

103<sup>D</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4202

To increase access to high quality, affordable health insurance.

---

## IN THE HOUSE OF REPRESENTATIVES

APRIL 13, 1994

Mr. McCRERY (for himself, Mr. TAUZIN, Mr. BAKER of Louisiana, Mr. DELAY, Mr. DOOLITTLE, Mr. HOUGHTON, Mr. INHOFE, Mr. SAM JOHNSON of Texas, Mr. LIVINGSTON, Mr. HAYES, Mr. INGLIS of South Carolina, and Mr. HOKE) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, the Judiciary, and Education and Labor

---

## A BILL

To increase access to high quality, affordable health insurance.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Health Savings and Security Act of 1994”.

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

### **TITLE I—INSURANCE REFORM**

#### **Subtitle A—Insurance Provisions**

## PART 1—REQUIREMENTS FOR TAX-FAVORED HEALTH PLANS

Sec. 101. Requirements for high deductible umbrella insurance plans and managed health care plans .....	6
Sec. 102. Benefits .....	9
Sec. 103. Rating practices .....	13
Sec. 104. Guaranteed issue .....	14
Sec. 105. Guaranteed renewability .....	16
Sec. 106. Restrictions on agent compensation and broker activities .....	17

## PART 2—CERTIFICATION OF HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED CARE HEALTH PLANS

Sec. 111. Establishment of regulatory program for certification of plans .....	18
Sec. 112. Standards for regulatory programs .....	20

**Subtitle B—Promoting Development of Voluntary Health Plan Purchasing Cooperatives**

Sec. 121. Establishment of standards; application in States .....	28
Sec. 122. Specification of HPPC areas .....	32
Sec. 123. Standards for health plan purchasing cooperatives .....	32
Sec. 124. Functions of health plan purchasing cooperatives .....	36
Sec. 125. Qualified health carriers .....	44
Sec. 126. Marketing HPPC plans .....	50
Sec. 127. Collection and submission of data .....	51
Sec. 128. Role of State; oversight; evaluation .....	53
Sec. 129. Definitions .....	55

**Subtitle C—Federal Preemption**

Sec. 141. Prohibition of State benefit mandates for group health plans	58
Sec. 142. Prohibition of provisions prohibiting employer groups from purchasing health insurance .....	59
Sec. 143. Restrictions on managed care .....	59
Sec. 144. Exemption of state laws preventing denial of lifesaving medical treatment pending transfer to another health care provider .....	61
Sec. 145. Definitions .....	62

**Subtitle D—Rules of Construction Regarding Abortion Services; Inseverability**

Sec. 151. Rules of construction regarding abortion services .....	64
Sec. 152. Inseverability .....	65

**TITLE II—AMENDMENTS OF INTERNAL REVENUE CODE OF 1986****Subtitle A—Limitations on Employer Deduction for Health Care Coverage for Employees and on Employee Exclusion for Employer-Provided Health Care Coverage**

Sec. 201. Employer deduction for health care coverage for employees limited to coverage under high-deductible plans and managed care plans and to contributions to medical savings accounts for employees .....	66
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----

Sec. 202. Limitation on exclusion for employer-provided coverage under health plan .....	74
Sec. 203. Health benefits may not be provided under cafeteria plans ...	77
Sec. 204. Effective date .....	78

**Subtitle B—Credits for Contributions to Medical Savings Accounts, for Purchase of Coverage Under Tax-Qualified Health Care Plans, and for Routine Preventive Care**

Sec. 211. Credit for contributions to medical savings accounts .....	79
Sec. 212. Refundable credit for purchase of coverage under tax-qualified health care plans .....	97
Sec. 213. Credit for cost of routine preventive care .....	103
Sec. 214. Effective date .....	105

**Subtitle C—Repeal of Medical Expense Deduction**

Sec. 221. Repeal of medical expense deduction .....	105
-----------------------------------------------------	-----

**Subtitle D—Veterans Medical Benefits and Services Unaffected**

Sec. 231. Veterans medical benefits and services unaffected .....	106
-------------------------------------------------------------------	-----

**TITLE III—SAVINGS IN MEDICARE AND MEDICAID PROGRAMS**

**Subtitle A—Medicare Program**

Sec. 301. Increase in Medicare part B premium for individuals with high income .....	106
Sec. 302. Imposition of 20 percent coinsurance on clinical laboratory services under Medicare .....	110
Sec. 303. Annual indexing of part B deductible .....	110

**Subtitle B—Medicaid Program**

PART 1—ACHIEVING SAVINGS IN PROGRAM

Sec. 311. Cap on Federal payments made for acute medical services furnished under the Medicaid program .....	111
--------------------------------------------------------------------------------------------------------------	-----

PART 2—OPTIONAL ENROLLMENT OF LOW-INCOME INDIVIDUALS UNDER HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS AND MANAGED HEALTH CARE PLANS

Sec. 321. Optional enrollment under plans .....	119
-------------------------------------------------	-----

PART 3—INCREASING STATE FLEXIBILITY TO USE MANAGED CARE UNDER MEDICAID

Sec. 331. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under Medicaid .....	128
---------------------------------------------------------------------------------------------------------------------------------------------------	-----

PART 4—LIMITATIONS ON FUNDING OF ABORTION SERVICES UNDER MEDICAID

Sec. 341. Limitations on funding of abortion services under Medicaid	182
----------------------------------------------------------------------	-----

**TITLE IV—CONTAINING HEALTH CARE COSTS****Subtitle A—Medical Malpractice Liability Reform**

## PART 1—GENERAL PROVISIONS

Sec. 401. Federal reform of medical malpractice liability actions .....	183
Sec. 402. Definitions .....	185
Sec. 403. Effective date .....	190

## PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

Sec. 411. Requirement for initial resolution of action through alternative dispute resolution .....	191
Sec. 412. Calculation and payment of damages .....	195
Sec. 413. Requiring party contesting ADR ruling to pay attorney's fees and other costs .....	198
Sec. 414. Joint and several liability for noneconomic damages .....	201
Sec. 415. Statute of limitations .....	202
Sec. 416. Uniform standard for determining negligence .....	202
Sec. 417. Special provision for certain obstetric services .....	202

## PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

Sec. 421. Basic requirements .....	203
Sec. 422. Certification of State systems; applicability of alternative Federal system .....	206
Sec. 423. Reports on implementation and effectiveness of alternative dispute resolution systems .....	208

## PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

Sec. 431. Permitting State professional societies to participate in disciplinary activities .....	209
Sec. 432. Study of incentives to encourage voluntary service by physicians .....	211
Sec. 433. Requirements for risk management programs .....	212
Sec. 434. Grants for medical safety promotion .....	213

**Subtitle B—Treatment of Certain Activities Under the Antitrust Laws**

Sec. 451. Exemption from antitrust laws for certain competitive and collaborative activities .....	216
Sec. 452. Safe harbors .....	218
Sec. 453. Designation of additional safe harbors .....	222
Sec. 454. Certificates of review .....	225
Sec. 455. Notifications providing reduction in certain penalties under antitrust law for health care cooperative ventures .....	237
Sec. 456. Review and reports on safe harbors and certificates of review .....	246
Sec. 457. Rules, regulations, and guidelines .....	247
Sec. 458. Establishment of HHS Office of Health Care Competition Policy .....	249
Sec. 459. Definitions .....	249

**TITLE V—SPECIAL ASSISTANCE FOR FRONTIER, RURAL,  
AND URBAN UNDERSERVED AREAS**

**Subtitle A—Frontier, Rural, and Urban Underserved Areas**

Sec. 501. Establishment of program to make community-based primary health grants and health service access grants for Federally-qualified health centers .....	252
Sec. 502. Tax incentives for practice in frontier, rural, and urban underserved areas .....	276
Sec. 503. Rural emergency access care hospitals .....	290
Sec. 504. Grants to States regarding aircraft for transporting rural victims of medical emergencies .....	295
Sec. 505. Demonstration projects to encourage the development and operation of rural health networks .....	301

**Subtitle B—Primary Care Provider Education**

Sec. 511. Graduate medical education demonstration projects .....	311
Sec. 512. Funding under Medicare for training in nonhospital-owned facilities .....	323
Sec. 513. Increase in National Health Service Corps funding .....	326
Sec. 514. Increase in health professions funding for primary care physicians .....	326
Sec. 515. Health professions funding for nurse practitioners and physician assistants programs .....	327
Sec. 516. State grants to increase the number of primary care providers .....	330

**Subtitle C—Programs Relating to Primary and Preventive  
Care Services**

Sec. 521. Maternal and infant care coordination .....	331
Sec. 522. Frontier States .....	335

**Subtitle D—Limitation on Funding for Abortions**

Sec. 531. Limitation on funding for abortions .....	335
-----------------------------------------------------	-----

**TITLE VI—ADMINISTRATIVE COST SAVINGS**

**Subtitle A—Standardization of Claims Processing**

Sec. 601. Adoption of data elements, uniform claims, and uniform electronic transmission standards .....	336
Sec. 602. Application of standards .....	338
Sec. 603. Periodic review and revision of standards .....	342
Sec. 604. Health insurance plan defined .....	343

**Subtitle B—Electronic Medical Data Standards**

Sec. 611. Medical data standards for hospitals and other providers .....	343
Sec. 612. Application of electronic data standards to certain hospitals .....	345
Sec. 613. Electronic transmission to Federal agencies .....	348
Sec. 614. Limitation on data requirements where standards in effect ...	348
Sec. 615. Advisory commission .....	350

**Subtitle C—Development and Distribution of Comparative Value Information**

Sec. 621. State comparative value information programs for health care purchasing .....	351
Sec. 622. Federal implementation .....	354
Sec. 623. Comparative value information concerning Federal programs .....	354

**Subtitle D—Preemption of State Quill Pen Laws**

Sec. 631. Preemption of State quill pen laws .....	355
----------------------------------------------------	-----

**TITLE VII—ANTI-FRAUD AND ANTI-RATIONING**

**Subtitle A—Criminal Prosecution of Health Care Fraud**

Sec. 701. Penalties for health care fraud .....	356
Sec. 702. Rewards for information leading to prosecution and conviction .....	357

**Subtitle B—Coordination of Health Care Anti-Fraud and Abuse Activities**

Sec. 711. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health insurance plan .....	359
---------------------------------------------------------------------------------------------------------------------------------------	-----

**Subtitle C—Protection Against Rationing of Treatment**

Sec. 721. Prohibition on denial or treatment based on age, disability, degree of medical need, or quality of life .....	363
Sec. 722. Enforcement .....	364

**1 TITLE I—INSURANCE REFORM**

**2 Subtitle A—Insurance Provisions**

**3 PART 1—REQUIREMENTS FOR TAX-FAVORED**

**4 HEALTH PLANS**

**5 SEC. 101. REQUIREMENTS FOR HIGH DEDUCTIBLE UM-**

**6 BRELLA INSURANCE PLANS AND MANAGED**

**7 HEALTH CARE PLANS.**

8 (a) IN GENERAL.—For purposes of section 162(o) of  
9 the Internal Revenue Code of 1986 and this Act:

10 (1) HIGH DEDUCTIBLE UMBRELLA INSURANCE

11 PLAN.—A “high deductible umbrella insurance plan”

1 is a health insurance plan offered, issued, or re-  
2 newed on or after January 1, 1996, which is cer-  
3 tified by the applicable regulatory authority as meet-  
4 ing, at a minimum, the applicable requirements of  
5 sections 102, 103, 104, 105, and 106 with respect  
6 to such a plan and providing for the regulatory pro-  
7 gram described in section 112.

