I

103D CONGRESS
2D SESSION

H. R. 3955

To increase the availability and continuity of health coverage for employees and their families, to prevent fraud and abuse in the health care delivery system, to reform medical malpractice liability standards, to reduce paperwork and simplify administration of health care claims, to promote preventive care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 1994

Mr. ROWLAND (for himself, Mr. BILIRAKIS, Mr. SPRATT, Mr. BLILEY, Mr. TAUZIN, Mr. DUNCAN, Mr. PARKER, Mr. HASTERT, Mr. MONTGOMERY, Mr. BARTON of Texas, Mr. PETE GEREN of Texas, Mr. UPTON, Mr. SISISKY, Mr. MOORHEAD, Mr. TANNER, Mrs. VUCANOVICH, Mr. LAUGHLIN, Mr. GOSS, Mr. PICKETT, Mr. CRAPO, Mr. LANCASTER, Mr. GOODLATTE, Mr. HAYES, Mr. ZELIFF, Mrs. LLOYD, Mr. LINDER, Mr. BROWDER, Mr. CASTLE, Mr. ORTON, and Mr. YOUNG of Florida) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Education and Labor, the Judiciary, and Ways and Means

APRIL 5, 1994

Additional sponsors: Mr. BREWSTER, Mr. LEWIS of Florida, Mr. DARDEN, Mr. FIELDS of Texas, Mr. NEAL of North Carolina, Mr. GREENWOOD, Mr. MORAN, Mr. KYL, Mr. CLEMENT, Mr. EWING, Mr. GLICKMAN, Mr. BALLENGER, Mr. STENHOLM, and Mr. CANADY

JULY 20, 1994

Additional sponsors: Mr. BISHOP, Mr. BUNNING, Mr. PENNY, Mr. PAXON, Mr. HEFNER, Mr. LIVINGSTON, Mr. BARLOW, Mr. BOEHNER, Mr. VALENTINE, Mr. COLLINS of Georgia, Mr. CRAMER, Mr. THOMAS of Wyoming, Mr. JOHNSON of Georgia, Mr. SUNDQUIST, Mr. PETERSON of Minnesota, Mr. STEARNS, Mr. DEAL, Mr. HERGER, Mr. MURPHY, Mr. HUTCHINSON, Mr. HUTTO, Mr. GILLMOR, Mr. ORTIZ, Mrs. FOWLER, Mr. JACOBS, Mr. GILCHREST, Mr. BAESLER, and Mr. DICKEY

A BILL

To increase the availability and continuity of health coverage for employees and their families, to prevent fraud and abuse in the health care delivery system, to reform medical malpractice liability standards, to reduce paperwork and simplify administration of health care claims, to promote preventive care, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Reform Consensus Act of 1994''.

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

TITLE I—INSURANCE REFORM

Subtitle A—Increased Availability and Continuity of Health Coverage for Employees and Their Families

PART 1—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES, SPOUSES, AND DEPENDENTS

SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF COVERAGE FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Each employer shall make available with respect to each eligible employee a group health plan under which—

(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year,

(2) subject to subsection (d), coverage is provided for at least the required coverage specified in subsection (c), and

(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

An employer is not required under this subsection to make any contribution to the cost of coverage under such a plan.

(b) SPECIAL RULES.—

(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 2 years,

(B) such employer has no more than 2 eligible employees, or

(C) no more than 2 eligible employees are not covered under any group health plan.

(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as an eligible employee for purposes of applying the requirements of subsection (a). In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan shall not be treated as failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is required under the plan for coverage under the plan of eligible individuals with respect to such employee.

(c) REQUIRED COVERAGE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the required coverage specified in this subsection is standard coverage (consistent with section 1102(b)).

(2) SPECIAL TREATMENT OF SMALL EMPLOYERS NOT CONTRIBUTING TO EMPLOYEE COVERAGE.—In the case of a small employer (as defined in section 1107(9)) that has not contributed during the previous plan year to the cost of coverage for any eligible employee under any group health plan, the required coverage specified in this subsection for the plan year (with respect to each eligible employee) is—

(A) coverage under a standard plan, and

(B) coverage under a catastrophic plan,

as such terms are defined in section 1102(a)(2).

(3) CONSTRUCTION.—Nothing in this section shall be construed as limiting the group health plans, or types of coverage under such a plan, that an employer may offer to an employee.

(d) 5-YEAR TRANSITION FOR EXISTING GROUP HEALTH PLANS.—

(1) IN GENERAL.—The requirement of subsection (a)(2), and section 1002(c)(2), shall not apply to a group health plan for a plan year if—

(A) the group health plan is in effect in the plan year in which September 1, 1993, occurs, and

(B) the employer makes (or offers to make), in such plan year and the plan year involved, a contribution to the plan on behalf of each employee who is eligible to participate in the plan.

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan for each of the 5 plan years beginning with the first plan year to which the requirement of subsection (a) applies.

PART 2—ASSURING PORTABILITY OF HEALTH COVERAGE

SEC. 1011. LIMITATION ON PREEXISTING CONDITION CLAUSES.

(a) IN GENERAL.—A group health plan may not impose (and an insurer may not require an employer under a group health plan to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual if—

(1) the condition relates to a condition that was not diagnosed or treated within 3 months before the date of coverage under the plan;

(2) the limitation or exclusion extends over more than 6 months after the date of coverage under the plan;

(3) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan; or

(4) the limitation or exclusion relates to pregnancy.

(b) TREATMENT OF WAITING PERIODS.—In the case of an individual who is eligible for coverage under a plan but for a waiting period imposed by the employer, in ap-

plying paragraphs (1) and (2) of subsection (a), the individual shall be treated as having been covered under the plan as of the earliest date of the beginning of the waiting period.

SEC. 1012. ASSURANCE OF CONTINUITY OF COVERAGE THROUGH PREVIOUS SATISFACTION OF PREEXISTING CONDITION REQUIREMENT.

(a) IN GENERAL.—Each group health plan shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual, prior to the date of such individual's enrollment in such plan, was covered for the condition under any other health plan that was in effect before such date.

(b) CONTINUOUS COVERAGE REQUIRED.—

(1) IN GENERAL.—Subsection (a) shall no longer apply if there is a continuous period of more than 60 days (or, in the case of an individual described in paragraph (3), 6 months) on which the individual was not covered under a group health plan.

(2) TREATMENT OF WAITING PERIODS.—In applying paragraph (1), any waiting period imposed by an employer before an employee is eligible to be covered under a plan shall be treated as a period in

which the employee was covered under a group health plan.

(3) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination of employment.

(4) EXCLUSION OF CASH-ONLY AND DREAD DISEASE PLANS.—In this subsection, the term ''group health plan'' does not include any group health plan which is offered primarily to provide—

(A) coverage for a specified disease or illness, or

(B) a hospital or fixed indemnity policy, unless the Secretary determines that such a plan provides sufficiently comprehensive coverage of a benefit so that it should be treated as a group health plan under this subsection.

SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIEMPLOYER PLANS AND EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.—A multiemployer plan and an exempted multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer,

(3) for noncompliance with plan provisions,

(4) for misuse of a provider network provision, or

(5) because the plan is ceasing to provide any coverage in a geographic area.

(b) INSURERS.—

(1) IN GENERAL.—An insurer may not cancel a health insurance plan or deny renewal of coverage under such a plan other than—

(A) for nonpayment of premiums,

(B) for fraud or other misrepresentation by the insured,

(C) for noncompliance with plan provisions,

(D) in the case of a plan issued to a small employer, for failure to maintain minimum participation rates (consistent with paragraph (3)),

(E) for misuse of a provider network provision, or

(F) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(2) LIMITATION ON MARKET REENTRY.—If an insurer terminates the offering of health insurance plans in an area, the insurer may not offer such a health insurance plan to any employer in the area until 5 years after the date of the termination.

(3) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health insurance plan issued to a small employer, that a minimum percentage of eligible employees who do not otherwise have health insurance are enrolled in such plan if such percentage is applied uniformly to all plans offered to employers of comparable size.

PART 3—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 1021. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts 1 and 2 of this subtitle shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor

under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES FOR INSURERS.—

(1) IN GENERAL.—Subject to paragraph (2), an insurer that fails to comply with the requirements applicable to the insurer under part 2 of this subtitle is subject to a civil money penalty under this subsection.

(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

(3) AMOUNT OF PENALTY.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount of the civil money penalty imposed under this subsection shall be $100 for each day during which such failure persists for each individual to which such failure relates.

(B) LIMITATION.—The amount of the penalty imposed by this subsection for an insurer

with respect to a health insurance plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

(4) EXCEPTIONS.—

(A) CORRECTIONS WITHIN 30 DAYS.—No civil money penalty be imposed under this subsection by reason of any failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected within the 30-day period beginning on the earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

(B) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by this subsection to the extent that payment of such penalty would be excessive relative to the failure involved.

(5) PROCEDURES.—The Secretary by regulation shall provide for procedures for the imposition of civil money penalties under this subsection. Such

procedures shall assure written notice and opportunity for a determination to be made on the record after a hearing at which the insurer is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the insurer.The provisions of subsections (e), (f), (j), and (k) of section 1128A of the Social Security Act shall apply to determinations and civil money penalties under this section in the same manner as they apply to determinations and civil money penalties under such section.

SEC. 1022. EFFECTIVE DATES.

(a) PART 1.—The requirements of part 1 shall apply to plans years beginning after December 31, 1996.

(b) PART 2.—The requirements of part 2 with respect to—

(1) group health plans and employers shall apply to plans years beginning after December 31, 1996, and

(2) insurers shall take effect on January 1, 1997.

SEC. 1023. DEFINITIONS AND SPECIAL RULES.

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

(1) DEPENDENT.—The term ''dependent'' means, with respect to any individual, any person who is—

(A) the spouse or surviving spouse of the individual, or

(B) under regulations of the Secretary, a child (including an adopted child) of such individual and—

(i) under 19 years of age, or

(ii) under 25 years of age and a full-time student.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

(3) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to an eligible employee, such employee, and any dependent of such employee.

(4) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(5) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''exempted multiple employer health plan'' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 2 of subtitle C of this title).

(6) GROUP HEALTH PLAN; PLAN.—(A) The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan under section 1107(4)(B).

(B) The term ''plan'' means, unless used with a modifying term or the context specifically indicates otherwise, a group health plan (including any such plan which is a multiemployer plan), an exempted multiple employer health plan, or an insured multiple employer health plan.

(7) HEALTH INSURANCE PLAN.—The term ''health insurance plan'' has the meaning given such term in section 1107(4).

(8) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''insured multiple employer health plan'' has the meaning given such term in section 701(11) of Employee Retirement Income Security Act of 1974 (as added by section 1211 of this title).

(9) INSURER.—The term ''insurer'' has the meaning given such term in section 1107(6).

(b) SPECIAL RULES.—

(1) GENERAL RULE.—Except as otherwise provided in this subtitle, for definitions of terms used in this subtitle, see section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

(2) SECRETARY.—Except with respect to references specifically to the Secretary of Labor, the term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle B—Reform of Health Insurance Marketplace for Small Business

SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER STANDARD AND CATASTROPHIC PLANS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each insurer (as defined in section 1107(6)) that makes available any health insurance plan (as defined in section 1107(4)) to a small employer (as defined in section 1107(9)) in a State shall make available to each small employer in the State—

(A) a standard plan (as defined in section 1102(a)(2)), and

(B) a catastrophic plan (as defined in such section).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraph (1)(B) shall not apply with respect to a health insurance plan that—

(A) is a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not such an organization but is recognized under State law as a health mainte-

nance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) EXCEPTION IF STATE PROVIDES FOR GUARANTEED AVAILABILITY (RATHER THAN GUARANTEED ISSUE).—Paragraph (1) shall not apply to an insurer in a State if the State is providing—

(A) access to each small employer in the State to a standard plan and to a catastrophic plan, and

(B) a risk allocation mechanism described in subsection (c).

(b) GUARANTEED ISSUE OF STANDARD AND CATASTROPHIC PLANS.—Subject to subsection (c)—

(1) IN GENERAL.—Subject to paragraph (2), each insurer that offers a standard or catastrophic plan to a small employer in a State—

(A) must accept every small employer in the State that applies for coverage under the plan; and

(B) must accept for enrollment under the plan every eligible individual (as defined in paragraph (4)) who applies for enrollment on a timely basis (consistent with paragraph (3)) and may not place any restriction on the eligi-

bility of an individual to enroll so long as such individual is an eligible individual.

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a plan offered by a health maintenance organization, the plan may—

(A) limit the employers that may apply for coverage to those with eligible individuals residing in the service area of the plan;

(B) limit the individuals who may be enrolled under the plan to those who reside in the service area of the plan; and

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

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

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

In this paragraph, the term ''health maintenance organization'' includes an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) CLARIFICATION OF TIMELY ENROLLMENT.—

(A) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in this paragraph, a standard or catastrophic plan may consider enrollment of an eligible individual not to be timely if the eligible employee or dependent fails to enroll in the plan during an initial enrollment period, if such period is at least 30 days long.

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS EMPLOYER COVERAGE.—Enrollment in a standard or catastrophic plan is considered to be timely in the case of an eligible individual who—

(i) was covered under another health insurance plan or group health plan at the time of the individual's initial enrollment period,

(ii) stated at the time of the initial enrollment period that coverage under a health insurance plan or a group health plan was the reason for declining enrollment,

(iii) lost coverage under another health insurance plan or group health plan (as a result of the termination of the other plan's coverage, termination or reduction of employment, or other reason), and

(iv) requests enrollment within 30 days after termination of such coverage.

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each standard or catastrophic plan shall provide for at least one period (of not less than 30 days) each year during which enrollment under the plan shall be considered to be timely.

(D) EXCEPTION FOR COURT ORDERS.—Enrollment of a spouse or minor child of an employee shall be considered to be timely if—

(i) a court has ordered that coverage be provided for the spouse or child under a covered employee's group health plan, and

(ii) a request for enrollment is made within 30 days after the date the court issues the order.

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse) and any dependent child of an eligible employee shall be considered to be timely if a request for enrollment is made either—

(I) within 30 days of the date of the marriage or of the date of the birth or adoption of a child, if family coverage is available as of such date, or

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If a plan makes family coverage available and enrollment is made under the plan on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date

of the marriage or the date of birth or adoption of the child (as the case may be).

