. PERIOD OF CERTAIN WAIVERS.**

24 (a) IN GENERAL.—Section 1915(h) of the Social Se-
25 curity Act (42 U.S.C. 1396n(h)) is amended by striking

1 “No waiver” and all that follows through “unless the Sec-
 2 retary” and inserting “A waiver under this section (other
 3 than under subsection (c), (d), or (e)) shall be for an ini-
 4 tial term of 3 years and, upon the request of a State, shall
 5 be extended for additional 5 year periods unless the Sec-
 6 retary”.

7 (b) EFFECTIVE DATE.—The amendment made by
 8 subsection (a) shall apply to waivers pursuant to applica-
 9 tions which are approved, and with respect to continu-
 10 ations of waivers for which requests are made, later than
 11 30 days after the date of the enactment of this Act.

12 **TITLE III—REFUNDABLE CREDIT**
 13 **FOR COSTS OF PROVIDING**
 14 **EMERGENCY INDIGENT CARE**

15 **SEC. 301. REFUNDABLE CREDIT FOR COSTS OF PROVIDING**
 16 **EMERGENCY INDIGENT CARE.**

17 (a) IN GENERAL.—Subpart C of part IV of sub-
 18 chapter A of chapter 1 of the Internal Revenue Code of
 19 1986 (relating to refundable credits) is amended by redес-
 20 ignating section 35 as section 36 and by inserting after
 21 section 34 the following new section:

22 **“SEC. 35. COSTS OF PROVIDING EMERGENCY INDIGENT**
 23 **CARE.**

24 “(a) ALLOWANCE OF CREDIT.—There shall be al-
 25 lowed as a credit against the tax imposed by this subtitle

1 for the taxable year an amount equal to 15 percent of the
2 unreimbursed eligible costs incurred by the taxpayer in
3 providing emergency health care services.

4 “(b) DEFINITIONS.—For purposes of this section—

5 “(1) UNREIMBURSED ELIGIBLE COSTS.—The
6 term ‘unreimbursed eligible costs’ means costs—

7 “(A) which are recognized as reasonable
8 for purposes of payment under title XVIII of
9 the Social Security Act, and

10 “(B) for which the taxpayer (other than as
11 an employee) is entitled to reimbursement.

12 “(2) EMERGENCY HEALTH CARE SERVICES.—

13 The term ‘emergency health care services’ means
14 medical screening, examination, and treatment pro-
15 vided to an individual pursuant to the requirements
16 of subsections (a) and (b)(1) of section 1867 of the
17 Social Security Act but only if the individual has no
18 coverage under a health insurance or health benefit
19 plan with respect to the screening, examination, or
20 treatment.

21 “(c) SPECIAL RULES.—For purposes of this sec-
22 tion—

23 “(1) UNREIMBURSED COSTS.—Costs shall be
24 treated as unreimbursed not earlier than the time
25 such costs would be allowable as a deduction under

1 section 166 were the obligation to pay such costs a
2 debt to which section 166 applies.

3 “(2) NO CREDIT FOR DEDUCTIBLE WORTHLESS
4 DEBTS.—No credit shall be allowed under this sec-
5 tion for any debt which would be allowable as a de-
6 duction under section 166 if the debt became worth-
7 less.

8 “(d) PAYMENTS TO TAX-EXEMPT ENTITIES.—

9 “(1) IN GENERAL.—In the case of a tax-exempt
10 entity, in lieu of the credit under subsection (a), the
11 Secretary shall pay the amount determined under
12 this section if claim therefor is filed at such time
13 and in such manner as the Secretary may prescribe.

14 “(2) TAX-EXEMPT ENTITY.—For purposes of
15 paragraph (1), the term ‘tax-exempt entity’ means—

16 “(A) a State, a political subdivision of a
17 State, the District of Columbia, any possession
18 of the United States, and an agency or instru-
19 mentality of 1 or more of the foregoing, and

20 “(B) an organization exempt from tax
21 under section 501(a) (other than an organiza-
22 tion required to make a return of tax imposed
23 under this subtitle).”

1 (b) CLERICAL AMENDMENT.—The table of sections
2 for such subpart C is amended by striking the last item
3 and inserting the following new items:

“Sec. 35. Costs of providing emergency indigent care.
“Sec. 36. Overpayments of tax.”

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to costs incurred with respect to
6 emergency health care services provided on or after the
7 1st day of the 1st calendar month which begins more than
8 60 days after the date of the enactment of this Act in
9 taxable years ending after such date.

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