8 (2) MANAGED HEALTH CARE PLAN.—A “man-  
9 aged health care plan” is a health insurance plan of-  
10 fered, issued, or renewed on or after January 1,  
11 1996, which is certified by the applicable regulatory  
12 authority as meeting, at a minimum, the applicable  
13 requirements of sections 102, 103, 104, 105, and  
14 106 with respect to such a plan and providing for  
15 the regulatory program described in section 112.

16 (3) TAX-QUALIFIED HEALTH CARE PLAN.—The  
17 term “tax-qualified health care plan” means a high  
18 deductible umbrella insurance plan or managed  
19 health care plan.

20 (b) GENERAL DEFINITIONS.—As used in this title:

21 (1) HEALTH INSURANCE PLAN.—The term  
22 “health insurance plan” means any hospital or medi-  
23 cal service policy or certificate, hospital or medical  
24 service plan contract, or health maintenance organi-  
25 zation group contract and, in States which have dis-

1 tinct licensure requirements, a multiple employer  
2 welfare arrangement, but does not include any (or  
3 any combination) of the following offered by an  
4 insurer:

5 (A) Accident only, dental only, disability  
6 only, or long-term care only insurance.

7 (B) Coverage issued as a supplement to  
8 liability insurance.

9 (C) Workers' compensation or similar  
10 insurance.

11 (D) Automobile medical-payment insur-  
12 ance.

13 (2) APPLICABLE REGULATORY AUTHORITY.—

14 The term “applicable regulatory authority” means—

15 (A) in the case of a State with a program  
16 described in section 111, the State commis-  
17 sioner or superintendent of insurance or other  
18 State authority responsible for regulation of  
19 health insurance; or

20 (B) if the State has not established such a  
21 program or such program has been decertified  
22 under section 111(b), the Secretary.

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

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

7           (c) ESTABLISHMENT OR OPERATION OF MANAGED  
8 HEALTH CARE PLANS BY STATES.—A State may estab-  
9 lish or operate a managed health care plan.

10 **SEC. 102. BENEFITS.**

11           (a) IN GENERAL.—The requirements of this section  
12 are met, if the health insurance plan—

13                 (1) provides coverage for all medically necessary  
14 acute medical care described in subsection (b),

15                 (2) does not exclude coverage for selected ill-  
16 nesses or selected treatments if consistent with  
17 medically accepted practices, and

18                 (3) meets the applicable patient cost-sharing re-  
19 quirements of subsection (c).

20           (b) ACUTE MEDICAL CARE.—Acute medical care de-  
21 scribed in this subsection includes—

22                 (1) physician services,

23                 (2) inpatient, outpatient, and emergency hos-  
24 pital services and appropriate alternatives to hos-  
25 pitalization, and

1 (3) inpatient and outpatient prescription drugs.

2 (c) COST SHARING REQUIREMENTS.—The require-  
3 ments of this subsection are as follows:

4 (1) LIMITATION ON DEDUCTIBLES.—

5 (A) HIGH DEDUCTIBLE UMBRELLA  
6 HEALTH INSURANCE PLAN.—

7 (i) IN GENERAL.—In the case of a  
8 high deductible umbrella insurance plan,  
9 the plan shall provide a deductible amount  
10 for benefits provided in any plan year  
11 which is at least \$1,500 (but not to exceed  
12 \$3,000) for items and services furnished to  
13 a family (composed of one or more individ-  
14 uals) enrolled under the plan in a year.

15 (ii) INDEXING DOLLAR AMOUNTS.—  
16 For any calendar year beginning with  
17 1997, the dollar amount specified in clause  
18 (i) (as previously increased under this  
19 clause) shall be increased by the percent-  
20 age increase in the consumer price index  
21 for all urban consumers (United States  
22 city average, as published by the Bureau of  
23 Labor Statistics) for the 12-month period  
24 ending with September of the preceding  
25 calendar year. Any dollar amount in-

1           creased under the previous sentence that is  
2           not a multiple of \$10, shall be rounded to  
3           the next highest multiple of \$10.

4           (B) MANAGED HEALTH CARE PLANS.—In  
5           the case of a managed health care plan, the  
6           plan may provide a deductible the amount of  
7           which does not exceed the amount of the de-  
8           ductible permitted under subparagraph (A).

9           (2) LIMITATION ON COPAYMENTS AND COIN-  
10          SURANCE.—

11           (A) IN GENERAL.—A health insurance  
12           plan may not require the payment of any  
13           copayment or coinsurance for an item or service  
14           for which coverage is required under this sec-  
15           tion after an individual or a family covered  
16           under the plan has incurred out-of-pocket ex-  
17           penses under the plan that are equal to the out-  
18           of-pocket limit for a plan year.

19           (B) LIMIT ON OUT-OF-POCKET EX-  
20          PENSES.—As used in this paragraph—

21           (i) OUT-OF-POCKET EXPENSES DE-  
22           FINED.—The term “out-of-pocket ex-  
23           penses” means, with respect to an individ-  
24           ual or a family in a plan year, amounts  
25           payable under the plan as deductibles and

1 coinsurance with respect to items and serv-  
2 ices provided under the plan and furnished  
3 in the plan year on behalf of the individual  
4 or the family covered under the plan.

5 (ii) OUT-OF-POCKET LIMIT DE-  
6 FINED.—The term “out-of-pocket limit”  
7 means for a plan year beginning in—

8 (I) a calendar year prior to 1998,  
9 \$5,000; or

10 (II) for a subsequent calendar  
11 year, the limit specified in this clause  
12 for the previous calendar year in-  
13 creased by the percentage increase in  
14 the consumer price index for all urban  
15 consumers (United States city aver-  
16 age, as published by the Bureau of  
17 Labor Statistics) for the 12-month pe-  
18 riod ending on September 30 of the  
19 preceding calendar year.

20 If the limit computed under subclause (II)  
21 is not a multiple of \$10, it shall be round-  
22 ed to the next highest multiple of \$10.

1 **SEC. 103. RATING PRACTICES.**

2 (a) IN GENERAL.—The requirements of this section  
3 are met, if, except as provided in subsection (b), the health  
4 insurance plan provides for—

5 (1) a variation in premium rates only—

6 (A) on the basis of age, sex, geography,  
7 and family enrollment,

8 (B) on the basis of individual and group  
9 coverage, and

10 (C) in the case of group coverage, on the  
11 basis of the number of individuals covered with-  
12 in the group;

13 (2) a charge of the same premium rates to new  
14 applicants and existing policyholders with the same  
15 age, sex, geographic characteristics, and family en-  
16 rollment; and

17 (3) the highest premium for the plan for a par-  
18 ticular class of family enrollment and geographic  
19 characteristics may not exceed four times the lowest  
20 premium for such plan for the same enrollment and  
21 geographic characteristics.

22 (b) INCENTIVE DISCOUNTS.—A plan may discount  
23 an individual's premium rate by not more than 10 percent  
24 as an incentive for participating in a program, approved  
25 by the applicable regulatory authority to be offered in con-

1 junction with the coverage, which has as its objective, 1  
2 or more of the following:

3 (1) To promote healthy behavior.

4 (2) To prevent or delay the onset of illness.

5 (3) To provide for screening or early detection  
6 of illness.

7 (c) CLASSES OF FAMILY ENROLLMENT DE-  
8 SCRIBED.—In this section, each of the following shall be  
9 considered a separate “class of family enrollment”:

10 (1) Single individual without children.

11 (2) Married couple without children.

12 (3) Single individual with 1 or more children.

13 (4) Married couple with 1 or more children.

14 (d) TREATMENT OF HPPCs.—For purposes of sub-  
15 section (a), any coverage obtained through a health plan  
16 purchasing cooperative approved under subtitle B shall be  
17 treated as a form of group coverage.

18 **SEC. 104. GUARANTEED ISSUE.**

19 (a) IN GENERAL.—The requirements of this section  
20 are met, if the health insurance plan—

21 (1) provides guaranteed issue at standard rates  
22 to all applicants, and

23 (2) does not exclude from coverage, or limit  
24 coverage for, any preexisting condition except as  
25 provided in subsection (b).

1 (b) TREATMENT OF PREEXISTING CONDITIONS.—

2 (1) NO EXCLUSION FOR PREEXISTING CONDI-  
3 TION FOR APPLICANTS CONTINUOUSLY COVERED.—

4 A health insurance plan may not exclude from cov-  
5 erage, or limit coverage for, any preexisting condi-  
6 tion for any applicant who, on the date the applica-  
7 tion is made, has been continuously insured for a pe-  
8 riod of at least 6 months prior to the date of the ap-  
9 plication under 1 or more of the following health in-  
10 surance plans or programs:

11 (A) A high deductible umbrella insurance  
12 plan or a managed health care plan.

13 (B) An employer-sponsored group health  
14 insurance plan in effect before the date of the  
15 enactment of this Act.

16 (C) An individual health insurance plan in  
17 effect before such date.

18 (D) A program described in—

19 (i) title XVIII or XIX of the Social  
20 Security Act,

21 (ii) chapter 55 of title 10, United  
22 States Code,

23 (iii) chapter 17 of title 38, United  
24 States Code,

1 (iv) chapter 89 of title 5, United  
2 States Code, or

3 (v) the Indian Health Care  
4 Improvement Act.

5 (2) LIMITATION ON PERIOD OF EXCLUSION FOR  
6 OTHER APPLICANTS.—In the case of an applicant  
7 not described in paragraph (1), the health insurance  
8 plan may exclude from coverage, or limit coverage  
9 for, any preexisting condition for a period no greater  
10 than the lesser of—

11 (A) the number of months immediately  
12 prior to the date of the application during  
13 which the individual was not insured since the  
14 illness or condition in question was first diag-  
15 nosed, or

16 (B) 6 months.

17 (c) PREEXISTING CONDITION.—For purposes of this  
18 section, the term “preexisting condition” means, with re-  
19 spect to coverage under a health insurance plan, a condi-  
20 tion which has been diagnosed or treated during the 6-  
21 month period ending on the day before the first date of  
22 such coverage (without regard to any waiting period).

23 **SEC. 105. GUARANTEED RENEWABILITY.**

24 The requirements of this section are met, if the  
25 health insurance plan provides the policyholder with a con-

1 contractual right to renew the coverage which stipulates that  
2 the insurer cannot cancel or refuse to renew the coverage  
3 except for cases of—

4 (1) nonpayment of premiums by the policy-  
5 holder, or

6 (2) fraud or misrepresentation by the policy-  
7 holder.