(4) DEFINITIONS.—In this subsection, the terms ''eligible individual'' and ''group health plan'' have the meanings given such terms in section 1023(a).

(c) STATE OPTION OF GUARANTEED AVAILABILITY THROUGH ALLOCATION OF RISK (RATHER THAN THROUGH GUARANTEED ISSUE).—The requirements of subsection (b) shall not apply in a State if the State has provided (in accordance with standards established under this subtitle) a mechanism under which—

(1) each insurer offering a health insurance plan to a small employer in the State must participate in a program for assigning high-risk small employer groups (or individuals within such a group) among some or all such insurers, and

(2) the insurers to which such high-risk small employer groups or individuals are so assigned comply with the requirements of subsection (b).

SEC. 1102. HEALTH PLAN, STANDARD PLAN, AND CATASTROPHIC PLAN DEFINED.

(a) HEALTH PLAN DEFINED.—In this subtitle:

(1) IN GENERAL.—The term ''health plan'' means a health insurance plan (whether a managed-

care plan, indemnity plan, or other plan) that meets the following requirements:

(A) The plan—

(i) is designed to provide standard coverage (consistent with subsection (b) or (d)) with substantial cost-sharing, or

(ii) is designed to provide only catastrophic coverage (consistent with subsection (c) or (d)).

(B) The plan meets the applicable requirements of section 1101(b) (relating to guaranteed issue).

(C) The plan meets the consumer protection standards established under section 1103(a)(1)(B).

(D) The plan meets any participation requirements with respect to an applicable reinsurance or allocation of risk mechanism established by a State or the Secretary under section 1106.

(2) STANDARD AND CATASTROPHIC PLANS.—The terms ''standard plan'' and ''catastrophic plan'' mean a health plan that provides for at least standard coverage (referred to in paragraph (1)(A)(i)) or

for only catastrophic coverage (referred to in paragraph (1)(A)(ii)), respectively.

(b) STANDARD BENEFIT PACKAGE.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, subsection (d) (permitting variation of benefits among actuarially equivalent plans), and subsection (e) (permitting plans not to cover specific treatments, procedures, or classes), a health insurance plan is considered to provide standard coverage consistent with this subsection if the benefits are limited to payment for—

(A) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in subparagraph (E)(i);

(B) inpatient and outpatient physicians' services, except that psychotherapy or counseling for a mental disorder is subject to the special limitations described in subparagraph (E)(ii);

(C) diagnostic tests;

(D) preventive services limited to—

(i) prenatal care and well-baby care provided to children who are 1 year of age or younger;

(ii) well child care;

(iii) Pap smears;

(iv) mammograms; and

(v) colorectal screening services; and

(E)(i) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care; and

(ii) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

(I) is a physician; or

(II) is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

(2) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—

(A) IN GENERAL.—Except as provided in subparagraph (B) and in paragraph (3), a

health insurance plan providing for standard coverage shall place no limits on the amount, scope, or duration of benefits described in subparagraphs (A) through (C) of paragraph (1).

(B) PREVENTIVE SERVICES.—A health insurance plan providing for standard coverage may limit the amount, scope, and duration of preventive services described in subparagraph (D) of paragraph (1) provided that the amount, scope, and duration of such services are reasonably consistent with recommendations and periodicity schedules developed by appropriate medical experts.

(3) EXCEPTIONS.—Paragraph (1) shall not be construed as requiring a plan to include payment for—

(A) items and services that are not essential and medically necessary;

(B) routine physical examinations or preventive care (other than care and services described in subparagraph (D) of paragraph (1)); or

(C) experimental services and procedures.

(4) LIMITATION ON DEDUCTIBLES.—

(A) IN GENERAL.—Except as permitted under subparagraph (B), a health insurance plan providing standard coverage shall not provide a deductible amount for benefits provided in any plan year that exceeds—

(i) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

(I) a calendar year prior to 1996, $450; or

(II) for a subsequent calendar year, the limitation specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

(ii) with respect to benefits payable for items and services furnished to any employee with a family member enrolled

under the standard benefit package plan, for a plan year beginning in—

(I) a calendar year prior to 1996, $450 per family member and $780 per family; or

(II) for a subsequent calendar year, the limitation specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation computed under clause (i)(II) or (ii)(II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

(B) WAGE-RELATED DEDUCTIBLE.—A health insurance plan may provide for any other deductible amount instead of the limitations under—

(i) subparagraph (A)(i), if such amount does not exceed (on an annualized

basis) 1 percent of the total wages paid to the employee in the plan year; or

(ii) subparagraph (A)(ii), if such amount does not exceed (on an annualized basis) 1 percent per family member or 2 percent per family of the total wages paid to the employee in the plan year.

(5) LIMITATION ON COPAYMENTS AND COINSURANCE.—

(A) IN GENERAL.—Subject to subparagraphs (B) through (D), a health insurance plan providing standard coverage may not require the payment of any copayment or coinsurance for an item or service for which coverage is required under this section—

(i) in an amount that exceeds 20 percent of the amount payable for the item or service under the plan; or

(ii) after an employee and family covered under the plan have incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in subparagraph (E)(ii)) for a plan year.

(B) EXCEPTION FOR MANAGED CARE PLANS.—A health insurance plan that is a man-

aged care plan may require payments in excess of the amount permitted under subparagraph (A) in the case of items and services furnished by nonparticipating providers.

(C) EXCEPTION FOR IMPROPER UTILIZATION.—A health insurance plan may provide for copayment or coinsurance in excess of the amount permitted under subparagraph (A) for any item or service that an individual obtains without complying with procedures established by a managed care plan or under a utilization program to ensure the efficient and appropriate utilization of covered services.

(D) EXCEPTIONS FOR MENTAL HEALTH CARE.—In the case of care described in paragraph (1)(E)(ii), a health insurance plan shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this subtitle in an amount that exceeds 50 percent of the amount payable for the item or service.

(6) LIMIT ON OUT-OF-POCKET EXPENSES.—

(A) OUT-OF-POCKET EXPENSES DEFINED.—As used in this section, the term ''out-of-pocket expenses'' means, with respect to an

employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan.

(B) OUT-OF-POCKET LIMIT DEFINED.—As used in this section and except as provided in subparagraph (C), the term ''out-of-pocket limit'' means for a plan year beginning in—

(i) a calendar year prior to 1996, $3,400; or

(ii) for a subsequent calendar year, the limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limit computed under clause (ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health insurance plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the family of the employee, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

(7) LIMITED PREEMPTION OF STATE MANDATED BENEFITS.—No State law or regulation in effect in a State that requires health insurance plans offered to small employers in the State to include specified items and services other than those specified by this subsection shall apply with respect to a health insurance plan providing standard coverage offered by an insurer to a small employer.

(c) CATASTROPHIC BENEFITS PACKAGE.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, subsection (d) (permitting variation of benefits among actuarially equivalent plans), and subsection (e) (permitting plans not to cover specific treatments, procedures, or classes), a health insurance plan is considered to provide catastrophic coverage consistent with this subsection if benefits are limited to payment for—

(A) inpatient and outpatient hospital care, including emergency services;

(B) inpatient and outpatient physicians' services;

(C) diagnostic tests; and

(D) preventive services (which may include one or more of the following services)—

(i) prenatal care and well-baby care provided to children who are 1 year of age or younger;

(ii) well-child care;

(iii) Pap smears;

(iv) mammograms; and

(v) colorectal screening services.

(2) COST-SHARING.—Each health insurance plan providing catastrophic coverage issued to a small employer by an insurer may impose premiums, deductibles, copayments, or other cost-sharing on enrollees of such plan.

(3) OUT-OF-POCKET LIMIT.—Each health insurance plan providing catastrophic coverage shall provide for a limit on out-of-pocket expenses.

(4) LIMITED PREEMPTION OF STATE MANDATED BENEFITS.—No State law or regulation in effect in a State that requires health insurance plans

offered to small employers in the State to include specified items and services other than those described in this subsection shall apply with respect to a health insurance plan providing catastrophic coverage offered by an insurer to a small employer.

(d) ACTUARIAL EQUIVALENCE IN BENEFITS PERMITTED.—

(1) STANDARD BENEFIT PACKAGE.—A health insurance plan also is considered to provide standard coverage consistent with subsection (b) if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under paragraph (3), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (4).

(2) CATASTROPHIC BENEFIT PACKAGE.—A health insurance plan also is considered to provide catastrophic coverage consistent with subsection (c) if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under paragraph (3), to have a value that is within 5 percentage points of the target actuarial value for catastrophic coverage established under paragraph (5).

(3) RULES OF ACTUARIAL EQUIVALENCE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules which the NAIC determines is sufficient for determining, in the case of any health insurance plan and for purposes of this subsection, the actuarial value of the coverage offered by the plan.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of subparagraph (A), the Secretary shall certify such set of rules for use under this subsection. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

(4) DETERMINATION OF TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for standard coverage equal to the average actuarial value of

the standard coverage described in subsection (b). No specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees to be offered standard coverage and a single set of standardized utilization and cost factors.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for standard coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such value for use under this subsection. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

(5) DETERMINATION OF TARGET ACTUARIAL VALUE FOR CATASTROPHIC COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of

this Act, a target actuarial value for catastrophic coverage equal to the average actuarial value of the catastrophic coverage described in subsection (c). No specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees to be offered catastrophic coverage and a single set of standardized utilization and cost factors.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for catastrophic coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such value for use under this subsection. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

(6) SUBSEQUENT REVISIONS OF RULES AND TARGET VALUES.—

(A) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence and target actuarial values previously established or determined under this subsection if the NAIC determines such revision necessary to take into account changes in the relevant types of health benefits provisions, in deductible levels for catastrophic coverage, or in demographic conditions which form the basis for such set of rules or values. The provisions of paragraph (3)(B) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

(B) SECRETARY.—The Secretary may by regulation revise such set or rules and values from time to time if the Secretary determines such revision necessary to take into account changes described in subparagraph (A).

(e) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section may be construed to require the coverage of any specific procedure, treatment, or class of service in a health plan under this Act or through regulations.

SEC. 1103. ESTABLISHMENT OF HEALTH PLAN STANDARDS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A)(i) The requirement, under section 1101(a), that insurers make available health plans.

(ii) The requirements of guaranteed availability of health plans to small employers under section 1101(b).

(iii) The requirements for standard and catastrophic coverage under subsections (b) and (c) of section 1102.

(B)(i) The requirements of section 1104 (relating to limits on premiums and miscellaneous consumer protections).

(ii) The requirement of section 1105 (relating to limitation on annual premium increases).

If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the

regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements described in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

(3) EFFECTIVE DATE.—The health plan standards and consumer protection standards (as defined in paragraph (5)) shall apply to health plans and health insurance plans in a State on or after the respective date the standards are implemented in the State under subsections (b) and (c).

(4) DEFINITIONS.—In this section:

(A) CONSUMER PROTECTION STANDARDS.—The term ''consumer protection standards'' means the standards established under paragraph (1)(B).

(B) HEALTH PLAN STANDARDS.—The term ''health plan standards'' means the stand-

ards established under paragraph (1)(A) (relating to the requirements of sections 1101 and 1102), and includes the consumer protection standards insofar as they relate to health plans.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF HEALTH PLAN STANDARDS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to implement and enforce the consumer protection standards with respect to insurers, and health plans offered, not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the health plan standards are established under subsection (a).

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

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and health plans offered to meet the health plan standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the health plan standards

under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and health plans offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected. In exercising authority under this subparagraph, the Secretary shall determine whether the use of a risk-allocation mechanism, described in section 1101(c), would be more consistent with the small employer group health coverage market in the State than the guaranteed availability provisions of section 1101(b).

(3) APPLICATION OF CONSUMER PROTECTION STANDARDS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified

in subparagraph (B), a report on steps the State is taking to implement and enforce the health plan standards with respect to insurers, and health insurance plans (other than health plans) offered, not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the consumer protection standards are established under subsection (a).

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

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and health insurance plans offered to meet the consumer protection standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1994 in a

legislative session in which such legislation may be considered,

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

(4) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the consumer protection standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards

in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and health insurance plans (other than health plans) offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

SEC. 1104. LIMITS ON PREMIUMS AND MISCELLANEOUS CONSUMER PROTECTIONS.

(a) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF INDEX RATES BETWEEN CLASSES OF BUSINESS.—

(A) IN GENERAL.—As a standard under section 1103(a)(1)(B)(i), the index rate for a rating period for any class of business of an insurer may not exceed by more than 20 percent the index rate for any other class of business.

(B) EXCEPTION.—The limitation of subparagraph (A) shall not apply to a class of business if—

(i) the class is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the class

of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status,

(ii) the insurer does not involuntarily transfer, and never has involuntarily transferred, a health insurance plan into or out of the class of business, and

(iii) the class of business is currently available for purchase.

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A CLASS OF BUSINESS.—For a class of business of an insurer, as a standard under section 1103(a)(1)(B)(i), the highest premium rates charged during a rating period to small employers with similar demographic and other similar objective characteristics (and not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for the same or similar coverage, or the highest rates which could be charged to such employers under the rating system for that class of business, shall not exceed an amount that is 1.5 times the base premium rate for the class of business for a rating period (or portion thereof) that occurs in the first 3 years in which this section is

in effect, and 1.35 times the base premium rate thereafter.

(3) OBJECTIVE BASIS FOR DIFFERENCES IN PREMIUMS FOR STANDARD AND CATASTROPHIC PLANS.—The difference between the index rates for catastrophic plans and the index rates for standard plans shall be reasonable and shall reflect the difference in plan design and shall not take into account differences due to the nature of the groups assumed to select particular health plans.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG CLASSES OF BUSINESS.—As a standard under section 1103(a)(1)(B)(i), an insurer may not involuntarily transfer a small employer into or out of a class of business. An insurer may not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to demographic characteristics, claim experience, health status, industry, occupation, or duration since issue.

(5) DEFINITIONS.—In this subsection:

(A) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each class of business for each rating period, the lowest pre-

mium rate charged or which could have been charged under a rating system for that class of business by the insurer to small employers with similar demographic characteristics and other similar objective characteristics (not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for health insurance plans with the same or similar coverage.