8 **SEC. 106. RESTRICTIONS ON AGENT COMPENSATION AND**  
9 **BROKER ACTIVITIES.**

10 The requirements of this section are not met if—

11 (1) the health insurance plan varies compensa-  
12 tion or commissions to an agent, broker, contractor,  
13 or producer based, directly or indirectly, on the an-  
14 ticipated or actual claims experience or health status  
15 associated with particular small employers or eligible  
16 individuals to which each plan is sold, or

17 (2) the health insurance plan (or agent, broker,  
18 contractor, or producer for a health insurance plan)  
19 engages, directly, or indirectly, in any activity or  
20 marketing practice that would encourage small em-  
21 ployers or eligible individuals to refrain from enroll-  
22 ing in the plan, or seek coverage from another  
23 health insurance plan, because of the health status  
24 or claims experience of the employer or individual.

1 **PART 2—CERTIFICATION OF HIGH DEDUCTIBLE**  
2 **UMBRELLA INSURANCE PLANS AND MAN-**  
3 **AGED CARE HEALTH PLANS**

4 **SEC. 111. ESTABLISHMENT OF REGULATORY PROGRAM**  
5 **FOR CERTIFICATION OF PLANS.**

6 (a) ENFORCEMENT OF PROGRAM THROUGH  
7 STATES.—

8 (1) IN GENERAL.—Each State shall submit to  
9 the Secretary, by the deadline specified in paragraph  
10 (2), a report on steps the State is taking to imple-  
11 ment and enforce the regulatory program developed  
12 under section 112 with respect to high deductible  
13 umbrella insurance plans and managed care health  
14 plans offered not later than such deadline.

15 (2) DEADLINE FOR REPORT.—

16 (A) 1 YEAR AFTER STANDARDS ESTAB-  
17 LISHED.—Subject to subparagraph (B), the  
18 deadline under this paragraph is 1 year after  
19 the date the regulatory program is developed  
20 under section 112.

21 (B) EXCEPTION FOR LEGISLATION.—In  
22 the case of a State which the Secretary identi-  
23 fies, in consultation with the NAIC, as—

24 (i) requiring State legislation (other  
25 than legislation appropriating funds) in  
26 order for high deductible umbrella insur-

1           ance plans and managed care health plans  
2           to meet the requirements of the program  
3           developed under section 112, but

4                   (ii) having a legislature which is not  
5                   scheduled to meet in 1996 in a legislative  
6                   session in which such legislation may be  
7                   considered,

8           the date specified in this paragraph is the first  
9           day of the first calendar quarter beginning after  
10          the close of the first legislative session of the  
11          State legislature that begins on or after Janu-  
12          ary 1, 1996. For purposes of the previous sen-  
13          tence, in the case of a State that has a 2-year  
14          legislative session, each year of such session  
15          shall be deemed to be a separate regular session  
16          of the State legislature.

17          (b) FEDERAL ROLE.—

18                   (1) FAILURE OF STATE TO ENFORCE PRO-  
19                   GRAM.—If the Secretary determines that a State has  
20                   failed to submit a report by the deadline specified  
21                   under subsection (a) or finds that the State has not  
22                   implemented and provided adequate enforcement of  
23                   the regulatory program developed under section 112,  
24                   the Secretary shall notify the State and provide the

1 State a period of 60 days in which to submit such  
2 report or to implement and enforce such program.

3 (2) PROCEDURES FOR FEDERAL ENFORCE-  
4 MENT.—If, after the 60-day period referred to in  
5 paragraph (1), the Secretary finds that such a fail-  
6 ure has not been corrected, the Secretary shall pro-  
7 vide for such mechanism for the implementation and  
8 enforcement of such program in the State as the  
9 Secretary determines to be appropriate. Such imple-  
10 mentation and enforcement shall take effect with re-  
11 spect to high deductible umbrella insurance plans  
12 and managed care health plans offered or renewed,  
13 on or after 3 months after the date of the Sec-  
14 retary’s finding under the previous sentence, and  
15 until the date the Secretary finds that such a failure  
16 has been corrected.

17 **SEC. 112. STANDARDS FOR REGULATORY PROGRAMS.**

18 (a) IN GENERAL.—The Secretary, in consultation  
19 with the National Association of Insurance Commissioners  
20 (in this section referred to as “NAIC”) shall develop by  
21 not later than 1 year after the date of the enactment of  
22 this Act, in the form of model Acts and model regulations,  
23 State regulatory program standards which include—

24 (1) procedures for certifying that the require-  
25 ments of part 1 of this subtitle have been met by a

1 health insurance plan applying for certification as a  
2 high deductible umbrella insurance plan or a man-  
3 aged care health plan,

4 (2) the requirements described in subsections  
5 (b) and (c) with respect to such a plan,

6 (3) requirements with respect to solvency stand-  
7 ards and guaranty funds for carriers of such plans,  
8 and

9 (4) reporting requirements under which carriers  
10 report to the Internal Revenue Service regarding the  
11 acquisition and termination by individuals of cov-  
12 erage under such plans.

13 (b) **MARKETING PRACTICES.**—The requirements of  
14 this subsection are met, if the carrier offering the plan  
15 retains the right to select agents with whom such plan  
16 contracts and to determine the amount and form of com-  
17 pensation to such agents, except that—

18 (1) if the carrier chooses to contract with an  
19 agent, the carrier may not terminate or refuse to  
20 renew the agency contract for any reason related to  
21 the age, sex, health status, claims experience, occu-  
22 pation, or geographic location of the insureds placed  
23 by the agent with such plan, and

24 (2) the carrier may not, directly or indirectly,  
25 enter into any contract, agreement, or arrangement

1 with an agent that provides for, or results in, any  
2 consideration provided to such agent for the issu-  
3 ance or renewal of such a plan to vary on account  
4 of the age, sex, health status, claims experience, oc-  
5 cupation, or geographic location of the insureds  
6 placed by the agent with such plan.

7 (c) REINSURANCE OR ALLOCATION OF RISK MECHA-  
8 NISMS.—

9 (1) ESTABLISHMENT OF STANDARDS.—

10 (A) ROLE OF NAIC.—The Secretary shall  
11 request the NAIC to develop, within 9 months  
12 after the date of the enactment of this Act,  
13 models for reinsurance or allocation of risk  
14 mechanisms (each in this section referred to as  
15 a “reinsurance or allocation of risk mecha-  
16 nism”) for high deductible umbrella insurance  
17 plans and managed care health plans made  
18 available to individuals for whom an insurer is  
19 at risk of incurring high costs under the plan.  
20 If the NAIC develops such models within such  
21 period, the Secretary shall review such models  
22 to determine if they provide for an effective re-  
23 insurance or allocation of risk mechanism. Such  
24 review shall be completed within 30 days after  
25 the date the models are developed. Unless the

1 Secretary determines within such period that  
2 such a model is not an effective reinsurance or  
3 allocation of risk mechanism, such remaining  
4 models shall serve as the models under this sub-  
5 section, with such amendments as the Secretary  
6 deems necessary.

7 (B) CONTINGENCY.—If the NAIC does not  
8 develop such models within such period or the  
9 Secretary determines that all such models do  
10 not provide for an effective reinsurance or allo-  
11 cation of risk mechanism, the Secretary shall  
12 specify, within 15 months after the date of the  
13 enactment of this Act, models to carry out this  
14 subsection.

15 (2) IMPLEMENTATION OF REINSURANCE OR AL-  
16 LOCATION OF RISK MECHANISMS.—

17 (A) BY STATES.—Each State shall estab-  
18 lish and maintain one or more reinsurance or  
19 allocation of risk mechanisms that are consist-  
20 ent with a model established under paragraph  
21 (1) by not later than the deadline specified in  
22 section 111(a)(2). A State may establish and  
23 maintain such a mechanism jointly with one or  
24 more other States.

25 (B) FEDERAL ROLE.—

1 (i) IN GENERAL.—If the Secretary de-  
2 termines that a State has failed to estab-  
3 lish or maintain a reinsurance or allocation  
4 of risk mechanism in accordance with sub-  
5 paragraph (A), the Secretary shall estab-  
6 lish and maintain such a reinsurance or al-  
7 location of risk mechanism meeting the re-  
8 quirements of this subparagraph.

9 (ii) REINSURANCE MECHANISM.—Un-  
10 less the Secretary determines under clause  
11 (iii) that an allocation of risk mechanism is  
12 the appropriate mechanism to use in a  
13 State under this subparagraph, the Sec-  
14 retary shall establish and maintain for use  
15 under this subsection for each State an ap-  
16 propriate reinsurance mechanism.

17 (iii) ALLOCATION OF RISK MECHA-  
18 NISM.—If the Secretary determines that,  
19 due to the nature of the health coverage  
20 market in the State (including a relatively  
21 small number of high deductible umbrella  
22 insurance plans or managed care health  
23 plans offered or a relatively small number  
24 of uninsurable individuals), an allocation of  
25 risk mechanism would be a better mecha-

1 nism than a reinsurance mechanism, the  
2 Secretary shall establish and maintain for  
3 use under this section for a State an allo-  
4 cation of risk mechanism under which un-  
5 insurable individuals would be equitably as-  
6 signed among insurers offering high de-  
7 ductible umbrella insurance plans or man-  
8 aged care health plans.

9 (iv) FINANCING DEFICIT FOR REIN-  
10 SURANCE MECHANISMS.—

11 (I) IN GENERAL.—Chapter 43 of  
12 the Internal Revenue Code of 1986  
13 (relating to qualified pension plans,  
14 etc.) is amended by adding at the end  
15 thereof the following new section:

16 **“SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN**  
17 **STATES UNDER FEDERAL REINSURANCE.**

18 “(a) IMPOSITION OF TAX.—There is hereby imposed  
19 a tax on the providing of any high deductible umbrella  
20 insurance plan or managed care health plan which covers  
21 any individual in a Federal reinsurance State.

22 “(b) AMOUNT OF TAX.—

23 “(1) IN GENERAL.—The tax imposed by sub-  
24 section (a) shall be equal to the applicable percent-

1 age of the amount received by the insurer for provid-  
2 ing such plan in such Federal reinsurance State.

3 “(2) APPLICABLE PERCENTAGE.—For purposes  
4 of paragraph (1), the term ‘applicable percentage’  
5 means, with respect to any State for any period, the  
6 lowest percentage estimated by the Secretary as gen-  
7 erating sufficient revenues to carry out section  
8 112(c)(2)(B) of the Health Savings and Security  
9 Act of 1994 in such State for such period.

10 “(c) LIABILITY FOR TAX.—The tax imposed by this  
11 section shall be paid by the insurer.

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

13 “(1) HIGH DEDUCTIBLE INSURANCE PLAN;  
14 MANAGED CARE HEALTH PLAN.—The terms ‘high  
15 deductible insurance plan’ and ‘managed care health  
16 plan’ have the meaning given such terms in section  
17 101(a) of the Health Savings and Security Act of  
18 1994.

19 “(2) FEDERAL REINSURANCE STATE.—The  
20 term ‘Federal reinsurance State’ means any State  
21 with respect to which a determination is in effect  
22 under section 112(c)(2)(B) of the Health Savings  
23 and Security Act of 1994 and for which the Sec-  
24 retary of Health and Human Services has estab-

1 lished and is maintaining a reinsurance mechanism  
2 under clause (ii) of such section for the State.

3 “(3) INSURER.—The term ‘insurer’ means a li-  
4 censed insurance company, a prepaid hospital or  
5 medical service plan, and a health maintenance orga-  
6 nization offering such a plan, and includes a similar  
7 organization regulated under State law for sol-  
8 vency.”

9 (II) CLERICAL AMENDMENT.—  
10 The table of sections for chapter 43 of  
11 such Code is amended by adding at  
12 the end thereof the following new  
13 item:

“Sec. 4980D. Additional tax to fund reinsurance in States under  
Federal reinsurance.”

14 (3) CONSTRUCTION.—Nothing in this section  
15 shall be construed to prohibit reinsurance or alloca-  
16 tion of risk arrangements relating to high deductible  
17 umbrella insurance plans or managed care health  
18 plans, whether on a State or multi-state basis, not  
19 required under this subsection.

1 **Subtitle B—Promoting Develop-**  
2 **ment of Voluntary Health Plan**  
3 **Purchasing Cooperatives**

4 **SEC. 121. ESTABLISHMENT OF STANDARDS; APPLICATION**  
5 **IN STATES.**

6 (a) ESTABLISHMENT OF STANDARDS.—

7 (1) IN GENERAL.—The Secretary of Health and  
8 Human Services, in consultation with the National  
9 Association of Insurance Commissioners, shall estab-  
10 lish standards under this subtitle to carry out the  
11 requirements of this subtitle, including standards re-  
12 lating to—

13 (A) the establishment of health plan pur-  
14 chasing cooperatives (or HPPCs),

15 (B) qualifications for qualified health car-  
16 riers, and

17 (C) the roles of States under this subtitle.

18 (2) DEADLINE.—The Secretary shall establish  
19 and publish the standards by not later than 6  
20 months after the date of the enactment of this Act.

21 (3) REVISION.—The Secretary from time to  
22 time may revise standards established under this  
23 subsection. The revisions shall only become effective  
24 in a manner that permits States sufficient time to

1 change laws and regulations in order to implement  
2 the revisions.

3 (b) APPLICATION OF STANDARDS THROUGH  
4 STATES.—

5 (1) APPLICATION OF STANDARDS.—

6 (A) IN GENERAL.—Subject to subsection  
7 (c), each State shall submit to the Secretary, by  
8 the deadline specified in subparagraph (B), a  
9 report on steps the State is taking to implement  
10 the standards established under subsection (a)  
11 in order to permit HPPCs to be established and  
12 operate in all parts of the State, and to con-  
13 form its insurance laws to meet the require-  
14 ments of this subtitle, not later than that dead-  
15 line.

16 (B) DEADLINE FOR REPORT.—

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

22 (ii) EXCEPTION FOR LEGISLATION.—  
23 In the case of a State which the Secretary  
24 identifies, in consultation with the National

1 Association of Insurance Commissioners,  
2 as—

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

8 (II) having a legislature which is  
9 not scheduled to meet in 1995 in a  
10 legislative session in which such legis-  
11 lation may be considered,

12 the date specified in this subparagraph is  
13 the first day of the first calendar quarter  
14 beginning after the close of the first legis-  
15 lative session of the State legislature that  
16 begins on or after January 1, 1996. For  
17 purposes of the previous sentence, in the  
18 case of a State that has a 2-year legislative  
19 session, each year of the session shall be  
20 deemed to be a separate regular session of  
21 the State legislature.

22 (2) FEDERAL ROLE.—

23 (A) NOTICE TO STATES.—If the Secretary  
24 determines that a State has failed to submit a  
25 report by the deadline specified under para-

1 graph (1) or finds that the State has not taken  
2 sufficient steps to permit establishment and op-  
3 eration of HPPCs in accordance with the stand-  
4 ards established under subsection (a), the Sec-  
5 retary shall notify the State and provide the  
6 State a period of 60 days in which to submit  
7 the report or to implement the standards under  
8 paragraph (1).

9 (B) FEDERAL FALL-BACK PARTICIPA-  
10 TION.—If, after the 60-day period, the Sec-  
11 retary finds that the failure has not been cor-  
12 rected, the Secretary shall provide for such  
13 mechanism as will—

14 (i) permit the establishment and oper-  
15 ation of HPPCs in accordance with the  
16 standards established under subsection (a)  
17 in the State as the Secretary determines to  
18 be appropriate, and

19 (ii) provide for the Secretary assum-  
20 ing the role of the State otherwise provided  
21 under this subtitle.

22 (C) DURATION.—The Secretary's exercise  
23 of authority under subparagraph (B) shall take  
24 effect with respect to carriers, and health plans  
25 offered or renewed, on or after 3 months after

1           the date of the Secretary's finding under that  
2           subparagraph and until the date the Secretary  
3           finds that the failure of the State has been  
4           corrected.

5           (c) IMPLEMENTATION.—The report under subsection  
6 (b) shall specify the State official (or officials), or State  
7 board, commission, or department, responsible for carry-  
8 ing out the standards under subsection (a).

9   **SEC. 122. SPECIFICATION OF HPPC AREAS.**

10          (a) IN GENERAL.—Each State shall establish bound-  
11 aries for HPPC areas in the State.

12          (b) STANDARDS.—Each part of the State shall be in  
13 one, and only one, HPPC area. Each HPPC area shall  
14 include a sufficient number of potential enrollees, health  
15 care providers, and qualified health carriers to carry out  
16 the purposes of this subtitle. A HPPC area may include  
17 portions of more than one State.

18          (c) REVISIONS.—A State may revise the boundaries  
19 of HPPC areas not more frequently than annually.

20   **SEC. 123. STANDARDS FOR HEALTH PLAN PURCHASING CO-**  
21                           **OPERATIVES.**

22          (a) ESTABLISHMENT.—

23               (1) IN GENERAL.—One or more State-char-  
24               tered, nonprofit private corporations may be estab-  
25               lished in accordance with this section to serve as a

1 HPPC for each HPPC area specified under section  
2 122 for the benefit of small employers and eligible  
3 individuals in the area. A carrier may not form, un-  
4 derwrite, or possess a majority vote of a HPPC, but  
5 may administer a HPPC.

6 (2) RULES OF CONSTRUCTION.—

7 (A) ESTABLISHMENT NOT REQUIRED.—

8 Nothing in this section shall be construed as re-  
9 quiring—

10 (i) that a HPPC be established in  
11 each HPPC area; and

12 (ii) that there be only one HPPC es-  
13 tablished with respect to any HPPC area.

14 (B) SINGLE ORGANIZATION SERVING MUL-  
15 TIPLE AREAS.—Nothing in this section shall be  
16 construed as preventing a single not-for-profit  
17 corporation from being a HPPC for more than  
18 one HPPC area.

19 (b) BYLAWS AND BOARD OF DIRECTORS.—

20 (1) BYLAWS.—Each HPPC shall establish by-  
21 laws, consistent with this section, for its operation,  
22 including the election of members of its board of di-  
23 rectors.

24 (2) BOARD OF DIRECTORS.—

1           (A) IN GENERAL.—Each HPPC shall oper-  
2           ate under the supervision of a board of direc-  
3           tors established under the bylaws of the HPPC.  
4           A majority of the members of the board shall  
5           be small employers or eligible individuals, or  
6           representatives thereof, that participate in the  
7           HPPC.

8           (B) APPOINTMENT AND ELECTION.—After  
9           the initial appointment of members to the board  
10          of directors of a HPPC (in accordance with the  
11          articles of incorporation of the HPPC), the  
12          board shall be elected by small employer mem-  
13          bers and individual members of the HPPC in  
14          accordance with bylaws of the HPPC. The elec-  
15          tions shall occur not less frequently than once  
16          every 2 years. The standards may provide, at  
17          the option of a State, for different voting rights  
18          for members that are small employers to reflect  
19          the number of individuals receiving coverage  
20          through those employers.

21          (3) LIMITATION ON LIABILITY.—There shall be  
22          no liability on the part of, and no cause of action of  
23          any nature shall arise against, any member of the  
24          board of directors of a HPPC, or its employees or  
25          agent, for any action taken in good faith by them in

1 the performance of duties of HPPCs specified in this  
2 subtitle.

3 (c) OFFICERS AND EMPLOYEES.—Each HPPC shall  
4 provide, consistent with its bylaws, for—

5 (1) the appointment of officers from among its  
6 members, and

7 (2) the appointment of an executive director to  
8 serve as the chief operating officer of the HPPC.

9 (d) ADVISORY COMMITTEES.—Each HPPC shall es-  
10 tablish such advisory committees as may be necessary to  
11 assist in carrying out its duties under this subtitle. An  
12 advisory committee may include representation from quali-  
13 fied health carriers, agents, and health care providers.

14 (e) ANNUAL REPORT; RECORDS; AUDIT.—Each  
15 HPPC shall—

16 (1) prepare, and submit to the State and the  
17 Secretary, an annual report on its operations, in-  
18 cluding its program and financial operations;

19 (2) conduct such annual internal and independ-  
20 ent audits as it determines to be appropriate; and

21 (3) maintain records on its operations.

22 (f) GENERAL AUTHORITIES; LIMITATIONS ON AU-  
23 THORITY.—

24 (1) IN GENERAL.—A HPPC may—

25 (A) sue (or be sued), and

1 (B) subject to paragraph (2), accept and  
2 expend grants or funds from any public or pri-  
3 vate agency.

4 (2) LIMITATIONS.—A HPPC may not—

5 (A) purchase health care services or per-  
6 form any activity (including review, approval, or  
7 enforcement) relating to payment rates for  
8 providers;

9 (B) assume financial risk for the cost or  
10 provision of health care services;

11 (C) contract directly with health care pro-  
12 viders (other than with qualified health carriers  
13 under section 124) for the provision of health  
14 care services for members; or

15 (D) accept any funds from any private  
16 agency that is (or is affiliated with) a qualified  
17 health carrier or other party that would pose a  
18 conflict of interest (as specified by the Sec-  
19 retary).

20 **SEC. 124. FUNCTIONS OF HEALTH PLAN PURCHASING CO-**  
21 **OPERATIVES.**

22 (a) CONTRACTS WITH QUALIFIED HEALTH CAR-  
23 RIERS; ENROLLMENT IN PLANS.—

24 (1) CONTRACTS WITH PLANS.—Each HPPC  
25 shall enter into contracts and hold policies with

1 qualified health carriers which elect to offer HPPC  
2 plans to members, in accordance with subsection (d).

3 (2) ENROLLMENT.—

4 (A) IN GENERAL.—Each HPPC shall pro-  
5 vide for the enrollment of eligible employees of  
6 small employers and eligible individuals in  
7 HPPC plans of qualified health carriers offered  
8 by the HPPC.