(B) CLASS OF BUSINESS.—The term ''class of business'' means, with respect to an insurer, all (or a distinct group of) small employers as shown on the records of the insurer.

(C) RULES FOR ESTABLISHING CLASSES OF BUSINESS.—For purposes of subparagraph (B)—

(i) an insurer may establish, subject to clause (ii), a distinct group of small employers on the basis that the applicable health insurance plans either—

(I) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct

groups of small employers for the insurer,

(II) have been acquired from another insurer as a distinct group, or

(III) are provided through an association that has a membership of not less than 100 small employers and that has been formed for purposes other than obtaining health coverage;

(ii) an insurer may not establish more than 2 groupings under each class of business based on the insurer's use of managed-care techniques if the techniques are expected to produce substantial variation in health care costs; and

(iii) notwithstanding clauses (i) and (ii), a State commissioner of insurance, upon application and if authorized under State law, may approve additional distinct groups upon a finding that such approval would enhance the efficiency and fairness of the small employer marketplace.

(D) INDEX RATE.—The term ''index rate'' means, with respect to a class of business, the arithmetic average of the applicable base pre-

mium rate and the corresponding highest premium rate for the class.

(E) DEMOGRAPHIC CHARACTERISTICS.—Except as otherwise permitted under the standard under section 1103(b)(1)(B)(i), the term ''demographic characteristics'' means age, gender, geographic area, family composition, and group size.

(b) FULL DISCLOSURE OF RATING PRACTICES.—At the time an insurer offers a health insurance plan to a small employer, the insurer shall fully disclose to the employer rating practices for health insurance plans, including rating practices for different populations and benefit designs.

(c) ACTUARIAL CERTIFICATION.—Each insurer that offers a health insurance plan to a small employer in a State shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health insurance plans—

(1) the insurer is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each such insurer shall retain a copy of such statement for examination at its principal place of business.

(d) REGISTRATION AND REPORTING.—Each insurer that issues any health insurance plan to a small employer in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such a plan.

SEC. 1105. LIMITATION ON VARIATION IN ANNUAL PREMIUM INCREASES AMONG COVERED SMALL EMPLOYERS.

An insurer may not provide for an increase in the premium charged a small employer for a health insurance plan in a percentage that exceeds the percentage change in the premium charged under the plan for a newly covered small employer within the same class of business rate plus 10 percentage points.

SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS FOR HIGH RISK INDIVIDUALS IN MARKETPLACE FOR SMALL BUSINESS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (each in this section referred to as a ''reinsurance or allocation of risk mechanism'') for health insurance plans made available to small employers and for whom an insurer is at risk of incurring high costs under the plan. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance or allocation of risk mechanism, such remaining models shall serve as the models under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance or allocation of risk mechanism, the Secretary shall specify, within 15

months after the date of the enactment of this Act, models to carry out this section.

(b) IMPLEMENTATION OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

(1) BY STATES.—Each State shall establish and maintain one or more reinsurance or allocation of risk mechanisms that are consistent with a model established under subsection (a) by not later than the deadline specified in section 1103(b)(1)(B). A State may establish and maintain such a mechanism jointly with one or more other States.

(2) FEDERAL ROLE.—

(A) IN GENERAL.—If the Secretary determines that a State has failed to establish or maintain a reinsurance or allocation of risk mechanism in accordance with paragraph (1), the Secretary shall establish and maintain such a reinsurance or allocation of risk mechanism meeting the requirements of this paragraph.

(B) REINSURANCE MECHANISM.—Unless the Secretary determines under subparagraph (C) that an allocation of risk mechanism is the appropriate mechanism to use in a State under this paragraph, the Secretary shall establish and maintain for use under this section for

each State an appropriate reinsurance mechanism. Such mechanism may require insurers to make contributions in proportion to the amounts received by the insurers for providing health insurance plans in the State.

(C) ALLOCATION OF RISK MECHANISM.—If the Secretary determines that, due to the nature of the health coverage market in the State (including a relatively small number of health insurance plans offered or a relatively small number of uninsurable small employers), an allocation of risk mechanism would be a better mechanism than a reinsurance mechanism, the Secretary shall establish and maintain for use under this section for a State an allocation of risk mechanism under which uninsurable small employers would be equitably assigned among insurers offering health insurance plans to small employers.

(c) CONSTRUCTION.—Nothing in this section shall be construed to prohibit reinsurance or allocation of risk arrangements relating to health insurance plans, whether on a State or multi-State basis, not required under this section.

SEC. 1107. DEFINITIONS.

Except as otherwise specifically provided, for purposes of this subtitle:

(1) DEPENDENT CHILD.—The term ''dependent child'' means a child (including an adopted child) who is under 19 years of age or who is a full-time student and under 25 years of age.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

(3) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(5) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as defined in standards established under section 1103, a health insurance plan that meets specified standards and that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(6) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

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

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

(9) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term ''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(10) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(11) STATE COMMISSIONER OF INSURANCE.—The term ''State commissioner of insurance'' includes a State superintendent of insurance.

SEC. 1108. OFFICE OF PRIVATE HEALTH CARE COVERAGE; ANNUAL REPORTS ON EVALUATION OF HEALTH CARE COVERAGE REFORM.

(a) IN GENERAL.—In order to carry out the responsibilities of the Secretary under this subtitle, the Secretary

shall establish an Office of Private Health Care Coverage, to be headed by a Director (in this section and section 1109 referred to as the ''Director'') appointed by the Secretary.

(b) ANNUAL REPORT.—

(1) IN GENERAL.—The Director shall submit to Congress an annual report on the implementation of this subtitle.

(2) INFORMATION TO BE INCLUDED.—Each annual report shall include information concerning at least the following:

(A) Implementation and enforcement of the applicable health plan standards and consumer protection standards under this subtitle by the States and by the Secretary.

(B) An evaluation of the impact of the reforms under this subtitle on the availability of affordable health coverage for small employers that purchase group health coverage and for their employees, and, in particular, the impact of—

(i) guaranteed availability of health coverage,

(ii) limitations of restrictions from coverage of preexisting conditions,

(iii) requirement for continuity of coverage,

(iv) risk-management mechanisms for health coverage,

(v) limits on premium variations,

(vi) limits on annual premium increases, and

(vii) preemption of State benefit mandates.

In performing such evaluation, the Secretary shall seek to discount the effect of the insurance cycle on health insurance premiums.

(C) An assessment of the implications of the reforms on adverse selection among health insurance plans and the distribution of risk among health insurance plans.

(c) ADVISORY COMMITTEE.—The Secretary shall provide for appointment of an advisory committee to advise the Director concerning activities of the Office under this subtitle. Membership on the committee shall consist of 17 individuals and shall include individuals from the general public, small and large business, labor, insurance and other group health plans, and health care providers, and shall include individuals who are experts in the fields of the actuarial science, health economics, and health services

research. The Secretary may include, as additional, ex officio members of the committee, such representatives of government agencies as the Secretary deems appropriate. The chairperson of the committee shall not be a health care provider or receive any direct or indirect compensation from an insurer, health insurance plan, or a health care provider.

SEC. 1109. RESEARCH AND DEMONSTRATION PROJECTS; DEVELOPMENT OF A HEALTH RISK POOLING MODEL.

(a) RESEARCH AND DEMONSTRATIONS.—The Director is authorized, directly, by contract, and through grants and cooperative agreements within the Department of Health and Human Services and outside the Department—

(1) to conduct research on the impact of this subtitle on the availability of affordable health coverage for employees and dependents in the small employers group health care coverage market and other topics described in section 1108(b), and

(2) to conduct demonstration projects relating to such topics.

(b) DEVELOPMENT OF METHODS OF MEASURING RELATIVE HEALTH RISK.—

(1) IN GENERAL.—The Director shall develop methods for measuring, in terms of the expected costs of providing benefits under health insurance plans and, in particular, health plans, the relative health risks of eligible individuals.

(2) METHODOLOGY.—The methods—

(A) shall rely on diagnosis or other health-related information that is predictive of individual health care needs,

(B) may rely upon information routinely collected in the process of making payments under group health plans, and

(C) may provide for such random, sample audits of records as may be necessary to verify the accuracy of measurements.

(c) DEVELOPMENT OF A HEALTH RISK POOLING MODEL.—

(1) IN GENERAL.—The Director shall develop a model, based on the methods of measuring risks under subsection (b), for equitably distributing health risks among insurers in the small employer health care coverage market.

(2) REDISTRIBUTION OF RISK.—Under such model, insurers with below average health risks would be required to contribute to a common fund

for payment to insurers with above average health risks, each in relation to the degree of their favorable or adverse risk selection.

(3) INCENTIVES.—Such model shall include incentives to encourage continuous coverage of eligible individuals and small employers.

(d) CONSULTATION.—The methods and model under this section shall be developed in consultation with the NAIC and the advisory committee established under section 1108(c).

(e) REPORT.—By not later than January 1, 1996, the Director shall submit to Congress a report on the methods and model developed under this section (as well as on research and demonstration projects conducted under subsection (a)). The Director shall include in the report such recommendations respecting the application of the model to insurers (and, in particular, to health plans) under this subtitle as the Director deems appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary in each of fiscal years 1995 through 1999.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under an insured multiple employer health plan.

SEC. 1203. RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

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

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

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring a licensed physician or other health care professional be available at some time in the review or appeal process, or (ii) requiring that any decision in an appeal from such a review be made by a licensed physician.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

SEC. 1204. DEFINITIONS.

For purposes of this part, the terms ''dependent'', ''employee'', ''employer'', ''group health plan'', ''health insurance plan'', ''insured multiple employer health plan'',

and ''State'' have the meanings given such terms in section 1023(a).

PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

SEC. 1211. LIMITED EXEMPTION UNDER PREEMPTION RULES FOR MULTIPLE EMPLOYER PLANS PROVIDING HEALTH BENEFITS SUBJECT TO CERTAIN FEDERAL STANDARDS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

''Part 7—Multiple Employer Health Plans

"SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

''(2) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

''(3) EXCESS/STOP LOSS COVERAGE.—The term 'excess/stop loss coverage' means, in connection with a multiple employer welfare arrangement, a contract under which an insurer provides for payment with respect to claims under the arrangement, relating to participants or beneficiaries individually or otherwise, in excess of an amount or amounts specified in such contract.

''(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(5) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

''(6) STATE LOCATION OF COVERED INDIVIDUALS.—

''(A) IN GENERAL.—A multiple employer welfare arrangement shall be treated as covering individuals located in a State only if the minimum required number of individuals who are covered under the arrangement are located in such State, except that if the minimum re-

quired number of individuals are not located in any State, such arrangement shall be treated as covering individuals in any State in which any covered individual is located.

''(B) MINIMUM REQUIRED NUMBER.—For purposes of subparagraph (A), the minimum required number is the greater of—

''(i) 5 percent of the total number of individuals described in subparagraph (A), or

''(ii) 50.

''(C) LOCATION OF INDIVIDUALS IN STATE.—For purposes of subparagraph (A), an individual shall be treated as located in a State if such individual is employed in such State or the address of such individual last known by the arrangement is located in such State.

''(7) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

''(8) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this part, most individuals to be covered under the arrange-

ment are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

''(9) FULLY INSURED ARRANGEMENT.—A multiple employer welfare arrangement shall be treated as fully insured only if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective of any recourse they may have against other parties).

''(10) MULTIPLE EMPLOYER HEALTH PLAN.—The term 'multiple employer health plan' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under this part.

''(11) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'insured multiple employer health plan' means a fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) (dis-

regarding such incidental benefits as the Secretary shall specify by regulations).

''(12) PREPAID HEALTH CARE ARRANGEMENT.—The term 'prepaid health care arrangement' means a nonprofit entity which—

''(A) offers benefits consisting of medical care described in section 607(1) on a prepaid basis, and

''(B) is established and controlled by a group medical practice or similar group, by a hospital, or by such a practice (or group) and a hospital.

"SEC. 702. EXEMPTED MULTIPLE EMPLOYER PLANS PROVIDING BENEFITS IN THE FORM OF MEDICAL CARE RELIEVED OF CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW AND TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.

''(a) IN GENERAL.—Subject to subsection (b), a multiple employer welfare arrangement which is not fully insured and with respect to which there is in effect an exemption granted by the Secretary under this part (or with respect to which there is pending a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate)—

''(1) shall be treated for purposes of subtitle A and the preceding parts of this subtitle as an employee welfare benefit plan, irrespective of whether such arrangement is an employee welfare benefit plan, and

''(2) shall be exempt from section 514(b)(6)(A)(ii).

''(b) BENEFITS MUST CONSIST OF MEDICAL CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided thereunder consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation).

''(c) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care described in section 607(1) which has not commenced operations as of January 1, 1995, may commence operations only if an exemption granted to the arrangement under this part is in effect (or there is pending with respect to the arrangement a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate).

"SEC. 703. EXEMPTION PROCEDURE.

''(a) IN GENERAL.—The Secretary shall grant an exemption described in section 702(a) to a multiple employer welfare arrangement if—

''(1) an application for such exemption with respect to such arrangement, identified individually or by class, has been duly filed in complete form with the Secretary in accordance with this part,

''(2) such application demonstrates compliance with the requirements of section 704 with respect to such arrangement, and

''(3) the Secretary finds that such exemption is—

''(A) administratively feasible,

''(B) not adverse to the interests of the individuals covered under the arrangement, and

''(C) protective of the rights and benefits of the individuals covered under the arrangement.

''(b) NOTICE AND HEARING.—Before granting an exemption under this section, the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall

afford interested persons opportunity to present views. The Secretary may not grant an exemption under this section unless the Secretary affords an opportunity for a hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

''(a) APPLICATION FOR EXEMPTION.—

''(1) IN GENERAL.—An exemption may be granted by the Secretary under this part only on the basis of an application filed with the Secretary in such form and manner as shall be prescribed in regulations of the Secretary. Any such application shall be signed by the operating committee and the sponsor of the arrangement.

''(2) FILING FEE.—The arrangement shall pay to the Secretary at the time of filing an application under this section a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the

sole purpose of administering the exemption procedures under this part.

''(3) INFORMATION INCLUDED.—An application filed under this section shall include, in a manner and form prescribed in regulations of the Secretary, at least the following information:

''(A) IDENTIFYING INFORMATION.—The names and addresses of—

''(i) the sponsor, and

''(ii) the members of the operating committee of the arrangement.