9 (B) OPEN ENROLLMENT PERIODS.—Each  
10 HPPC shall provide for an annual open enroll-  
11 ment period of 30 days to be available within  
12 60 days before the anniversary date of each  
13 member's coverage under a HPPC plan.

14 (3) PROVISION OF INFORMATION.—Each HPPC  
15 shall provide to its members and eligible employees  
16 of small employer members comparison sheets, in ac-  
17 cordance with standards established by the Sec-  
18 retary, which provide clear standardized information  
19 on each qualified health carrier and each HPPC  
20 plan offered by a qualified health carrier, including  
21 information on price, consumer satisfaction, and (if  
22 feasible) health outcomes and enrollment and en-  
23 rollee responsibilities and obligations.

24 (b) MEMBERSHIP REQUIREMENTS.—

1           (1) IN GENERAL.—Each HPPC shall establish  
2 requirements for participation of small employers  
3 and eligible individuals as members of the HPPC  
4 consistent with any standards the Secretary estab-  
5 lishes consistent with this subsection. Each HPPC  
6 shall maintain eligibility records to carry out its  
7 functions.

8           (2) SMALL EMPLOYER STANDARDS.—Under  
9 those standards—

10                   (A) each small employer in the area that  
11 meets requirements for membership is per-  
12 mitted to become a member;

13                   (B) a small employer that is not a valid  
14 small employer group and was formed for the  
15 purpose of securing health benefits coverage  
16 shall be denied membership;

17                   (C) each small employer member shall  
18 offer to eligible employees a choice of at least  
19 2 different HPPC plans, of which—

20                           (i) at least one is a high deductible  
21 umbrella insurance plan, and

22                           (ii) at least one is a managed care  
23 health plan;

24                   (D) no small employer is required, as a  
25 condition of membership, to make any contribu-

1           tion towards the premium for coverage of any  
2           eligible employee; and

3           (E) if a small employer member terminates  
4           coverage purchased through the HPPC, the  
5           former member shall be ineligible to purchase a  
6           HPPC plan through the HPPC for a period of  
7           12 months.

8           (3) INDIVIDUAL MEMBERS.—Under those  
9           standards, eligible individuals residing in a HPPC  
10          area may become individual members of the HPPC  
11          for the area. Nothing in this subtitle shall be con-  
12          strued as requiring as a condition of membership for  
13          a HPPC serving a HPPC area that individual be re-  
14          siding in the area.

15          (4) PAYMENT OF PREMIUMS.—

16                (A) IN GENERAL.—A HPPC may condition  
17                membership upon prepayment of a monthly pre-  
18                mium (or compliance with other mechanisms)  
19                to assure that payment will be made for cov-  
20                erage of members on a timely basis.

21                (B) NOTIFICATION OF FAILURE TO RE-  
22                CEIVE PREMIUM.—If a HPPC fails to receive  
23                payment on a premium due with respect to an  
24                individual covered under a qualified health car-  
25                rier offered by the HPPC, the HPPC shall pro-

1           vide notice of the failure to the individual with-  
2           in the 20-day period after the date on which the  
3           premium payment was due.

4           (C) DIRECT PAYMENT ALLOWED IN CASE  
5           OF EMPLOYER NONPAYMENT.—In the case a  
6           small employer member of a HPPC fails to  
7           make payment of premiums due with respect to  
8           an eligible employee covered under a qualified  
9           health carrier offered through the HPPC, the  
10          HPPC shall notify the employee of the  
11          nonpayment and shall allow the employee to  
12          make direct payments to the HPPC effective  
13          with the next succeeding payment period.

14          (5) DISPUTE RESOLUTION PROCEDURES.—Each  
15          HPPC shall establish, in accordance with standards  
16          established under this subtitle dispute resolution  
17          procedures to resolve disputes between the HPPC  
18          and its members and disputes between the HPPC  
19          and qualified health carriers. Under those proce-  
20          dures, a member or HPPC may appeal the proposed  
21          resolution of a dispute to the State.

22          (c) CONTRACTS WITH MEMBERS.—

23                  (1) PREMIUM PAYMENTS.—

24                          (A) IN GENERAL.—Each contract between  
25                          a member and a HPPC shall provide that pay-

1           ment of all premiums shall be transmitted by  
2           the member (which in the case of a small em-  
3           ployer member shall be on behalf of eligible em-  
4           ployees) to (or on behalf of) the HPPC for the  
5           benefit of the qualified health carrier in which  
6           the eligible employee or individual is enrolled.  
7           The HPPC shall provide for procedures for the  
8           collection of premiums from members (includ-  
9           ing, in the case of a small employer member,  
10          eligible employees).

11           (B) AT LEAST BIMONTHLY.—The pre-  
12          miums are payable not less often than bi-  
13          monthly.

14           (C) LATE CHARGES.—A HPPC may pro-  
15          vide for penalties for late payment.

16           (D) NONPAYMENT.—Nonpayment of pre-  
17          miums by a member shall constitute a breach of  
18          the contract, a breach of the health care policy,  
19          and a default on the member's obligation.

20           (2) CONTRACT HOLDER.—The contract shall  
21          provide that—

22           (A) the HPPC may be the contract holder  
23          of the health benefit policy on behalf of the  
24          member (including eligible employees), and

1 (B) all eligible employees who obtain cov-  
2 erage under the HPPC plan offered by a small  
3 employer must obtain the coverage through any  
4 HPPC plan offered by a qualified health carrier  
5 through the HPPC.

6 (3) PREMIUM AMOUNTS.—The amount of pre-  
7 miums imposed shall include an amount that in-  
8 cludes the fixed overhead allowance percentage es-  
9 tablished by the HPPC under subsection (e).

10 (d) CONTRACTS WITH PLANS.—

11 (1) IN GENERAL.—Each contract between a  
12 qualified health carrier and a HPPC shall provide—

13 (A) that premiums of members shall be  
14 forwarded to the plan in which they are en-  
15 rolled, subject to any adjustment under section  
16 128, on the effective date of coverage (if that  
17 occurs more than once a month), on a monthly  
18 basis, or as agreed in the contract (but in no  
19 event less frequently than monthly); and

20 (B) that the HPPC shall transmit enroll-  
21 ment and eligibility information to the plan on  
22 a timely basis.

23 (2) TERMINATION.—A qualified health carrier  
24 may not terminate the contract unless the plan—

1 (A) provides advance notice to the HPPC,  
2 and

3 (B) provides notice at least 180 days be-  
4 fore the nonrenewal of any HPPC plan to en-  
5 rollees.

6 In the case of a contract termination, the qualified  
7 health carrier shall not write new business with the  
8 HPPC for a period of 3 years from the date of the  
9 notice of termination.

10 (e) OVERHEAD ALLOWANCE.—Each HPPC shall es-  
11 tablish a fixed overhead allowance percentage that shall  
12 be—

13 (1) applied as addition to the premiums  
14 charged for enrollment in a qualified health carrier  
15 offered through the HPPC to its members, and

16 (2) used to cover administrative costs of the  
17 HPPC, as well as defaults by members of premium  
18 payments.

19 (f) UNIFORM ADMINISTRATIVE AND ACCOUNTING  
20 PROCEDURES.—Each HPPC shall establish such uniform  
21 administrative and accounting procedures as are needed  
22 to conform with applicable national standards identified  
23 by the Secretary.

24 (g) CONTRACTS FOR ADMINISTRATIVE SERVICES.—

1           (1) IN GENERAL.—Each HPPC shall contract  
2 with a qualified, independent third party for any  
3 service necessary to carry out its duties under this  
4 subtitle. The contracts shall include—

5           (A) contracts with agents to assist in con-  
6 tracting with qualified health carriers and small  
7 employer members, and

8           (B) contracts to market and publicize the  
9 availability of HPPC plans through the HPPC.

10          (2) INFORMATION.—Unless permission is spe-  
11 cifically granted by the HPPC, a third party may  
12 not release, publish, or otherwise use any informa-  
13 tion to which the party has access under its con-  
14 tract.

15          (g) CONSTRUCTION.—Nothing in this subtitle shall  
16 be construed as requiring a small employer or eligible indi-  
17 vidual to obtain coverage from or through a HPPC.

18 **SEC. 125. QUALIFIED HEALTH CARRIERS.**

19          (a) DESIGNATION.—Each State shall establish a  
20 process whereby a carrier that demonstrates to the satis-  
21 faction of the State insurance commissioner that it has  
22 the capability to fulfill the following requirements (directly  
23 or through subcontracts) is designated as a qualified  
24 health carrier for purposes of this subtitle:

1           (1) LICENSURE.—The carrier is licensed and in  
2           good standing with the State insurance commis-  
3           sioner (or other comparable official for a State).

4           (2) ADMINISTRATIVE CAPACITY.—The carrier  
5           has the capacity to administer HPPC plans.

6           (3) ACCESS.—In the case of a carrier with a  
7           contractual obligation to provide or arrange for  
8           health services included in a HPPC plan, the ability  
9           to provide enrollees with adequate access to these  
10          covered services within the carrier’s service area.

11          (4) GRIEVANCE PROCEDURES.—The carrier has  
12          grievance procedures, including the ability to re-  
13          spond to enrollees’ calls, questions, and complaints.

14          (5) UTILIZATION MANAGEMENT PROCE-  
15          DURES.—The carrier has established utilization  
16          management procedures.

17          (6) QUALITY.—The carrier has the ability to  
18          monitor and evaluate the quality and cost-effective-  
19          ness of care.

20          (7) INFORMATION.—The carrier has the ability  
21          to provide information on enrollee satisfaction  
22          (based on standard surveys described in section  
23          127(b)(4)).

1           (8) DATA.—The carrier has the ability to pro-  
2           vide standard data elements (identified under section  
3           127(b)).

4           (b) FUNCTIONS OF QUALIFIED HEALTH CAR-  
5           RIERS.—

6           (1) IN GENERAL.—In every HPPC with which  
7           it has a contract under section 124(d), each quali-  
8           fied health carrier shall provide for activities de-  
9           scribed in this subsection.

10          (2) OFFERING PLAN.—Each qualified health  
11          carrier shall offer HPPC plans. If a qualified health  
12          carrier offers a high deductible umbrella insurance  
13          plan or a managed health care plan in a State (or  
14          geographic area) to employers that are not small  
15          employers, the carrier shall offer, as a HPPC plan,  
16          a similar high deductible umbrella insurance plan or  
17          managed health care plan in that State or geo-  
18          graphic area.

19          (3) PERFORMANCE INFORMATION.—Each quali-  
20          fied health carrier shall provide for the collection  
21          and reporting to the State and to the appropriate  
22          HPPC of information on the performance of the  
23          plan regarding the effectiveness in providing serv-  
24          ices, consistent with section 127(b).

1 (4) COMPLIANCE WITH REQUIREMENTS.—Each  
2 qualified health carrier shall—

3 (A) meet the requirements of part 1 of  
4 subtitle A (relating to benefits, rating practices,  
5 guaranteed issue, guaranteed renewability, and  
6 restrictions on agent compensation and broker  
7 activities) with respect to HPPC plans it offers;  
8 and

9 (B) file on a quarterly basis with the  
10 HPPC in which it is participating the premium  
11 rates for HPPC plans offered by the carrier.

12 (5) NOTICE OF TERMINATION OF HPPC CON-  
13 TRACT.—Each qualified health carrier may only ter-  
14 minate its contract with the HPPC in accordance  
15 with section 124(d)(2).

16 (6) GRIEVANCE PROCEDURES.—Each qualified  
17 health carrier shall provide a procedure for address-  
18 ing grievances that arise between the carrier and the  
19 HPPC or members of the HPPC (and, in the case  
20 of small employer members, their eligible employees)  
21 that requires both parties to fully exhaust the rem-  
22 edies provided under the procedure to resolve griev-  
23 ance before seeking any relief other than as provided  
24 in the procedure.

1           (7) USE OF UNIFORM CLAIMS FORMS.—Each  
2 qualified health carrier shall use standardized forms,  
3 including uniform claims forms, identified by the  
4 Secretary with respect to HPPC plans.

5           (c) COVERAGE.—

6           (1) IN GENERAL.—Coverage under a HPPC  
7 plan offered by a qualified health carrier shall be  
8 available to any member of the HPPC at the anni-  
9 versary date of each member’s coverage under a  
10 HPPC plan (or in the case of an employer or indi-  
11 vidual who has applied to become a member of a  
12 HPPC when the member first joins the HPPC).

13           (2) EXCEPTION.—A qualified health carrier is  
14 not required to offer coverage or accept enrollment  
15 if—

16           (A) the eligible individual or employee does  
17 not reside within the plan’s service area (as ap-  
18 proved by the State insurance commissioner);

19           (B) the plan provides 90 days prior notice  
20 that it will not have the capacity to deliver serv-  
21 ices adequately in the HPPC area to additional  
22 enrollees because of its obligations to existing  
23 groups and enrollees; or

24           (C) the State insurance commissioner de-  
25 termines that the acceptance of an application

1 or applications would place the plan in a finan-  
2 cially impaired condition.

3 (3) CONDITIONS.—

4 (A) INSUFFICIENT CAPACITY.—A qualified  
5 health carrier that cannot offer coverage under  
6 paragraph (2)(B) may not offer coverage to the  
7 employees of a new employer group until the  
8 later of 90 days following that refusal or the  
9 date on which the plan notifies the HPPC and  
10 the State insurance commissioner that it has  
11 regained capacity to deliver services to eligible  
12 individuals in the service area.

13 (B) FINANCIAL IMPAIRMENT.—A qualified  
14 health carrier that cannot offer coverage under  
15 paragraph (2)(C) may not offer coverage or ac-  
16 cept applications for any individual or employer  
17 group until a determination by the State insur-  
18 ance commissioner that acceptance of an appli-  
19 cation will not put the plan in a financially im-  
20 paired condition.

21 (d) DEEMED COMPLIANCE.—Carriers which comply  
22 with any of the requirements of a paragraph of subsection  
23 (a) through a requirement of State law shall be deemed  
24 to be in compliance with the corresponding paragraph of  
25 that subsection. Carriers receiving accreditation by nation-

1 ally recognized, health related accreditation organizations  
2 (including the National Committee on Quality Assurance,  
3 the Utilization Review Accreditation Commission, the  
4 Joint Commission on Accreditation of Health Care Orga-  
5 nizations), or qualification by Federal agencies, shall be  
6 deemed in compliance with the requirements of subsection  
7 (a) as they pertain to the relevant accreditation activities  
8 of the organizations.

9 (e) DETERMINATIONS.—Each State shall provide for  
10 a determination of whether a carrier is a qualified health  
11 carrier within 30 days of a completed application being  
12 submitted to the State.

13 (f) TERMINATION.—After notice and hearing, a State  
14 may suspend or revoke the designation as a qualified  
15 health carrier of a carrier that fails to maintain compli-  
16 ance with the requirements in subsections (a), (b), and  
17 (c).

18 **SEC. 126. MARKETING HPPC PLANS.**

19 (a) IN GENERAL.—Each HPPC shall use efficient  
20 and standardized means to notify small employers of the  
21 availability of HPPC plans through the HPPC.

22 (b) MARKETING MATERIALS.—Each HPPC shall  
23 make available to small employer and individual members  
24 marketing materials that accurately summarize the HPPC

1 plans, cost, and other relevant information concerning  
2 qualified health carriers offered by the HPPC.

3 (c) USE OF BROKERS.—Nothing in this subtitle shall  
4 be construed to prohibit a HPPC or qualified health car-  
5 rier from using the services of an agent, broker, contrac-  
6 tor, or producer in order to assist in marketing.

7 (d) MONITORING.—Each HPPC shall notify the  
8 State insurance commissioner (or other official identified  
9 by the State) of any marketing practices or materials that  
10 it finds contrary to the fair and affirmative marketing of  
11 qualified health carriers and HPPC plans under this sub-  
12 title.

13 (e) STATE ROLE.—Each State insurance commis-  
14 sioner shall monitor compliance with the marketing re-  
15 quirements of this subtitle and subtitle A, including the  
16 conduct of agents, brokers, contractors, and producers and  
17 investigate complaints of violations of those requirements.

18 **SEC. 127. COLLECTION AND SUBMISSION OF DATA.**

19 (a) FROM HPPCS TO STATES.—Each HPPC shall  
20 submit such data to the State, on a quarterly basis, as  
21 the Secretary may specify. The data shall include the  
22 following:

- 23 (1) With respect to small employer members—  
24 (A) employer enrollment by employer size,  
25 industry sector, previous insurance status, and

1 number of eligible employees within each small  
2 employer, and

3 (B) number of total eligible employers in  
4 the HPPC area.

5 (2) With respect to eligible individuals, the de-  
6 mographic characteristics of those individuals, in-  
7 cluding age, gender, employment status and employ-  
8 ment sector, and previous insurance status.

9 (3) Premium ranges for each HPPC plan for  
10 HPPC member categories.

11 (4) HPPC overhead charges.

12 (5) HPPC financial statements.

13 (b) COLLECTION OF DATA BY HPPCS.—

14 (1) IN GENERAL.—The Secretary shall establish  
15 uniform standards for data that a HPPC collects  
16 from qualified health carriers and providers and  
17 disseminates.

18 (2) COLLECTION.—Under the standards, each  
19 HPPC shall collect only such data as are necessary  
20 for evaluation of the performance of qualified health  
21 carriers (and any provider networks used by those  
22 carriers) by consumers and providers. The Secretary  
23 shall establish the standards consistent with the  
24 method of operation of qualified health carriers, with  
25 national health care data collection initiatives, and

1 with not imposing an unreasonable cost of compli-  
2 ance on qualified health carriers. The Secretary shall  
3 establish the standards only after a study of the fea-  
4 sibility and cost-effectiveness.

5 (3) DISSEMINATION.—Under the standards,  
6 each HPPC shall release the data collected in a uni-  
7 form and standardized format which compares all  
8 qualified health carriers or providers (as the case  
9 may be).

10 (4) ENROLLEE SATISFACTION SURVEYS.—All  
11 enrollee satisfaction surveys used by qualified health  
12 carriers in reporting to HPPCs shall be in a stand-  
13 ardized format promulgated by the Secretary.

14 **SEC. 128. ROLE OF STATE; OVERSIGHT; EVALUATION.**

15 (a) OVERSIGHT.—Each State shall—

16 (1) assure compliance of HPPCs, small employ-  
17 ers, and eligible employees and individuals with the  
18 requirements of this subtitle; and

19 (2) conduct reviews, not less frequently than  
20 annually, on the performance of each HPPC in as-  
21 suring access to health coverage to small employers  
22 and eligible individuals in the HPPC area in accord-  
23 ance with this subtitle.

24 (b) DISPUTE RESOLUTION.—Each State shall re-  
25 ceive, review, and act on appeals of disputes, between a

1 HPPC and a member, not resolved by the HPPC under  
2 section 124(b)(5).

3 (c) ANALYSIS OF INFORMATION.—Each State shall  
4 analyze information collected from qualified health car-  
5 riers and other sources and report findings that assist con-  
6 sumers, HPPCs, qualified health carriers, or health care  
7 providers in improving the delivery or purchase of cost-  
8 effective health care.

9 (d) DISSEMINATION OF INFORMATION.—Each State  
10 shall prepare and make available to HPPCs and employers  
11 located in the State (and to eligible individuals upon re-  
12 quest) information, in comparative form, concerning the  
13 HPPC plans in the State and HPPCs operating in the  
14 State. The information shall include a description of the  
15 following:

16 (1) The HPPCs in the State and HPPC plans  
17 of qualified health carriers available with respect to  
18 each HPPC.

19 (2) The existence of HPPCs within each HPPC  
20 area.

21 (3) Any other information determined appro-  
22 priate by the State.

23 (e) ANNUAL REPORT.—Each State shall report to the  
24 Secretary, at a frequency (not more often than annually)  
25 specified by the Secretary, on the impact of the reforms

1 under this subtitle in expanding the availability and af-  
2 fordability of health coverage to eligible employees and eli-  
3 gible individuals.

4 (f) ANTITRUST PROTECTION.—Each State shall ac-  
5 tively supervise HPPCs to ensure that actions that affect  
6 market competition accomplish the objectives of this sub-  
7 title, so as to provide State and Federal protection to  
8 HPPCs and the board of directors of HPPCs against Fed-  
9 eral and State laws intended to protect commerce from  
10 unlawful restraints, monopolies, and unfair business  
11 practices.

12 (g) NON-PREEMPTION.—Nothing in this subtitle  
13 shall be construed as preempting a State from taking any  
14 actions that are in addition to, and not directly inconsis-  
15 tent with, the provisions of this subtitle.

16 **SEC. 129. DEFINITIONS.**

17 In this subtitle:

18 (1) CARRIER.—The term “carrier” means a li-  
19 censed insurance company, a prepaid hospital or  
20 medical service plan, and a health maintenance orga-  
21 nization offering a health benefit plan, and includes  
22 a similar organization regulated under State law for  
23 solvency.

24 (2) ELIGIBLE EMPLOYEE.—The term “eligible  
25 employee” means, with respect to an employer, an

1 employee who normally performs on a monthly basis  
2 at least 30 hours of service per week for that  
3 employer.

4 (3) ELIGIBLE INDIVIDUAL.—The term “eligible  
5 individual” means an individual residing in the Unit-  
6 ed States who is a citizen or national of the United  
7 States or an alien lawfully residing permanently in  
8 the United States.

9 (4) EMPLOYER.—The term “employer” has the  
10 meaning given that term in section 3(5) of the Em-  
11 ployee Retirement Income Security Act of 1974.

12 (5) HEALTH PLAN PURCHASING COOPERATIVE;  
13 HPPC.—The terms “health plan purchasing coopera-  
14 tive” and “HPPC” mean a State-chartered, non-  
15 profit organization that—

16 (A) provides health coverage purchasing  
17 services to members in a HPPC area regarding  
18 HPPC plans offered by qualified health car-  
19 riers, and

20 (B) is established in accordance with sec-  
21 tion 123.