''(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

''(C) BONDING REQUIREMENTS.—Evidence provided by the operating committee that the bonding requirements of section 412 will be met as of the date of the application.

''(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be

provided to individuals covered under the arrangement.

''(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

''(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

''(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

''(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period be-

ginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

''(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and

other expenses associated with the operation of the arrangement.

''(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

''(b) OTHER REQUIREMENTS.—A complete application for an exemption under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

''(1) SPONSOR.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce or other business group, for substantial purposes other than that of obtaining or providing medical care described in section

607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

''(B) SPECIAL RULE FOR PREPAID HEALTH CARE ARRANGEMENTS.—In the case of an arrangement that is a prepaid health care arrangement (as defined in section 701(12)), the sponsor is the operating committee of the arrangement.

''(2) OPERATING COMMITTEE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of

the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(B) SPECIAL RULE FOR PREPAID HEALTH CARE ARRANGEMENTS.—In the case of an arrangement that is a prepaid health care arrangement (as defined in section 701(12)), the operating committee is the board of the entity that is the arrangement.

''(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 1212(a)(1), which—

''(A) provides that the committee serves as the named fiduciary required for plans under section 1212(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor is to serve as plan sponsor (referred to in section 3(16)(B)),

''(C) incorporates the requirements of section 707, and

''(D) provides that, effective upon the granting of an exemption under this part—

''(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an em-

ployer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(ii) all individuals thereafter commencing coverage under the arrangement must be—

''(I) active or retired owners, officers, directors, or employees of, or partners in, participating employers, or

''(II) the beneficiaries of individuals described in subclause (I).

''(4) CONTRIBUTION RATES.—The contribution rates referred to in subsection (a)(3)(F)(ii) are adequate.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

''(c) TREATMENT OF PARTY SEEKING EXEMPTION WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

''(1) IN GENERAL.—In the case of any application for an exemption under this part with respect to a multiple employer welfare arrangement, if the

Secretary determines that the sponsor of the arrangement or any other person associated with the arrangement is subject to disqualification under paragraph (2), the Secretary may deny the exemption with respect to such arrangement.

''(2) DISQUALIFICATION.—A person is subject to disqualification under this paragraph if such person—

''(A) has intentionally made a material misstatement in the application for exemption;

''(B) has obtained or attempted to obtain an exemption under this part through misrepresentation or fraud;

''(C) has misappropriated or converted to such person's own use, or improperly withheld, money held under a plan or any multiple employer welfare arrangement;

''(D) is prohibited (or would be prohibited if the arrangement were a plan) from serving in any capacity in connection with the arrangement under section 411;

''(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order law-

fully issued by the Secretary compelling such response;

''(F) has previously been subject to a determination under this part resulting in the denial, suspension, or revocation of an exemption under this part on similar grounds; or

''(G) has otherwise violated any provision of this title with respect to a matter which the Secretary determines of sufficient consequence to merit disqualification for purposes of this part.

''(d) FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting of its franchisees, such franchisor shall be treated as the sponsor referred to in the preceding provisions of this section, such network shall be treated as an association referred to in such provisions, and each franchisee shall be treated as a member (of the association and the sponsor) referred to in such provisions, if all participating employers are such franchisees and the requirements of subsection (b)(1) with respect to a sponsor are met with respect to the network.

''(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this sec-

tion in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but for the failure to meet any requirement of section 3(40)(C)—

''(1) paragraphs (1) and (2) of subsection (b) and subparagraphs (A), (B), and (D) of paragraph (3) of subsection (b) shall be disregarded, and

''(2) the joint board of trustees shall be considered the operating committee of the arrangement.

''(f) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

''(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer, subsection (b)(3)(D) shall be disregarded.

''(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO EXEMPTED ARRANGEMENTS.

''(a) NOTICE OF MATERIAL CHANGES.—In the case of any multiple employer welfare arrangement with respect to which there is in effect an exemption granted under this part, descriptions of material changes in any information which was required to be submitted with the application for the exemption shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the exemption.

''(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, not-

withstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

''(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The operating committee of each multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the arrangement.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''(d) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted to a multiple employer welfare arrangement under this part shall not be effective unless written notice of such exemption is filed with the

State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this paragraph, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

''SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY ARRANGEMENTS PROVIDING MEDICAL CARE.

''(a) IN GENERAL.—A multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) shall issue to each participating employer—

''(1) a document equivalent to the summary plan description required of plans under part 1,

''(2) information describing the contribution rates applicable to participating employers, and

''(3) a statement indicating—

''(A) whether or not the arrangement is fully insured,

''(B) whether or not there is in effect with respect to the arrangement an exemption granted under this part and, if there is in effect such

an exemption, that the arrangement is (or is treated as) an employee welfare benefit plan under this title, and

''(C) that the arrangement is not a licensed insurer under the laws of any State.

''(b) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

"SEC. 707. MAINTENANCE OF RESERVES.

''(a) IN GENERAL.—Each multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part and which is not fully insured shall establish and maintain reserves, consisting of—

''(1) a reserve for unearned contributions,

''(2) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims, and

''(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

''(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2)

shall not be less than an amount equal to 25 percent of expected incurred claims and expenses for the plan year.

''(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

''(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

''(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

''(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement (including a prepaid health care arrangement) to substitute, for all or part of the reserves required under subsection (a), such secu-

rity, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall continue to meet the requirements of section 707, irrespective of whether such exemption continues in effect. The operating committee of such arrangement shall determine semiannually whether the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as

the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

''(b) TERMINATION.—

''(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part determines that there is reason to believe that the arrangement will terminate, the committee shall so inform the Secretary, shall develop a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and shall submit such plan in writing to the Secretary. Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

''(2) ACTIONS REQUIRED IN CONNECTION WITH TERMINATION.—In any case in which—

''(A) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part to meet the requirements of section 707 and has not been notified by the operating committee of the arrangement that corrective action has restored compliance with such requirements, and

''(B) the Secretary determines that the continuing failure to meet the requirements of section 707 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated,

the operating committee of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the arrangement is obligated.

''SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF EXEMPTION.

''(a) EXPIRATION AND RENEWAL OF EXEMPTION.—An exemption granted to a multiple employer welfare arrangement under this part shall expire 3 years after the date on which the exemption is granted. An exemption which has expired may be renewed by means of application for an exemption in accordance with section 704.

''(b) SUSPENSION OR REVOCATION OF EXEMPTION BY SECRETARY.—The Secretary may suspend or revoke an exemption granted to a multiple employer welfare arrangement under this part—

''(1) for any cause that may serve as the basis for the denial of an initial application for such an exemption under section 704, or

''(2) if the Secretary finds that—

''(A) the arrangement, or the sponsor thereof, in the transaction of business while under the exemption, has used fraudulent, coercive, or dishonest practices, or has demonstrated incompetence, untrustworthiness, or financial irresponsibility,

''(B) the arrangement, or the sponsor thereof, is using such methods or practices in the conduct of its operations, so as to render its further transaction of operations hazardous or

injurious to participating employers, or covered individuals,

''(C) the arrangement, or the sponsor thereof, has refused to be examined in accordance with this part or to produce its accounts, records, and files for examination in accordance with this part, or

''(D) any of the officers of the arrangement, or the sponsor thereof, has refused to give information with respect to the affairs of the arrangement or the sponsor or to perform any other legal obligation relating to such an examination when required by the Secretary in accordance with this part.

Any such suspension or revocation under this subsection shall be effective only upon a final decision of the Secretary made after notice and opportunity for a hearing is provided in accordance with section 710.

''(c) SUSPENSION OR REVOCATION OF EXEMPTION UNDER COURT PROCEEDINGS.—An exemption granted to a multiple employer welfare arrangement under this part may be suspended or revoked by a court of competent jurisdiction in an action by the Secretary brought under paragraph (2), (5), or (6) of section 502(a), except that the suspension or revocation under this subsection shall

be effective only upon notification of the Secretary of such suspension or revocation.

''(d) NOTIFICATION OF PARTICIPATING EMPLOYERS.—All participating employers in a multiple employer welfare arrangement shall be notified of the expiration, suspension, or revocation of an exemption granted to such arrangement under this part, by such persons and in such form and manner as shall be prescribed in regulations of the Secretary, not later than 20 days after such expiration or after receipt of notice of a final decision requiring such suspension or revocation.

''(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS, AND REVOCATIONS.—The Secretary shall publish all expirations of, and all final decisions to suspend or revoke, exemptions granted under this part.

"**SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

''(a) IN GENERAL.—Any decision by the Secretary which involves the denial of an application by a multiple employer welfare arrangement for an exemption under this part or the suspension or revocation of such an exemption shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the exemption and the statutory provision or provisions relevant to the determination.

''(b) DENIALS OF APPLICATIONS.—In the case of the denial of an application for an exemption under this part, the Secretary shall send a copy of the decision to the applicant by certified or registered mail at the address specified in the records of the Secretary. Such decision shall constitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the decision, files a written appeal of the denial within 30 days after the mailing of such decision. The Secretary may affirm, modify, or reverse the initial decision. The decision on appeal shall become final upon the mailing of a copy by certified or registered mail to the arrangement or party that filed the appeal.

''(c) SUSPENSIONS OR REVOCATIONS OF EXEMPTION.—In the case of the suspension or revocation of an exemption granted under this part, the Secretary shall send a copy of the decision to the arrangement by certified or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrangement, or any party that would be prejudiced by the suspension or revocation, filed within 15 days of the mailing of the Secretary's decision, the Secretary shall schedule a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party requesting such hearing. Such notice shall set forth—

''(1) a specific date and time for the hearing, which shall be within the 10-day period commencing 20 days after the date of the mailing of the notice, and

''(2) a specific place for the hearing, which shall be in the District of Columbia or in the State and county thereof (or parish or other similar political subdivision thereof) in which is located the arrangement's principal place of business.

The decision as affirmed or modified in such hearing shall constitute the final decision of the Secretary, unless such decision is reversed in such hearing.''.

(b) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes the sponsor (as defined in section 701(5)) of a multiple employer welfare arrangement, or a multiple employer health plan (as defined in section 701(10)), with respect to which there is or has been in effect an exemption granted under part 7.''.

(c) ALTERNATIVE MEANS OF DISTRIBUTION OF SUMMARY PLAN DESCRIPTIONS.—Section 110 of such Act (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

''(c) The Secretary shall prescribe, as an alternative method for distributing summary plan descriptions in order to meet the requirements of section 104(b)(1) in the case of multiple employer welfare arrangements providing benefits consisting of medical care described in section 607(1), a means of distribution of such descriptions by participating employers.''.

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 608 the following new items:

SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting '', but only, in the case of an arrangement which provides medical care described in section 607(1) and with respect to

which an exemption under part 7 is not in effect,'' before ''to the extent not inconsistent with the preceding sections of this title''.

(b) CROSS-REFERENCE.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer welfare arrangements providing medical care, see part 7.''.

SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''common control'';

(2) in clause (iii), by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum inter-

est necessary for common control'', and by striking ''and'' at the end,

(3) by redesignating clause (iv) as clause (v), and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.''.

SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i) under or pursuant to one or more collective bargaining agreements,''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) Clause (i) of subparagraph (A) shall apply only if—

''(i) the plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

''(II) pay a commission or any other type of compensation to a person that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size

of the contributions made by participating employers or covered individuals to the plan or other arrangement,

''(ii) not less than 85 percent of the covered individuals under the plan or other arrangement are individuals who—

''(I) are employed within a bargaining unit covered by at least one of the collective bargaining agreements with a participating employer (or are covered on the basis of an individual's employment in such a bargaining unit), or

''(II) are present or former employees of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (or are covered on the basis of such present or former employment),

''(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause

(ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan statistical area, this clause shall be applied by reference to the State in which the sponsoring organization represents employees,

''(iv) the employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary—

''(I) that the plan or other arrangement meets the requirements of clauses (i), (ii), and (iii), and

''(II) if, for any year, 10 percent or more of the covered individuals under the plan are individuals not de-

scribed in subclause (I) or (II) of clause (ii), the total number of covered individuals and the total number of covered individuals not so described.

''(D)(i) Clause (i) of subparagraph (A) shall not apply to a plan or other arrangement that is established or maintained pursuant to one or more collective bargaining agreements which the National Labor Relations Boards determines to have been negotiated or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

''(ii)(I) Whenever a State insurance commissioner has reason to believe that this subparagraph is applicable to part or all of a plan or other arrangement, the State insurance commissioner may file a petition with the National Labor Relations Board for a determination under clause (i), along with sworn written testimony supporting the petition.

''(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I)

or cases given priority under section 10 of the National Labor Relations Act (29 U.S.C. 160).

''(III) The Board shall determine, upon the petition and any response, whether, on the facts before it, the plan or other arrangement was negotiated, created, or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)). Such determination shall constitute a final determination for purposes of this subparagraph and shall be binding in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

''(IV) A person aggrieved by the determination of the Board under subclause (III) may obtain review of the determination in any United States court of appeals in the circuit in which the collective bargaining at issue occurred. Commencement of proceedings under this subclause shall not, unless specifically ordered by the court, operate as a stay of any State administrative or judicial action or proceeding related to the status of the plan or other arrangement, except that in no case may

the court stay, before the completion of the review, an order which prohibits the enrollment of new individuals into coverage under a plan or arrangement.''.

SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

(a) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT DEFINED.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

''(43) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'employee leasing healthcare arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which—

''(i) one business or other entity (hereinafter in this paragraph referred to as the 'lessee'), under a lease or other arrangement entered into with any other business or other entity (hereinafter in this paragraph referred to as the 'lessor'), receives from the lessor the

services of individuals to be performed under such lease or other arrangement, and

''(ii) benefits consisting of medical care described in section 607(1) are provided to such individuals or such individuals and their dependents as participants and beneficiaries.

''(B) EXCEPTION.—Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the individuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.''.

(b) TREATMENT OF EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) (as amended by the preceding provisions of this title) is further amended by adding at the end the following new subparagraph:

''(E) The term 'multiple employer welfare arrangement' includes any employee leasing healthcare arrangement, except that such term does not include any employee

leasing healthcare arrangement which is a multiple employer health plan (as defined in section 701(10)).''.