22 (6) HPPC AREA.—The term “HPPC area”  
23 means an area designated under section 123.

24 (7) HPPC PLAN.—The term “HPPC plan”  
25 means, with respect to a HPPC, a high deductible

1 umbrella insurance plan or managed health care  
2 plan, as defined in section 101, offered by the  
3 HPPC that is marketed in accordance with section  
4 126 and submits data in accordance with section  
5 127.

6 (8) HEALTH MAINTENANCE ORGANIZATION.—  
7 The term “health maintenance organization” in-  
8 cludes, as determined under standards established  
9 by the Secretary, a health insurance plan that meets  
10 specified standards and that offers to provide health  
11 services on a prepaid, at-risk basis primarily through  
12 a defined set of providers.

13 (9) MEMBER.—The term “member” means,  
14 with respect to a HPPC, a small employer or eligible  
15 individual that meets membership requirements for  
16 the HPPC under section 124(b).

17 (10) QUALIFIED HEALTH CARRIER.—The term  
18 “qualified health carrier” means a carrier designated  
19 under section 125(a) by a State insurance commis-  
20 sioner.

21 (11) SERVICE AREA.—The term “service area”  
22 means a geographic region in which a carrier is li-  
23 censed to operate.

24 (12) SMALL EMPLOYER.—The term “small em-  
25 ployer” means, with respect to a calendar year, an

1 employer that normally employs more than 1 but  
2 less than 501 eligible employees on a typical busi-  
3 ness day in any 3-consecutive-month-period in the  
4 year. For the purposes of this paragraph, the term  
5 “employee” includes a self-employed individual. For  
6 purposes of determining if an employer is a small  
7 employer, rules similar to the rules of subsection (b)  
8 and (c) of section 414 of the Internal Revenue Code  
9 of 1986 shall apply.

10 (13) SMALL EMPLOYER MEMBER.—The term  
11 “small employer member” means, with respect to a  
12 HPPC, a small employer that is a member of the  
13 HPPC.

14 (14) STATE INSURANCE COMMISSIONER.—The  
15 term “State insurance commissioner” includes a  
16 State superintendent of insurance and includes, with  
17 respect to a health maintenance organization or  
18 other carrier not regulated by that official, the State  
19 official who is responsible for regulation of the orga-  
20 nization or carrier.

## 21 **Subtitle C—Federal Preemption**

### 22 **SEC. 141. PROHIBITION OF STATE BENEFIT MANDATES FOR** 23 **GROUP HEALTH PLANS.**

24 In the case of a group health plan, no provision of  
25 State or local law shall apply that requires the coverage

1 of one or more specific benefits, services, or categories of  
2 health care, or services of any class or type of provider  
3 of health care.

4 **SEC. 142. PROHIBITION OF PROVISIONS PROHIBITING EM-**  
5 **PLOYER GROUPS FROM PURCHASING**  
6 **HEALTH INSURANCE.**

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

10 **SEC. 143. RESTRICTIONS ON MANAGED CARE.**

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

14 (1) RESTRICTIONS ON REIMBURSEMENT RATES  
15 OR SELECTIVE CONTRACTING.—Any law that re-  
16 stricts the ability of a group health plan to negotiate  
17 reimbursement rates with providers or to contract  
18 selectively with one provider or a limited number of  
19 providers.

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

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

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

5           (B) requires that such review be made (i)  
6 by a resident of the State in which the treat-  
7 ment is to be offered or by an individual li-  
8 censed in such State, or (ii) by a physician in  
9 any particular specialty or with any board cer-  
10 tified specialty of the same medical specialty as  
11 the provider whose services are being reviewed,

12           (C) requires the use of specified standards  
13 of health care practice in such reviews or re-  
14 quires the disclosure of the specific criteria used  
15 in such reviews,

16           (D) requires payments to providers for the  
17 expenses of responding to utilization review re-  
18 quests, or

19           (E) imposes liability for delays in perform-  
20 ing such review.

21 Nothing in subparagraph (B) shall be construed as  
22 prohibiting a State from (i) requiring a licensed phy-  
23 sician or other health care professional be available  
24 at some time in the review or appeal process, or (ii)

1 requiring that any decision in an appeal from such  
2 a review be made by a licensed physician.

3 (b) GAO STUDY.—

4 (1) IN GENERAL.—The Comptroller General  
5 shall conduct a study of the benefits and cost effec-  
6 tiveness of the use of managed care in the delivery  
7 of health services.

8 (2) REPORT.—By not later than 4 years after  
9 the date of the enactment of this Act, the Comptrol-  
10 ler General shall submit a report to Congress on the  
11 study conducted under paragraph (1) and shall in-  
12 clude in the report such recommendations (including  
13 whether the provisions of subsection (a) should be  
14 extended) as may be appropriate.

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

18 **SEC. 144. EXEMPTION OF STATE LAWS PREVENTING DE-**  
19 **NIAL OF LIFESAVING MEDICAL TREATMENT**  
20 **PENDING TRANSFER TO ANOTHER HEALTH**  
21 **CARE PROVIDER.**

22 Nothing in this subtitle shall be construed to invali-  
23 date any State law that has the effect of preventing invol-  
24 untary denial of lifesaving medical treatment when such  
25 denial would cause the involuntary death of the patient

1 pending transfer of the patient to a health care provider  
2 willing to provide such treatment.

3 **SEC. 145. DEFINITIONS.**

4 In this subtitle, the following definitions shall apply:

5 (1) EMPLOYER.—The term “employer” shall  
6 have the meaning applicable under section 3(5) of  
7 the Employee Retirement Income Security Act of  
8 1974.

9 (2) GROUP HEALTH PLAN; PLAN.—(A) The  
10 term “group health plan” means an employee wel-  
11 fare benefit plan providing medical care (as defined  
12 in section 213(d) of the Internal Revenue Code of  
13 1986) to participants or beneficiaries directly or  
14 through insurance, reimbursement, or otherwise, but  
15 does not include any type of coverage excluded from  
16 the definition of a health insurance plan.

17 (B) The term “plan” means, unless used with  
18 a modifying term or the context specifically indicates  
19 otherwise, a group health plan (including any such  
20 plan which is a multiemployer plan), an exempted  
21 multiple employer health plan, or an insured mul-  
22 tiple employer health plan.

23 (3) HEALTH INSURANCE PLAN.—

24 (A) IN GENERAL.—Except as provided in  
25 subparagraph (B), the term “health insurance

1 plan” means any hospital or medical service  
2 policy or certificate, hospital or medical service  
3 plan contract, or health maintenance organiza-  
4 tion group contract offered by an insurer.

5 (B) EXCEPTION.—Such term does not in-  
6 clude any of the following—

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

10 (ii) medicare supplemental health in-  
11 surance,

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

14 (iv) worker’s compensation or similar  
15 insurance, or

16 (v) automobile medical-payment insur-  
17 ance,

18 or any combination thereof.

19 (4) INSURED MULTIPLE EMPLOYER HEALTH  
20 PLAN.—The term “insured multiple employer health  
21 plan” means a fully insured multiple employer wel-  
22 fare arrangement under which benefits consist solely  
23 of medical care described in section 607(1) of the  
24 Employee Retirement Income Security Act of 1974

1 (disregarding such incidental benefits as the Sec-  
2 retary shall specify by regulations).

3 (5) INSURER.—The term “insurer” means a li-  
4 censed insurance company, a prepaid hospital or  
5 medical service plan, and a health maintenance orga-  
6 nization offering such a plan to an employer, and in-  
7 cludes a similar organization regulated under State  
8 law for solvency.

9 (6) SECRETARY.—The term “Secretary” means  
10 the Secretary of Health and Human Services.

11 (7) STATE.—The term “State” means the 50  
12 States, the District of Columbia, Puerto Rico, the  
13 Virgin Islands, Guam, and American Samoa.

14 **Subtitle D—Rules of Construction**  
15 **Regarding Abortion Services;**  
16 **Inseverability**

17 **SEC. 151. RULES OF CONSTRUCTION REGARDING ABOR-**  
18 **TION SERVICES.**

19 Nothing in this title or title II may be construed—

20 (1) to require any health plan to include any  
21 abortion services, or

22 (2) to condition tax deductibility on the inclu-  
23 sion of such services.

1 **SEC. 152. INSEVERABILITY.**

2 If section 151 is judicially determined to be invalid  
3 or any provision in this title or title II is judicially deter-  
4 mined—

5 (1) to require any health plan to include any  
6 abortion services, or

7 (2) to condition tax deductibility on the inclu-  
8 sion of such services,

9 then all the provisions of this title and title II shall be  
10 deemed to be invalid and shall not be given any effect.

1 **TITLE II—AMENDMENTS OF IN-**  
2 **TERNAL REVENUE CODE OF**  
3 **1986**

4 **Subtitle A—Limitations on Em-**  
5 **ployer Deduction for Health**  
6 **Care Coverage for Employees**  
7 **and on Employee Exclusion for**  
8 **Employer-Provided Health Care**  
9 **Coverage**

10 **SEC. 201. EMPLOYER DEDUCTION FOR HEALTH CARE COV-**  
11 **ERAGE FOR EMPLOYEES LIMITED TO COV-**  
12 **ERAGE UNDER HIGH-DEDUCTIBLE PLANS**  
13 **AND MANAGED CARE PLANS AND TO CON-**  
14 **TRIBUTIONS TO MEDICAL SAVINGS AC-**  
15 **COUNTS FOR EMPLOYEES.**

16 (a) IN GENERAL.—Part IX of subchapter B of chap-  
17 ter 1 of the Internal Revenue Code of 1986 (relating to  
18 items not deductible) is amended by adding at the end  
19 the following new section:

20 **“SEC. 280I. CERTAIN HEALTH CARE COVERAGE FOR EM-**  
21 **PLOYEES.**

22 “(a) IN GENERAL.—Except as otherwise provided in  
23 this section, no deduction shall be allowed under this chap-  
24 ter to any employer for health care coverage for any em-  
25 ployee.

1 “(b) EXCEPTIONS.—

2 “(1) IN GENERAL.—Subsection (a) shall not  
3 apply to coverage under—

4 “(A) a high deductible umbrella insurance  
5 plan, or

6 “(B) a managed health care plan.

7 “(2) MEDICAL SAVINGS ACCOUNTS PERMITTED  
8 WITH HIGH DEDUCTIBLE UMBRELLA INSURANCE  
9 PLAN COVERAGE.—In the case of an employer who  
10 provides coverage under a high deductible umbrella  
11 insurance plan for an employee, subsection (a) also  
12 shall not apply to employer contributions to a medi-  
13 cal savings account (as defined in section 23(c)) for  
14 the benefit of such employee.

15 “(3) PERMITTED COVERAGE.—Subsection (a)  
16 shall not apply to permitted coverage (as defined in  
17 subsection (e)).