(c) SPECIAL RULES FOR EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added by the preceding provisions of this Act) is amended by adding at the end the following new section:

"SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

''(a) IN GENERAL.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrangement that is an employee leasing healthcare arrangement if the application for exemption includes information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

''(1) 3-YEAR TENURE.—The lessor has been in operation for not less than 3 years.

''(2) SOLICITATION RESTRICTIONS.—Employee leasing services provided under the arrangement are not solicited, advertised, or marketed through licensed insurance agents or brokers acting in such capacity.

''(3) CREATION OF EMPLOYMENT RELATIONSHIP.—

''(A) DISCLOSURE STATEMENT.—Written notice is provided to each applicant for employment subject to coverage under the arrangement, at the time of application for employment and before commencing coverage under the arrangement, stating that the employer is the lessor under the arrangement.

''(B) INFORMED CONSENT.—Each such applicant signs a written statement consenting to the employment relationship with the lessor.

''(C) INFORMED RECRUITMENT OF LESSEE'S EMPLOYEES.—In any case in which the lessor offers employment to an employee of a lessee under the arrangement, the lessor informs each employee in writing that his or her acceptance of employment with the lessor is voluntary and that refusal of such offer will not be deemed to be resignation from or abandonment of current employment.

''(4) REQUISITE EMPLOYER-EMPLOYEE RELATIONSHIP UNDER ARRANGEMENT.—Under the employer-employee relationship with the employees of the lessor—

''(A) the lessor retains the ultimate authority to hire, terminate, and reassign such employees,

''(B) the lessor is responsible for the payment of wages, payroll-related taxes, and employee benefits, without regard to payment by the lessee to the lessor for its services,

''(C) the lessor maintains the right of direction and control over its employees, except to the extent that the lessee is responsible for supervision of the work performed consistent with the lessee's responsibility for its product or service,

''(D) in accordance with section 301(a) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(a)), the lessor retains in the absence of an applicable collective bargaining agreement, the right to enter into arbitration and to decide employee grievances, and

''(E) no owner, officer, or director of, or partner in, a lessee is an employee of the lessor, and not more than 10 percent of the individuals covered under the arrangement consist of owners, officers, or directors of, or partners in, such a lessee (or any combination thereof).

''(b) DEFINITIONS.—For purposes of this section—

''(1) LESSOR.—The term 'lessor' means the business or other entity from which services of individuals are obtained under an employee leasing healthcare arrangement.

''(2) LESSEE.—The term 'lessee' means a business or other entity which receives the services of individuals provided under an employee leasing healthcare arrangement.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 710 the following new item:

''Sec. 711. Employee leasing healthcare arrangements.''.

SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

(a) ENFORCEMENT OF FILING REQUIREMENTS.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking ''subsection (c)(2) or (i) or (l)'' and inserting ''paragraph (2) or (4) of subsection (c) or subsection (i) or (l)''; and

(2) by adding at the end of subsection (c) the following new paragraph:

''(4) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(e).''.

(b) ACTIONS BY STATES IN FEDERAL COURT.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (5), by striking ''or'' at the end;

(2) in paragraph (6), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(7) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any provision of part 7 which such State has the power to enforce under part 7.''.

(c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

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

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as being a multiple employer welfare arrangement granted an exemption under part 7, as being an employee leasing healthcare arrangement under such an exemption, or as having been established or maintained under or pursuant to a collective bargaining agreement shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(d) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(m)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) that—

''(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, or

''(B) is not operating in accordance with the terms of an exemption granted by the Secretary under part 7,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that it—

''(A) is fully insured, within the meaning of section 701(9),

''(B) is licensed, registered, or otherwise approved in each State in which it offers or provides benefits, except to the extent that such State does not require licensing, registration, or approval of fully insured multiple employer welfare arrangements, and

''(C) with respect to each such State, is operating in accordance with applicable State insurance laws that are not superseded under section 514.

''(3) The court may grant such additional equitable or remedial relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.''.

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: ''The terms of each multiple employer welfare arrangement to which this section applies and which provides benefits consisting of medical care described in section 607(1) shall require the operating committee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the arrangement.''.

SEC. 1217. FILING REQUIREMENTS FOR HEALTH BENEFIT MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

''(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1995) and no later than February 15 of each year (in the case of an arrangement

in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care described in section 607(1).

''(2) Each registration statement—

''(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

''(B) if the arrangement is not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

''(i) in the case of an arrangement with respect to which an exemption under part 7 is in effect, the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not so exempt, the State insurance commissioner of each State in which the arrangement is located.

''(3) The person or persons responsible for filing the annual registration statement are—

''(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

''(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

''(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.''.

SEC. 1218. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements with respect to which an exemption under part 7 is or has been in effect. The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent

consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

''(2) ASSISTANCE TO STATES.—The Secretary shall—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through

the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

''(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

''(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

''(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''.

SEC. 1219. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this part shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1995, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

PART 3—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS

SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

(a) IN GENERAL.—Paragraph (9) of section 501(c) of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended—

(1) by inserting ''(A)'' after ''(9)''; and

(2) by adding at the end the following:

''(B) Any determination of whether a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) or an insured multiple employer health plan (as defined in section 701(11) of such Act) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

''(i) such plan provides at least standard coverage (consistent with section 1102(b) of the Health Reform Consensus Act of 1994), and

''(ii) in the case of an insured multiple employer health plan, it meets the requirements enforceable under section 514(b)(6)(B)(i) of the

Employee Retirement Income Security Act of 1974 to the extent not preempted by section 1202 of the Health Reform Consensus Act of 1994.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1995.

PART 4—SIMPLIFYING FILING OF REPORTS FOR EMPLOYERS COVERED UNDER INSURED MULTIPLE EMPLOYER HEALTH PLANS

SEC. 1231. SINGLE ANNUAL FILING FOR ALL EMPLOYERS COVERED UNDER AN INSURED MULTIPLE EMPLOYER HEALTH PLAN.

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030), as amended by section 1211(c) of this subtitle, is amended by adding at the end the following new subsection:

''(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are covered under the same insured multiple employer health plan (as defined in section 701(11)).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enact-

ment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(d) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

PART 5—COMPLIANCE WITH COVERAGE OPTION REQUIREMENTS

SEC. 1241. COMPLIANCE WITH COVERAGE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

(a) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIEMPLOYER PLANS.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 1001(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (c) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(b) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH OTHER MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.—

(1) IN GENERAL.—In any case in which an employer is, for any plan year, a participating employer

(as defined in paragraph (3)) in an exempted multiple employer health plan or an insured multiple employer health plan, the requirements of section 1001(a) shall be deemed to be met (and the ERISA requirements of paragraph (2) shall be deemed to be met by the employer) with respect to an eligible employee of the employer if—

(A) the employer requirements of subsection (c) are met with respect to the eligible employee, and

(B) the applicable ERISA requirements of paragraph (2) are met by the plan with respect to the plan,

irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(2) APPLICABLE ERISA REQUIREMENTS.—The applicable ERISA requirements of this paragraph are the requirements of—

(A) part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (relating to reporting and disclosure),

(B) section 503 of such Act (relating to claims procedure), and

(C) part 6 of subtitle B of such title I (relating to group health plans),

to the extent that such requirements relate to employers as plan sponsors or plan administrators.

(3) PARTICIPATING EMPLOYER.—In this subsection, the term ''participating employer'' means, in connection with an exempted multiple employer health plan or an insured multiple employer health plan, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such plan in connection with the employment of the employees.

(c) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a plan with respect to an eligible employee if—

(1) the employee is eligible under the plan to elect coverage on an annual basis and is provided a reasonable opportunity to make the election in such form and manner and at such times as are provided by the plan,

(2) subject to section 1001(c), such coverage includes at least the standard coverage (consistent with section 1102(c)),

(3) the employer facilitates collection of any employee contributions under the plan and permits

the employee to elect to have employee contributions under the plan collected through payroll deduction, and

(4) in the case of a plan to which part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of such Act in the form and manner and at such times as are required under such part 1 with respect to employee welfare benefit plans.

Subtitle D—Health Deduction Fairness

SEC. 1301. PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) PERMANENT EXTENSION OF DEDUCTION.—

(1) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1995.

(b) INCREASE IN AMOUNT OF DEDUCTION.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of such Code is amended by striking ''25 percent of'' and inserting ''100 percent (50 percent in the case of taxable years beginning in 1996 or 1997) of''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1995.

TITLE II—PREVENTING FRAUD AND ABUSE

Subtitle A—Establishment of All-Payer Health Care Fraud and Abuse Control Program

SEC. 2001. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Attorney General shall establish a program—

(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) in consultation with the Inspector General of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

(1) IN GENERAL.—The Attorney General shall by regulation establish standards to carry out the program under subsection (a).

(2) INFORMATION STANDARDS.—

(A) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health insurers (including self-insured health benefit plans), providers, and others to enable the Attorney General to carry out the program (including coordination with law enforcement agencies under subsection (b) and third party insurers under subsection (c)).

(B) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B

of title XI of such Act, with respect to the performance of such a contract.

SEC. 2002. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such sums as may be necessary to enable the Attorney General to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 2001 in a fiscal year.

SEC. 2003. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Anti-Fraud and Abuse Trust Fund'' (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this subtitle and section 1128A(f)(3) of the Social Security Act.

(b) MANAGEMENT.—

(1) IN GENERAL.—The Trust Fund shall be managed by the Attorney General through a Managing Trustee designated by the Attorney General.

(2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the trustee's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-

bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Trustee determines that the purchase of such other obligations is in the public interest.

(3) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(4) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(5) The receipts and disbursements of the Attorney General in the discharge of the functions of the Attorney General shall not be included in the totals of the budget of the United States Government. For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Attorney General and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(c) USE OF FUNDS.—Amounts in the Trust Fund shall be used to assist the Attorney General in carrying out the all-payor fraud and abuse control program established under section 2001(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 2003(a) of the Health Reform Consensus Act of 1994''.

(e) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-

SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a–7a(f)) is amended in the matter preceding paragraph (1) by striking ''Secretary and disposed of as follows:'' and inserting the following: ''Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:''.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 2101. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been con-

victed, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 2102. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b),

the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 2103. CIVIL MONETARY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY PROGRAMS OR PLANS.—

(1) INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER MEDICARE.—

(A) OFFER OF REMUNERATION.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) by striking ''or'' at the end of paragraph (1)(D);

(ii) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(iii) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(iv) by inserting after paragraph (3) the following new paragraph:

''(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to significantly influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;''.

(B) REMUNERATION DEFINED.—Section 1128A(i) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for

free or for other than fair market value. The term 'remuneration' does not include the waiver of coinsurance and deductible amounts by a person, if—

''(A) the waiver is not offered as part of any advertisement or solicitation;

''(B) the person does not routinely waive coinsurance or deductible amounts; and

''(C) the person—

''(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.''.

(2) INDUCEMENTS TO EMPLOYEES.—Section 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is further amended—

(A) by striking ''or'' at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) pays a bonus, reward, or any other remuneration, directly or indirectly, to an employee to induce the employee to encourage individuals to seek or obtain covered items or services for which payment may be made under the medicare program, or a State health care program where the amount of the remuneration is determined in a manner that takes into account (directly or indirectly) the value or volume of any referrals by the employee to the employer for covered items or services;''.

(b) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING.—Section 1128A(a)(1)(A) of such Act (42 U.S.C. 1320a–7a(a)(1)) is amended by striking ''claimed,'' and inserting the following: ''claimed, including any person who presents or causes to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,''.

SEC. 2104. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

(D) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that

the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1876(i)(6)(B) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1995, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy

and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1995.

SEC. 2105. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1996.

Subtitle C—Administrative and Miscellaneous Provisions

SEC. 2201. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) FINDINGS.—The Congress finds the following:

(1) Fraud and abuse with respect to the delivery of and payment for health care services is a significant contributor to the growing costs of the Nation's health care.

(2) Control of fraud and abuse in health care services warrants greater efforts of coordination than those that can be undertaken by individual States or the various Federal, State, and local law enforcement programs.

(3) There is a national need to coordinate information about health care providers and entities that have engaged in fraud and abuse in the delivery of and payment for health care services.

(4) There is no comprehensive national data collection program for the reporting of public information about final adverse actions against health care providers, suppliers, or licensed health care practitioners that have engaged in fraud and abuse in the deliver of and payment for health care services.

(5) A comprehensive national data collection program for the reporting of public information about final adverse actions will facilitate the enforcement of the provisions of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) GENERAL PURPOSE.—Not later than January 1, 1995, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements where no finding of liability has been made) against health care providers, suppliers, or practitioners as required by subsection (c), with access as set forth in subsection (d).

(c) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each government agency and health care plan shall report any final adverse action (not including settlements where no finding of liability has been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the information is pro-

vided and utilized in a manner that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements where no findings of liability has been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health care plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(e) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to the public, Federal and State government agencies, and health care plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (c)(5) shall be held

liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) The term ''final adverse action'' includes:

(A) Civil judgments against a health care provider in Federal or State court related to the delivery of a health care item or service.

(B) Federal or State criminal convictions related to the delivery of a health care item or service, as determined in accordance with section 1128(j) of the Social Security Act.

(C) Actions by State or Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(i) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation, or

(ii) any other loss of license of the provider, supplier, or practitioner, by operation of law.

(D) Exclusion from participation in Federal or State health care programs.

(2) The term ''Government agency'' includes:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Department of Veterans Affairs.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

(F) State or Federal agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(3) The term ''health care plan'' means a public or private program for the delivery of or payment for health care services other than the medicare program or a State health care program described in section 1128(h) of the Social Security Act.

(4) The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act, and any entity, including a health maintenance organization, group medical

practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(5) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(6) The term ''supplier'' means a supplier of health care items and services described in sections 1819 (a) and (b), and section 1861 of the Social Security Act.

(h) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 2201 of the Health Reform Consensus Act of 1994'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

SEC. 2202. QUARTERLY PUBLICATION OF FINAL ADVERSE ACTIONS TAKEN.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

''QUARTERLY PUBLICATION OF FINAL ADVERSE ACTIONS TAKEN

''SEC. 1144. (a) IN GENERAL.—Not later than 30 days after the end of each calendar quarter, the Secretary shall publish in the Federal Register a listing of all final adverse actions taken during the quarter under this part (including penalties imposed under section 1107, exclusions under section 1128, the imposition of civil monetary penalties under section 1128A, and the imposition of criminal penalties under section 1128B) and under section 1156.

''(b) FINAL ADVERSE ACTION DEFINED.—In subsection (a), the term 'final adverse action' has the meaning given such term under section 2201(g)(1) of the Health Reform Consensus Act of 1994.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1996.

Subtitle D—Amendments to Criminal Law

SEC. 2301. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,

United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

''(b) In determining the amount or scope of any penalty or assessment, the court shall take into account:

''(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

''(2) the degree of culpability and history of prior offenses by the convicted health care provider;

''(3) the extent to which restitution is paid; and

''(4) such other matters as justice may require.

''(c) A principal is liable for penalties and assessments under this section for the acts of the principal's agents acting within the scope of the agency.

''(d) For purposes of this section, the term 'health care plan' means a Federally-funded public program or private program for the delivery of or payment for health care items or services.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 2302. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1347.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agen-

cy or instrumentality who furnishes information discovered or gathered in the course of government employment.

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

TITLE III—MALPRACTICE REFORM

Subtitle A—Findings; Purpose; Definitions

SEC. 3001. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) the costs of health care consume more than 14 percent of the Gross Domestic Product of the United States, significantly affecting interstate commerce and the budget of the Federal Government;

(2) claims for medical malpractice are a significant factor in the cost of health care and cause physicians, hospitals, and other health care providers to undertake diagnostic tests and procedures partly as defensive measures against the possibility of malpractice claims;

(3) the health care and insurance industries are industries affecting interstate commerce and the medical malpractice litigation systems existing throughout the United States affect interstate commerce by contributing to the high cost of health care

and premiums for malpractice insurance purchased by health care providers; and

(4) the Federal Government has a major interest in health care as a direct provider of health care and as a source of payment for health care, and has a demonstrated interest in assessing the quality of care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

(b) PURPOSE.—It is the purpose of this title to—

(1) provide grants to States to develop alternative dispute resolution procedures to attain a more efficient, expeditious, and equitable resolution of health care malpractice disputes;

(2) enhance general knowledge concerning the benefits of different forms of alternative dispute resolution mechanisms; and

(3) establish uniformity and curb excesses in the State-based medical liability systems through Federally mandated reforms.

SEC. 3002. DEFINITIONS.

As used in this title:

(1) ADR ADVISORY BOARD.—The term ''ADR Advisory Board'' means the Alternative Dispute Resolution Advisory Board established by the Sec-

retary of Health and Human Services under section 3202(a).

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term ''alternative dispute resolution system'' means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a medical malpractice liability claim and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such a claim is brought.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(5) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical ex-

penses, lost wages, lost employment, and other pecuniary losses.

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

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice claim.

(9) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any

action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(10) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means any claim relating to the provision of (or the failure to provide) health care services or the use of a medical product, without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counterclaim, or contribution claim in a medical malpractice liability action.

(11) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect

to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(12) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and

emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(13) PUNITIVE DAMAGES.—The term ''punitive damages'' means compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

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

(15) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Subtitle B—Uniform Standards for Malpractice Claims

SEC. 3101. APPLICABILITY.

Except as provided in section 3111, this subtitle shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 3102. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 3202(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 3202(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish

an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

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

(2) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—If no party files a notice of intent to contest a decision reached under an alternative dispute resolution system pursuant to section 3103(a)(1), the decision shall be enforced by a court of competent jurisdiction in the same manner as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court.

SEC. 3103. PROCEDURAL REQUIREMENTS FOR FILING OF ACTIONS.

(a) PROCEDURES FOR FILING ACTIONS AFTER DECISION.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought with respect to a medical malpractice liability claim that

is the subject of a decision under an alternative dispute resolution system unless—

(A) a party has filed a notice of intent to contest the decision under the alternative dispute resolution system pursuant to paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 60 days after the notice of intent is filed pursuant to paragraph (1) (or, if such notice of intent is filed by a party other than the claimant, not later than 90 days after such notice is filed).

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

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

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(b) CERTIFICATE OF MERIT.—

(1) IN GENERAL.—Each individual who files a notice of intent to contest a decision under the alternative dispute resolution system pursuant to subsection (a)(1) shall, not later than 90 days after the

applicable medical malpractice liability action is filed—

(A) submit a certificate of merit described in subsection (b); or

(B) post a surety (or equivalent security) bond of $4,000 (or, during the 45-day period that begins on the date the action is filed, a cost bond of $2,000) with the court.

(2) EXTENSION OF DEADLINE.—On the motion of any party to the action or upon a written agreement of the parties filed with the court, the court may extend the deadline specified in paragraph (1) for a period not to exceed 30 days.

(3) WAIVER FOR GOOD CAUSE.—The court may waive the application of paragraph (1) to a plaintiff if the plaintiff shows good cause that such paragraph should not apply.

(4) CERTIFICATE OF MERIT DESCRIBED.—In this subsection, a ''certificate of merit'' means—

(A) with respect to a plaintiff, an affidavit declaring that the individual (or the individual's attorney) has obtained a written opinion from a medical expert who is knowledgeable of the relevant medical issues involved in the action that the defendant was negligent and the defend-

ant's conduct was a proximate cause of the alleged injury that is the subject of the action; and

(B) with respect to a defendant, an affidavit declaring that the individual (or the individual's attorney) has obtained a written opinion from a medical expert who is knowledgeable of the relevant medical issues involved in the action that the defendant followed the appropriate standards or procedures and exercised due care, and that the defendant's conduct was not the proximate cause of the alleged injury that is the subject of the action.

(c) EFFECT OF FAILURE TO MEET REQUIREMENT TO FILE CERTIFICATE.—If an individual fails to file a certificate of merit with respect to a medical malpractice liability action under subsection (b)—

(1) if the individual is a plaintiff, the court shall dismiss the action without prejudice to the refiling of the action by the individual;

(2) if the individual is a defendant, the court shall award judgment to the plaintiff based on the plaintiff's pleadings; and

(3) the court shall require the individual to pay any court costs incurred by the opposing parties as a result of the filing of the action.

(d) JUDICIAL NOTICE OF DECISION UNDER ADR SYSTEM.—A medical malpractice liability action brought after a decision on the claim that is the subject of the action has been reached under an alternative dispute resolution system shall be tried de novo, except that the court shall take judicial notice of such decision and (in the case of an action tried by a jury) shall read the decision to the jury prior to any opening statements and make the decision available to the jury during the trial.

SEC. 3104. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) TREATMENT OF PUNITIVE DAMAGES AWARDED AGAINST MANUFACTURER OF MEDICAL PRODUCT.—

(1) LIMITATION ON AMOUNT OF AWARD.—The total amount of punitive or exemplary damages that may be awarded with respect to an injury which is the subject of a medical malpractice liability action may not exceed twice the total amount of other damages awarded with respect to the injury.

(2) DISTRIBUTION OF AWARD.—Of the total amount of any punitive damages awarded in a medical malpractice liability action, 50 percent shall be paid to the claimant and 50 percent shall be paid to the State in which the action is brought (or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided) for the purposes of carrying out the activities described in paragraph (3).

(3) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to paragraph (2) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(A) implementing health care quality assurance programs;

(B) carrying out programs to reduce malpractice-related costs for providers volunteering

to provide services in medically underserved areas; and

(C) implementing and operating a State alternative dispute resolution system certified by the Secretary under section 3203.

(4) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (2) to supplement and not to replace amounts spent by the State for the activities described in paragraph (3).

(c) SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.—The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

SEC. 3105. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) PERIODIC PAYMENTS PERMITTED.—

(1) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on a periodic basis if the court—

(A) determines that economic damages incurred through the date of the award shall be paid;

(B) bases the periods for such payments upon projections of when such expenses are likely to be incurred; and

(C) determines that the periodic payments are adequately secured.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 3106. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a medical malpractice liability claim may not charge, demand, receive, or collect for services rendered in connection with such claim in excess of the following amount recovered by judgment or settlement under such claim:

(A) 25 percent of the first $100,000 (or portion thereof) recovered.

(B) 20 percent of the next $150,000 (or portion thereof) recovered.

(C) 15 percent of the next $250,000 (or portion thereof) recovered.

(D) 10 percent of any amount in excess of $500,000 recovered.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 3107. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that

is the subject of such claim was discovered or the date on which such injury should reasonably have been discovered, whichever is earlier.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may be initiated after the expiration of the period described in subsection (a) if the claim is initiated before the minor attains 8 years of age.

SEC. 3108. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a medical malpractice claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose

members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

SEC. 3109. APPLICATION OF MEDICAL PRACTICE PARAMETERS IN MALPRACTICE LIABILITY ACTIONS.

(a) USE OF PARAMETERS AS AFFIRMATIVE DEFENSE.—In any medical malpractice liability action, it shall be a complete defense to any allegation that the defendant was negligent that, in the provision of (or the failure to provide) the services that are the subject of the action, the defendant followed the appropriate practice parameter.

(b) RESTRICTION ON PARAMETERS CONSIDERED APPROPRIATE.—

(1) PARAMETERS SANCTIONED BY SECRETARY.—For purposes of subsection (a), a practice parameter may not be considered appropriate with respect to actions brought during a year unless the Secretary has sanctioned the use of the parameter for purposes of an affirmative defense to medical malpractice liability actions brought during the year in accordance with paragraph (2) or (3).

(2) PROCESS FOR SANCTIONING PARAMETERS.—Not less frequently than October 1 of each

year (beginning with 1995), the Secretary shall review the practice guidelines and standards developed by the Administrator for Health Care Policy and Research pursuant to section 1142 of the Social Security Act, and shall sanction those guidelines which the Secretary considers appropriate for purposes of an affirmative defense to medical malpractice liability actions brought during the next calendar year as appropriate practice parameters for purposes of subsection (a).

(3) USE OF STATE PARAMETERS.—Upon the application of a State, the Secretary may sanction practice parameters selected by the State for purposes of an affirmative defense to medical malpractice liability actions brought in the State as appropriate practice parameters for purposes of subsection (a) if the parameters meet such requirements as the Secretary may impose.

(c) PROHIBITING APPLICATION OF FAILURE TO FOLLOW PARAMETERS AS PRIMA FACIE EVIDENCE OF NEGLIGENCE.—No plaintiff in a medical malpractice liability action may be deemed to have presented prima facie evidence that a defendant was negligent solely by showing that the defendant failed to follow the appropriate practice parameter.

SEC. 3110. JURISDICTION OF FEDERAL COURTS.

Nothing in this subtitle shall be construed to establish jurisdiction over any medical malpractice liability action in the district courts of the United States on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 3111. PREEMPTION.

(a) IN GENERAL.—This subtitle supersedes any State law only to the extent that the State law permits the recovery by a claimant or the assessment against a defendant of a greater amount of damages or establishes a less strict standard of proof for determining whether a defendant has committed malpractice, than the provisions of this subtitle.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

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

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

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

Subtitle C—Requirements for State Alternative Dispute Resolution Systems (ADR)

SEC. 3201. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

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

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

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

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a

professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

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

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of subtitle B (other than sections 3102 and 3103) shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 3202. ALTERNATIVE DISPUTE RESOLUTION ADVISORY BOARD.

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish an Alternative Dispute Resolution Advisory Board to advise the Secretary regarding the establishment

of alternative dispute resolution systems at the State and Federal levels.

(b) COMPOSITION.—The ADR Advisory Board shall be composed of members appointed by the Secretary from among representatives of the following:

(1) Physicians.

(2) Hospitals.

(3) Patient advocacy groups.

(4) State governments.

(5) Academic experts from applicable disciplines (including medicine, law, public health, and economics) and specialists in arbitration and dispute resolution.

(6) Health insurers and medical malpractice insurers.

(7) Medical product manufacturers.

(8) Pharmaceutical companies.

(9) Other professions and groups determined appropriate by the Secretary.

(c) DUTIES.—The ADR Advisory Board shall—

(1) examine various dispute resolution systems and provide advice and assistance to States regarding the establishment of such systems;

(2) not later than 1 year after the appointment of its members, submit to the Secretary—

(A) a model alternative dispute resolution system that may be used by a State for purposes of this subtitle, and

(B) a model alternative Federal system that may be used by the Secretary pursuant to section 3203(b)(1); and

(3) review the applications of States for certification of State alternative dispute resolution systems and make recommendations to the Secretary regarding whether the systems should be certified under section 3203.

SEC. 3203. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) APPLICATION BY STATE.—Each State shall submit an application to the ADR Advisory Board describing its alternative dispute resolution system and containing such information as the ADR Advisory Board may require to make a recommendation regarding whether the system meets the requirements of this subtitle.

(2) BASIS FOR CERTIFICATION.—Not later than October 1 of each year (beginning with 1995), the Secretary, taking into consideration the recommendations of the ADR Advisory Board, shall

certify a State's alternative dispute resolution system under this subsection for the following calendar year if the Secretary determines that the system meets the requirements of section 3201.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, taking into consideration the model alternative Federal system submitted by the ADR Advisory Board under section 3202(c)(2)(B), shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 3201(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and

resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

SEC. 3204. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and

evaluating State alternative dispute resolution systems operated pursuant to this subtitle and the alternative Federal system established under section 3203(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

TITLE IV—PAPERWORK REDUCTION AND ADMINISTRATIVE SIMPLIFICATION

SEC. 4001. PREEMPTION OF STATE QUILL PEN LAWS.

After 1995, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form.

SEC. 4002. CONFIDENTIALITY OF ELECTRONIC HEALTH CARE INFORMATION.

(a) PROMULGATION OF REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall promulgate, and may modify from time to time, requirements to facilitate and ensure the uniform, confidential treatment of individually identifiable health care information in electronic environments.

(2) ITEMS TO BE INCLUDED.—The requirements under this subsection shall—

(A) provide for the preservation of confidentiality and privacy rights in electronic health care claims processing and payment;

(B) apply to the collection, storage, handling, and transmission of individually identifiable health care data (including initial and sub-

sequent disclosures) in electronic form by all accountable health plans, public and private third-party payers, providers of health care, and all other entities involved in the transactions;

(C) not apply to public health reporting required under State or Federal law;

(D) delineate protocols for securing electronic storage, processing, and transmission of health care data;

(E) specify fair information practices that assure a proper balance between required disclosures and use of data, including—

(i) creating a proper balance between what an individual is expected to divulge to a record-keeping organization and what the individual seeks in return,

(ii) minimizing the extent to which information concerning an individual is itself a source of unfairness in any decision made on the basis of such information, and

(iii) creating and defining obligations respecting the uses and disclosures that will be made of recorded information about an individual;

(F) require publication of the existence of health care data banks;

(G) establish appropriate protections for highly sensitive data (such as data concerning mental health, substance abuse, and communicable and genetic diseases);

(H) encourage the use of alternative dispute resolution mechanisms (where appropriate); and

(I) provide for the deletion of information that is no longer needed to carry out the purpose for which it was collected.

(3) CONSULTATION WITH WORKING GROUP.—In promulgating and modifying requirements under this subsection, the Secretary shall consult with a working group of knowledgeable individuals representing all interested parties (including third-party payers, providers, consumers, employers, information managers, and technical experts).

(4) DEADLINE.—The Secretary shall first promulgate requirements under this subsection by not later than six months after the date of the enactment of this Act.

(b) APPLICATION OF REQUIREMENTS.—

(1) STATE ENFORCEMENT OF SIMILAR REQUIREMENTS.—The requirements promulgated under subsection (a) shall not apply to health care information in a State if—

(A) the State has applied to the Secretary for a determination that the State has in effect a law that provides for the application of requirements with respect to such information (and enforcement provisions with respect to such requirements) consistent with such requirements (and with the enforcement provisions of subsection (c)), and

(B) the Secretary determines that the State has such a law in effect.

(2) APPLICATION TO CURRENT INFORMATION.—The Secretary shall specify the extent to which (and manner in which) the requirements promulgated under subsection (a) apply to information collected before the effective date of the requirements.

(c) DEFENSE FOR PROPER DISCLOSURES.—An entity that establishes that it has disclosed health care information in accordance with the requirements promulgated under subsection (a) has established a defense in an action brought for improper disclosure of such information.

(d) PENALTIES FOR VIOLATIONS.—An entity that collects, stores, handles, transmits, or discloses health care information in violation of the requirements promulgated under subsection (a) is liable for civil damages, equitable remedies, and attorneys' fees (if appropriate), in accordance with regulations of the Secretary.

SEC. 4003. STANDARDIZATION FOR THE ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH PLAN INFORMATION.

(a) GOALS.—The Secretary shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in eliminating unnecessary paperwork and achieving appropriate standardization in the areas of electronic receipt and transmission of health care claims and health plan information and eligibility verification (consistent with the requirements promulgated under section 4002(a)).

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) standards and requirements concerning the electronic receipt and transmission of health plan claims forms and other health plan information.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health plan (other than a health plan described in paragraph (2)) that fails to comply with standards and requirements promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards and requirements promulgated under subsection (b), and

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

(d) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with the Accredited Standards Committee X–12 of the American National Standards Institute, insurers, providers, and others.

SEC. 4004. USE OF UNIFORM HEALTH CLAIMS FORMS AND IDENTIFICATION NUMBERS.

(a) GOALS.—The Secretary shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity—

(1) in the format and content of basic claims forms under health plans, and

(2) in the use of common identification numbers for beneficiaries and providers of health care items or services under health plans.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) standards and requirements concerning—

(1) the format and content of basic claims forms under health plans, and

(2) the common identification numbers to be used by health plans to identify health plan beneficiaries and health care providers.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health plan (other than a health plan described in paragraph (2)) that fails to comply with standards and requirements promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards and requirements promulgated under subsection (b), and

(B) the State regulatory program provides for the appropriate and effective enforcement of

such standards and requirements with respect to such plans.

(d) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with the Workgroup for Electronic Data Interchange and with insurers, providers, and others.

SEC. 4005. PRIORITY AMONG INSURERS.

(a) GOALS.—The Secretary shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity in the rules for determining the liability of insurers when benefits are payable under two or more health plans.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) rules for determining the liability of health plans when benefits are payable under two or more health plans.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health plan (other than a health plan described in paragraph (2)) that fails to comply with rules promulgated under subsection (b) in an amount not to exceed $100 for each such

failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the rules established under subsection (b), and

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

(d) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with health plans.

SEC. 4006. FURNISHING OF INFORMATION AMONG HEALTH PLANS.

(a) GOALS.—The Secretary shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity

in the availability of information among health plans when benefits are payable under two or more health plans.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) requirements concerning the transfer among health plans (and annual updating) of appropriate information (which may include requirements for the use of unique identifiers, and for the listing of all individuals covered under a health plan).

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health plan (other than a health plan described in paragraph (2)) that fails to comply with requirements promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirements promulgated under subsection (b), and

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

(d) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with health plans.

SEC. 4007. DEFINITIONS.

For purposes of this title—

(1) The term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract (including any closed accountable health plan), but does not include (except for purposes of sections 4005 and 4006)—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

(B) coverage issued as a supplement to liability insurance,

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

(2) The term ''provider'' means a physician, hospital, pharmacy, laboratory, or other person licensed or otherwise authorized under applicable State laws to furnish health care items or services.

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

TITLE V—EXPANDING ACCESS/ PREVENTIVE CARE

Subtitle A—Expanding Access Through Community Health Authorities

SEC. 5001. COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 13631(b) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) by redesignating section 1931 as section 1932; and

(2) by inserting after section 1930 the following new section:

''COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS

''SEC. 1931. (a) IN GENERAL.—In order to test the effectiveness of various innovative health care delivery approaches through the operation of community health authorities, the Secretary shall operate a program under which States establish projects to demonstrate the effectiveness of such approaches in providing access to cost-effective preventive and primary care and related services for various areas and populations, including low-income residents of medically underserved areas or for medically

underserved populations. A State may operate more than one such project.

''(b) SELECTION OF STATE PROJECTS.—

''(1) IN GENERAL.—A State is eligible to participate in the program, and establish a demonstration project, under this section only if—

''(A) the State submits to the Secretary an application, at such time and in such form as the Secretary may require, for participation in the program; and

''(B) the Secretary finds that—

''(i) the application contains assurances that the State will support the development of a community health authority that meets the requirements of this section,

''(ii) the community health authority will meet the requirements for such an authority under subsection (c),

''(iii) the State provides sufficient assurances that the demonstration project of a community health authority meets (or, when operational, will meet) the requirements of subsection (d), and

''(iv) the State will comply with the requirements of subsections (g) and (h).

''(2) CONTENTS OF APPLICATION.—Each application submitted under paragraph (1) for a demonstration project shall include at least the following:

''(A) A description of the proposed community health authority and of the area or population that the authority will serve.

''(B) A demonstration that the CHA will serve at least one geographic area or population group that is designated as medically underserved under section 330 of the Public Health Service Act or as having a shortage of health professionals under section 332 of such Act.

''(C) An assessment of the area's or population's need for services and an assurance that the services of the CHA will be responsive to those needs.

''(D) A list of the items and services to be furnished by the CHA under the project, broken down by those items and services that are treated as medical assistance under the State plan under this title and other items and services that will be provided by the CHA (either

directly or through coordination with other entities).

''(E) An assurance that the CHA has entered into (or plans to enter into) written participation agreements with a sufficient number of providers to enable the CHA to furnish all of such items and services to enrolled individuals.

''(F) An assurance that the State plan under this title will provide payment to the authority in accordance with subsection (e).

''(G) Evidence of support and assistance from other State agencies with responsibility for providing or supporting the provision of preventive and primary care services to underserved and at-risk populations.

''(H) A proposed budget for the CHA.

''(3) PRIORITY.—The Secretary shall give priority to those applications proposing to support a CHA that includes as participating providers all Federally-qualified health centers serving the area or population or (in areas for which there are no Federally-qualified health centers) all entities that would be Federally-qualified health centers but for the failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or

the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

''(4) PERIOD OF APPROVAL.—Each project approved under this section shall be approved for a period of not less than 5 years, subject to renewal for subsequent periods unless such approval is withdrawn for cause by the Secretary or at the request of the State.

''(c) COMMUNITY HEALTH AUTHORITY (CHA) DEFINED.—In this section, the terms 'community health authority' and 'CHA' mean a nonprofit entity that meets the following requirements:

''(1) The entity serves (or will serve at the time it becomes operational under a project) a geographic area or population group that includes those designated—

''(A) under section 330 of the Public Health Service Act as medically underserved, or

''(B) under section 332 of such Act as a health professions shortage area.

''(2) The entity enrolls—

''(A) individuals and families who are medicaid-eligible;

''(B) within the limits of its available resources and capacity, other individuals who have incomes below 200 percent of the Federal official poverty level; and

''(C) within the limits of its available resources and capacity, other individuals and families who are able to pay the costs of enrollment.

''(3) Through its participating providers, the entity provides or, through contracts, arranges for the provision of (or, by the time it become operational, will so provide or arrange for the provision of) at least preventive services, primary care services, inpatient and outpatient hospital services, and any other service provided by a participating provider for which payment may be made under the State plan under this title to enrolled individuals.

''(4) The entity must include (to the maximum extent practicable) as participating providers any of the following providers that furnish services provided by (or arranged by) the entity that are located in or serve the area or population to be covered:

''(A) Federally-qualified health centers.

''(B) Rural health clinics.

''(C) Local public health agencies that furnish such services.

''(D) A hospital (or other provider of inpatient or outpatient hospital services) which has a participation agreement in effect with the State under its plan under this title, which is located in or serving the area or population to be served.

''(5) The entity may include as participating providers other providers (which may include private physicians or group practice offices, other community clinics, limited service providers (such as prenatal clinics), and health professionals teaching programs (such as area health educational centers)) and take other appropriate steps, to the extent needed to assure that the network is reasonable in size and able to provide (or arrange for the provision of) the services it proposes to furnish to its enrollees.

''(6) The entity must maintain written agreements with each participating provider under which the provider agrees to participate in the CHA and agrees to accept payment from the CHA as payment in full for services furnished to individuals enrolled with the CHA (subject to the requirements of subsection (g)(4), in the case of services furnished by a

provider that are described in subparagraph (B) or (C) of section 1905(a)(2)).

''(7) Under the written agreements described in paragraph (6), if a majority of the board of directors of the entity has determined that a participating provider is failing to meet any of the requirements of the participation agreement, the board may terminate the provider's participation agreement in accordance with the following requirements:

''(A) Subject to subparagraph (B), prior to any termination of a provider's participation agreement, the provider shall be entitled to 30 days prior notice, a reasonable opportunity to correct any deficiencies, and an opportunity for a full and fair hearing conducted by the entity to dispute the reasons for termination. The provider shall be entitled to appeal the board of directors' decision directly to a committee consisting of representatives of all of the entity's participating providers.

''(B) If a majority of the board of directors of the entity determines that the continued participation of a provider presents an immediate threat to the health and safety of patients or a substantial risk of improper diversion of funds,

the board may suspend the provider's participation agreement (including the receipt of funds under the agreement) for a period of up to 60 days. During this period, the entity shall take steps to ensure that patients who were assigned to or cared for by the suspended provider are appropriately assigned or referred to alternative participating providers. The suspended provider shall be entitled to a hearing within the period of the suspension to show cause why the suspension should be lifted and its participation agreement restored. If dissatisfied with the board's decision, the provider shall be entitled to appeal the decision directly to a committee consisting of representatives of all of the entity's participating providers.

''(C) For all other disputes between the entity and its participating providers (including disputes over the amounts due or interim rates to be paid to a provider), the entity shall provide an opportunity for a full and fair hearing.

''(8) The entity must be governed by a board of directors that includes representatives of the participating providers and, as appropriate, other health professionals, civic or business leaders, elected offi-

cials, and residents of the area or population served. Not less than 51 percent of such board shall be composed of individuals who are enrolled in the CHA and who are representatives of the community served.

''(d) DEMONSTRATION PROJECT REQUIREMENTS.—The requirements of this subsection, with respect to a demonstration project of a CHA under this section, are as follows:

''(1)(A) All services furnished by the CHA under the project shall be available and accessible to all enrolled individuals and, except as provided in subparagraph (B), must be available without regard to an individual's ability to pay for such services.

''(B) A CHA shall prepare a schedule of discounts to be applied to the payment of premiums by individuals who are not medicaid-eligible individuals which shall be adjusted on the basis of the individual's ability to pay.

''(2) The CHA shall take appropriate steps to emphasize the provision of preventive and primary care services, and shall ensure that each enrolled individual is assigned to a primary care physician (to the greatest extent appropriate and feasible), except that the CHA shall establish a process through

which an enrolled individual may be assigned to another primary care physician for good cause shown.

''(3) The CHA must make reasonable efforts to reduce the unnecessary or inappropriate use of hospital or other high-cost services through an emphasis on preventive and primary care services, the implementation of utilization review or other appropriate methods.

''(4) The State must regularly provide the CHA with information on other medical, health, and related benefits that may be available to individuals enrolled with the CHA under programs other than the State plan under this title, and the CHA must provide its enrolled individuals with enrollment information and other assistance to assist them in obtaining such benefits.

''(5) The State and the CHA must meet such financial standards and requirements and reporting requirements as the Secretary specifies and must prepare and submit to the Secretary an annual independent financial audit conducted in accordance with requirements specified by the Secretary.

''(6) In collaboration with the State, the CHA must adopt and use community-oriented, patient-responsive quality assurance and control systems in

accordance with requirements specified by the Secretary. Such systems must include at least an ongoing quality assurance program that measures consumer satisfaction with the care provided under the network, stresses improved health outcomes, and operates a community health status improvement process that identifies and investigates community health problems and implements measures designed to remedy them.

''(e) CAPITATION PAYMENTS.—

''(1) IN GENERAL.—Under a demonstration project under this section, the State shall enter into an annual contract with the CHA under which the State shall make monthly payments to the CHA for covered services furnished through the CHA to individuals entitled to medical assistance under this title in the amount specified in paragraph (2). Payment shall be made at the beginning of each month on the basis of estimates of the amounts payable and amounts subsequently paid are subject to adjustment to reflect the amounts by which previous payments were greater or less than the amount of payments that should have been made.

''(2) AMOUNT OF CAPITATION PAYMENT.—The amount of a monthly payment under paragraph (1)

during a contract year, shall be not less than 1/12 of the product of—

''(A)(i) the average per capita amounts expended under this title under the State plan for covered services to be furnished under the demonstration project for similar Medicaid-eligible individuals for the most recent 12-month period ending before the date of the enactment of this section, increased by (ii) the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) during the period that begins upon the expiration of such 12-month period and ends upon the expiration of the most recent 12-month period ending before the first month of the contract year for which complete financial data on such index is available, and

''(B) the number of Medicaid-eligible individuals enrolled under the project as of the 15th day of the month prior to the first month of the contract year (or, in the case of the first year for which a contract is in effect under this subsection, the CHA's reasonable estimate of the number of such individuals who will be en-

rolled in the project as of the 15th day of such month).

''(f) ADDITIONAL STATE ASSISTANCE FOR PLANNING, DEVELOPMENT, AND OPERATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), in addition to the payments under subsection (e), demonstration projects approved under this section are eligible to have approved expenditures described in paragraph (3) treated, for purposes of section 1903(a)(7), as expenditures found necessary by the Secretary for the proper and efficient administration of the State plan under this title.

''(2) SPECIAL RULES.—

''(A) LIMITATION WITH RESPECT TO ANY COMMUNITY HEALTH AUTHORITY.—The total amount of expenditures with respect to any CHA that may be treated as expenditures for medical assistance under paragraph (1) for any 12-month period shall not exceed $250,000.

''(B) LIMITATION ON NUMBER OF YEARS.—The number of 12-month periods for which expenditures are treated as expenditures for medical assistance under paragraph (1) for a CHA shall not exceed—

''(i) 2 for expenditures for planning and development assistance, described in paragraph (3)(A), and

''(ii) 2 for expenditures for operational assistance, described in paragraph (3)(B).

''(C) NO RESULTING REDUCTION IN AMOUNTS PROVIDED UNDER PHSA GRANTS.—No grant to a CHA or one of its participating providers under the Public Health Service Act or this Act may be reduced on the ground that activities of the CHA that are considered approved expenditures under paragraph (3) are activities for which the CHA or the participating providers received funds under such Act.

''(3) APPROVED EXPENDITURES.—The approved expenditures described in this paragraph are as follows:

''(A) PLANNING AND DEVELOPMENT.—Expenditures for planning and development with respect to a CHA, including—

''(i) developing internal management, legal and financial and clinical, information, and reporting systems for the CHA,

and carrying out other operating activities of the CHA;

''(ii) recruiting, training and compensating management staff of the CHA and, as appropriate and necessary, management and clinical staff of any participating provider;

''(iii) purchasing essential equipment and acquiring, modernizing, expanding, or (if cost-effective) constructing facilities for the CHA and for participating providers (including amortization costs and payment of interest on loans); and

''(iv) entering into arrangements to obtain or participate in emerging medical technologies, including telemedicine.

''(B) OPERATIONS.—Expenditures in support of the operations of a CHA, including—

''(i) the ongoing management of the CHA, including daily program administration, recordkeeping and reporting, assurance of proper financial management (including billings and collections) and oversight of program quality;

''(ii) developing and operating systems to enroll eligible individuals in the CHA;

''(iii) data collection, in collaboration with the State medicaid agency and the State health department, designed to measure changes in patient access to care, the quality of care furnished, and patient health status, and health care outcomes;

''(iv) ongoing community outreach and community education to all residents of the area or population served, to promote the enrollment of eligible individuals and the appropriate utilization of health services by such individuals;

''(v) the establishment of necessary reserves or purchase of stop-loss coverage; and

''(vi) activities relating to health professions training, including residency training at participating provider sites.

''(g) ADDITIONAL REQUIREMENTS.—

''(1) MANDATORY ENROLLMENT OF MEDICAID-ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of section 1903(m), a State participating in a demonstration project under this section may require

that each medicaid-eligible resident in the service area of a CHA operating under the project is not eligible to receive any medical assistance under the State plan that may be obtained through enrollment with the CHA unless the individual receives such assistance through enrollment with the CHA.

''(2) CONTINUED ENTITLEMENT TO ADDITIONAL BENEFITS.—In the case of a medicaid-eligible individual enrolled with a CHA under a demonstration project under this section, the individual shall remain entitled to medical assistance for services which are not covered services under the project.

''(3) HMO-RELATED REQUIREMENTS.—A CHA under this section shall be deemed to meet the requirements of section 1903(m) (subject to paragraph (1)) in the same manner as an entity listed under section 1903(m)(2)(G).

''(4) TREATMENT OF FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—Payments under a demonstration project under this section to a Federally qualified health center or rural health clinic which is a participating provider shall be made consistent with section 1902(a)(13)(E) for all services offered by the CHA which are provided by such a center or clinic.

''(5) OUTSTATIONING ELIGIBILITY WORKERS.—Under the project, the State may (in addition to meeting the requirements of section 1902(a)(55)) provide for, or pay the reasonable costs of, stationing eligibility workers at appropriate service sites under the project, and may permit medicaid-eligible individuals to be enrolled under the State plan at such a CHA or at such a site.

''(6) PURCHASE OF STOP-LOSS COVERAGE.—The State shall ensure that the CHA has purchased stop-loss coverage to protect against default on its obligations under the project. If an entity otherwise qualified to serve as a CHA is prohibited under State law from purchasing such coverage, the State shall waive the application of such law to the extent necessary to permit the entity to purchase such coverage.

''(h) EVALUATION AND REPORTING.—

''(1) CHA.—Each CHA in a State with a demonstration project approved under this section shall prepare and submit to the State an annual report on its activities during the previous year.

''(2) STATE.—Taking into account the reports submitted pursuant to paragraph (1), each State with a demonstration project approved under this

section shall prepare and submit to the Secretary an annual evaluation of its activities and services under this section. Such evaluation shall include an analysis of the effectiveness of the project in providing cost-effective health care to enrolled individuals.

''(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the demonstration projects conducted under this section. Such report shall include an analysis of the effectiveness of such projects in providing cost-effective health care for the areas or populations served.

''(i) COLLABORATION IN ADMINISTRATION.—In carrying out this section, the Secretary shall assure the highest possible level of collaboration between the Health Care Financing Administration and the Public Health Service. Such collaboration may include (if appropriate and feasible) any of the following:

''(1) The provision by the Public Health Service of new or increased grant support to eligible entities participating in a CHA, in order to expand the availability of services (particularly preventive and primary care services).

''(2) The placement of health professionals at eligible locations and collaboration with Federally-as-

sisted health professions training programs located in or near the areas served by community health authorities.

''(3) The provision of technical and other non-financial assistance.

''(j) DEFINITIONS.—In this section:

''(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The term 'medicaid-eligible individual' means an individual described in section 1902(a)(10)(A) and entitled to medical assistance under the State plan.

''(2) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to a CHA, a provider that has entered into an agreement with the CHA for the provision of covered services under a project under this section.

''(3) PREVENTIVE AND PRIMARY CARE SERVICES.—'Preventive' and 'primary' services include those services described in section 1905(l)(2)(A) and included as Federally-qualified health center services.''.

(b) CONTINUED MEDICAID ELIGIBILITY FOR UP TO 1 YEAR.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A)—

(A) by inserting ''or with a community health authority under a demonstration project under section 1931'' after ''section 1876'', and

(B) by striking ''such organization or entity'' and inserting ''such organization, entity, or authority''; and

(2) in subparagraph (B), by striking ''effective.'' and inserting the following: ''effective (or, in the case of an individual enrolled with a community health authority under a demonstration project under section 1931, of not more than 1 year beginning on the date the individual's enrollment with the authority becomes effective).''.

(c) EXCEPTION TO ANTI-KICKBACK LAW.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

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

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

''(F) any remuneration paid, or received, by a Federally qualified health center, rural health clinic, or other entity which is a participating provider

under a demonstration project under section 1931 as part of an arrangement for the procurement of goods or services or the referral of patients or the lease or purchase of space or equipment.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after October 1, 1994.

SEC. 5002. HEALTH CENTER PROGRAM AMENDMENTS.

(a) AUTHORIZATION OF GRANTS FOR NETWORK DEVELOPMENT.—

(1) MIGRANT HEALTH CENTERS.—Section 329 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

''(j)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of health service networks (as defined in paragraph (3)) which will serve high impact areas, medically underserved areas, or medically underserved populations within the area they serve (or propose to serve).

''(2) A grant under this subsection for the planning and development of a health service network may be used for the following costs:

''(A) The costs of developing the network corporate entity, including planning and needs assessment.

''(B) The costs of developing internal management for the network, as well as costs of developing legal, financial, clinical, information, billing, and reporting systems, and other costs necessary to achieve operational status.

''(C) The costs of recruitment, training, and compensation of management staff of the network and, as appropriate and necessary, the management and clinical staff of any participating provider.

''(D) The costs of developing additional primary health and related service sites, including costs related to purchase of essential equipment, acquisition, modernization, expansion, or, if cost-effective, construction of facilities.

''(3) In this subsection, the term 'health service network' means a nonprofit private entity that—

''(A) through its participating providers (which may provide services directly or through contract) assures the provision of primary health and related services and, as appropriate, supplemental health services to residents of the high impact area or

medically underserved area or members of the medically underserved population covered by the network,

''(B) includes, as participating providers, at least all recipients of grants under this section or section 330, 340, or 340A that provide primary health and related services to the residents of the area it serves (or proposes to serve), and that may include, at the entity's option, any other providers of primary health or supplemental health services to residents of the high impact area or medically underserved area or members of the medically underserved population covered by the network, but only if such participating providers agree to provide services without regard to an individual's ability to pay, and

''(C) is governed by individuals a majority of whom are patients, employees, or board members of its participating providers that receive grants under this section or section 330, 340, or 340A.''.

(2) COMMUNITY HEALTH CENTERS.—Section 330 of such Act (42 U.S.C. 254c) is amended by adding at the end the following:

''(l)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of

health service networks (as defined in section 329(j)(3)) which will serve high impact areas, medically underserved areas, or medically underserved populations within the area they serve (or propose to serve).

''(2) A grant under this subsection for the planning and development of a health service network may be used for the costs described in section 329(j)(2).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—

(1) MIGRANT HEALTH CENTERS.—Section 329(h)(1)(A) of such Act (42 U.S.C. 254b(h)(1)(A)) is amended—

(A) by inserting ''and subsection (j)'' after ''through (e)'', and

(B) by striking ''1994'' and inserting ''1999''.

(2) COMMUNITY HEALTH CENTERS.—Section 330(g)(1)(A) of such Act (42 U.S.C. 254c(g)(1)(A)) is amended by striking ''1994'' and inserting ''1999''.

Subtitle B—Expansion of Public Health Programs on Preventive Health

SEC. 5101. IMMUNIZATIONS AGAINST VACCINE-PREVENTABLE DISEASES.

Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)), as redesignated by section 301(b)(1) of Public Law 103–183 (107 Stat. 2235), is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 5102. PREVENTION, CONTROL, AND ELIMINATION OF TUBERCULOSIS.

Section 317E(g) of the Public Health Service Act (42 U.S.C. 247b–6(g)), as added by section 301(a) of Public Law 103–183 (107 Stat. 2234), is amended—

(1) in paragraph (1)(A), by striking ''through 1998'' and inserting ''through 1999''; and

(2) in paragraph (2), by striking ''through 1998'' and inserting ''through 1999''.

SEC. 5103. LEAD POISONING PREVENTION.–

Section 317A(l)(1) of the Public Health Service Act (42 U.S.C. 247b–1(l)(1)) is amended by striking ''through 1997'' and inserting ''through 1999''.

SEC. 5104. PREVENTIVE HEALTH MEASURES WITH RESPECT TO BREAST AND CERVICAL CANCERS.

Section 1510(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)), as redesignated by section 102(a)(1) of Public Law 103–183 (107 Stat. 2229) and amended by section 103 of such Public Law (107 Stat. 2230), is amended by striking ''through 1998'' and inserting ''through 1999.''.

SEC. 5105. OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION.

(a) IN GENERAL.—Section 1701(b) of the Public Health Service Act (42 U.S.C. 300u(b)) is amended by striking ''through 1996'' and inserting ''through 1999''.

(b) PROMOTION OF INDIVIDUAL RESPONSIBILITY.—Section 1701(a)(11) of such Act (42 U.S.C. 300u(a)(11)) is amended—

(1) by striking ''and'' at the end of subparagraph (C),

(2) by redesignating subparagraph (D) as subparagraph (E), and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) promote individual responsibility in personal health care and in the use of valuable health care resources; and''.

(c) MINORITY HEALTH.—Section 1707(f) of such Act (42 U.S.C. 300u–6(f)) is amended by striking ''1993.'' and inserting ''1993, $35,000,000 for each of the fiscal years 1994 through 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999.''.

SEC. 5106. PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.

Section 1901(a) of the Public Health Service Act (42 U.S.C. 300w(a)) is amended by striking ''through 1997'' and inserting ''through 1999''.

TITLE VI—ANTITRUST PROVISIONS

SEC. 6001. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate the development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to Attorney General to obtain a prompt opinion (but

in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A); and

(2) the term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

(B) coverage issued as a supplement to liability insurance,

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 6002. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary of Health and Human Services, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such activity, and the parties to such activity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the activity is likely—

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative activity on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve

the benefits that are intended to be achieved by carrying out the activity.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care collaborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE ACTIVITY.—To be an eligible health care collaborative activity for purposes of this section, a health care collaborative activity shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the activity that the activity will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the activity,

(2) an agreement that the activity will submit to the Attorney General annually a report that describes the operations of the activity and information regarding the impact of the activity on health care and on competition in health care, and

(3) an agreement that the parties to the activity will notify the Attorney General and the Secretary of the termination of the activity not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care collaborative activity submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care collaborative activity with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws'' has the meaning given it in section 6001(c)(1).

(2) The term ''certificate'' means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term ''health care collaborative activity'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(4) The term ''health care services'' includes services related to the delivery or administration of health care services.

(5) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(6) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

TITLE VII—PREFUNDING GOVERNMENT HEALTH BENEFITS FOR CERTAIN ANNUITANTS

SEC. 7001. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term ''agency'' means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term ''health benefits plan'' means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term ''health-benefits coverage'' means coverage under a health benefits plan'';

(4) an individual shall be considered to be an ''annuitant of an agency'' if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term ''Office'' means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a ''pay-as-you-go'' basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been re-

sponsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of Standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

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