18 “(c) MAXIMUM DEDUCTION FOR PROVISION OF TAX-  
19 QUALIFIED HEALTH CARE PLANS AND MEDICAL SAV-  
20 INGS ACCOUNTS.—The amount allowed as a deduction by  
21 reason of paragraphs (1) and (2) of subsection (b) for any  
22 taxable year with respect to an employee shall not exceed  
23 the health care tax benefit limitation for such taxable year.

24 “(d) HEALTH CARE TAX BENEFIT LIMITATION.—

1           “(1) IN GENERAL.—The health care tax benefit  
2 limitation for any taxable year is the sum of—

3           “(A) \$2,500 (\$4,000 in the case of a joint  
4 return filed by individuals both of whom are  
5 covered under a tax-qualified health care plan  
6 provided by the employer), plus

7           “(B) \$1,000 if any individual (other than  
8 the taxpayer and the spouse (if any) of the tax-  
9 payer) is covered under such plan by reason of  
10 their relationship to such taxpayer or spouse.

11           “(2) VARIATION OF MAXIMUM DEDUCTION BY  
12 GEOGRAPHIC AREA.—

13           “(A) IN GENERAL.—In the case of any cal-  
14 endar year after 1996, each of the dollar  
15 amounts applicable under paragraph (1) (after  
16 the adjustment under paragraph (3)) shall be  
17 adjusted by the Secretary to reflect variations  
18 in the cost of tax-qualified health care plans be-  
19 tween statistical areas (as defined in section  
20 143(k)(2)). The amounts prescribed by the Sec-  
21 retary under this subparagraph for any cal-  
22 endar year shall apply to taxable years begin-  
23 ning in such calendar year.

24           “(B) METHOD.—

1           “(i) IN GENERAL.—Amounts pre-  
2           scribed under subparagraph (A) for any  
3           area for any calendar year shall be deter-  
4           mined by multiplying the dollar amounts  
5           applicable under paragraph (1) (after the  
6           adjustment under paragraph (3)) by the  
7           cost-of-living multiplier for such area for  
8           such calendar year. If any adjustment  
9           under the preceding sentence is not a mul-  
10          tiple of \$50, such adjustment shall be  
11          rounded to the nearest multiple of \$50.

12          “(ii) MULTIPLIER.—The cost-of-living  
13          multiplier for any area for any calendar  
14          year is the fraction—

15                 “(I) the numerator of which is  
16                 the cost-of-living for such area for  
17                 such calendar year; and

18                 “(II) the denominator of which is  
19                 the average cost-of-living for the  
20                 United States for such calendar year.

21          The Secretary shall determine the cost-of-  
22          living for an area using retail market  
23          prices selected and used under the same  
24          methodology as is used by the Bureau of  
25          Labor Statistics in developing the

1           Consumer Price Index for All Urban Con-  
2           sumers. The cost-of-living for any calendar  
3           year is the cost-of-living as of the close of  
4           the 12-month period ending on August 31  
5           of such calendar year.

6           “(3) INFLATION ADJUSTMENT.—

7           “(A) IN GENERAL.—In the case of any cal-  
8           endar year after 1996, each dollar amount con-  
9           tained in paragraph (1) shall be increased by  
10          an amount equal to—

11                   “(i) such dollar amount, multiplied by

12                           “(ii) the inflation adjustment for such  
13                   calendar year.

14          If any increase under the preceding sentence is  
15          not a multiple of \$50, such increase shall be  
16          rounded to the nearest multiple of \$50.

17          “(B) METHOD OF ADJUSTMENT.—For  
18          purposes of subparagraph (A), the inflation ad-  
19          justment for any calendar year is the greater  
20          of—

21                   “(i) the CPI adjustment, or

22                           “(ii) the MEI adjustment.

23          “(C) CPI ADJUSTMENT.—The CPI adjust-  
24          ment for any calendar year is the percentage (if  
25          any) by which the CPI-U for the preceding cal-

1           endar year exceeds the CPI-U for the second  
2           preceding calendar year.

3           “(D) MEI ADJUSTMENT.—The MEI ad-  
4           justment for any calendar year is—

5                   “(i) the percentage (if any) by which  
6                   MEI for the preceding calendar year ex-  
7                   ceeds the MEI for the second preceding  
8                   calendar year, reduced by

9                           “(ii) 2 percentage points (1 percent-  
10                           age point in the case of adjustments for  
11                           calendar years 1997 and 1998).

12           “(E) INDEX FOR ANY CALENDAR YEAR.—  
13           For purposes of this paragraph, the CPI-U and  
14           MEI for any calendar year is the CPI-U and  
15           MEI as of the close of the 12-month period  
16           ending on August 31 of such calendar year.

17           “(F) CPI-U AND MEI.—For purposes of  
18           this paragraph—

19                   “(i) The term ‘CPI-U’ means the  
20                   Consumer Price Index for all-urban con-  
21                   sumers published by the Department of  
22                   Labor.

23                   “(ii) The term ‘MEI’ means the Medi-  
24                   care Economic Index referred to in the 4th

1 sentence of section 1842(b)(3) of the So-  
2 cial Security Act.

3 “(e) PERMITTED COVERAGE.—For purposes of this  
4 section, the term ‘permitted coverage’ means—

5 “(1) any coverage providing wages or payments  
6 in lieu of wages for any period during which the em-  
7 ployee is absent from work on account of sickness or  
8 injury,

9 “(2) any coverage providing for payments re-  
10 ferred to in section 105(c),

11 “(3) insurance that limits benefits with respect  
12 to specific diseases (or conditions),

13 “(4) hospital or nursing home indemnity insur-  
14 ance,

15 “(5) insurance with respect to accidents,

16 “(6) any coverage provided to an employee or  
17 former employee after such employee has attained  
18 age 65, unless such coverage is provided by reason  
19 of the current employment of the individual (within  
20 the meaning of section 1862(b)(1)(A)(i)(I) of the  
21 Social Security Act) with the employer providing the  
22 coverage,

23 “(7) any coverage provided under Federal law  
24 to any individual (or spouse or dependent thereof)  
25 by reason of such individual being—

1           “(A) a member of the Armed Forces of the  
2           United States, or

3           “(B) a veteran, and

4           “(8) any other coverage to the extent that the  
5           Secretary determines that the continuation of an ex-  
6           clusion for such coverage is not inconsistent with the  
7           purposes of this section.

8           Insurance shall be treated as described in paragraph (3),  
9           (4), or (5) only if the amount of the benefits under the  
10          insurance do not vary based on the amount of expenses  
11          incurred.

12          “(f) SPECIAL RULES FOR DETERMINING AMOUNT OF  
13          DEDUCTION.—

14                 “(1) IN GENERAL.—For purposes of this sec-  
15                 tion, the cost of any coverage for an employee, his  
16                 spouse, and dependents shall be determined on the  
17                 basis of the average cost of providing such coverage  
18                 to the beneficiaries receiving such coverage.

19                 “(2) SPECIAL RULE.—To the extent provided  
20                 by the Secretary, cost determinations under para-  
21                 graph (1) may be made on the basis of reasonable  
22                 estimates.

23          “(g) DEFINITIONS.—For purposes of this section, the  
24          terms ‘high deductible umbrella insurance plan’, ‘managed  
25          health care plan’, and ‘tax-qualified health care plan’ have

1 the respective meanings given such terms by section 101  
2 of Health Savings and Security Act of 1994.”

3 (b) CLERICAL AMENDMENT.—The table of sections  
4 for such part IX is amended by adding at the end the  
5 following new item:

“Sec. 280I. Certain health care coverage for employees.”

6 **SEC. 202. LIMITATION ON EXCLUSION FOR EMPLOYER-PRO-**  
7 **VIDED COVERAGE UNDER HEALTH PLAN.**

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

12 “(a) IN GENERAL.—Except as provided in subsection  
13 (b), gross income of an employee does not include em-  
14 ployer-provided coverage under an accident or health plan.

15 “(b) LIMITATIONS.—

16 “(1) ONLY CERTAIN COVERAGE EXCLUD-  
17 ABLE.—Gross income of an employee shall include  
18 employer-provided coverage under any accident or  
19 health plan except to the extent that—

20 “(A) such coverage consists of coverage  
21 under a tax-qualified health care plan (as de-  
22 fined in section 101 of the Health Savings and  
23 Security Act of 1994),

24 “(B) such coverage consists of contribu-  
25 tions to a medical savings account (as defined

1 in section 23(c)) for the benefit of an employee,  
2 or

3 “(C) such coverage consists of permitted  
4 coverage (as defined in section 280I(e)).

5 “(2) MAXIMUM EXCLUSION FOR EMPLOYER-  
6 PROVIDED TAX-QUALIFIED HEALTH CARE PLANS  
7 AND MEDICAL SAVINGS ACCOUNTS.—

8 “(A) IN GENERAL.—The amount excluded  
9 from gross income by reason of subparagraphs  
10 (A) and (B) of paragraph (1) for any taxable  
11 year shall not exceed the health care tax benefit  
12 limitation for such taxable year determined  
13 under section 280I(d).

14 “(B) SPOUSES WITH DUAL COVERAGE.—If  
15 the taxpayer or the spouse of the taxpayer are  
16 covered under more than 1 tax-qualified health  
17 care plan, coverage under the least expensive  
18 such plan shall not be subject to subparagraph  
19 (A) and such coverage shall not be taken into  
20 account in applying subparagraph (A) to the  
21 other such plan.

22 “(c) SPECIAL RULES FOR DETERMINING AMOUNT OF  
23 INCLUSION.—

24 “(1) IN GENERAL.—For purposes of this sec-  
25 tion, the value of any coverage shall be determined

1 on the basis of the average cost of providing such  
2 coverage to the beneficiaries receiving such coverage.

3 “(2) SPECIAL RULE.—To the extent provided  
4 by the Secretary, cost determinations under para-  
5 graph (1) may be made on the basis of reasonable  
6 estimates.”

7 (b) EMPLOYMENT TAX TREATMENT.—

8 (1) SOCIAL SECURITY TAX.—

9 (A) Subsection (a) of section 3121 of such  
10 Code is amended by inserting after paragraph  
11 (21) the following new sentence:

12 “Nothing in paragraph (2) shall exclude from the term  
13 ‘wages’ any amount which is required to be included in  
14 gross income under section 106(b).”

15 (B) Subsection (a) of section 209 of the  
16 Social Security Act is amended by inserting  
17 after paragraph (21) the following new sen-  
18 tence:

19 “Nothing in paragraph (2) shall exclude from the term  
20 ‘wages’ any amount which is required to be included in  
21 gross income under section 106(b) of the Internal Revenue  
22 Code of 1986.”

23 (2) RAILROAD RETIREMENT TAX.—Paragraph  
24 (1) of section 3231(e) of such Code is amended by  
25 adding at the end thereof the following new sen-

1 tence: “Nothing in clause (i) of the second sentence  
2 of this paragraph shall exclude from the term ‘com-  
3 pensation’ any amount which is required to be in-  
4 cluded in gross income under section 106(b).”

5 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
6 section 3306 of such Code is amended by inserting  
7 after paragraph (16) the following new sentence:  
8 “Nothing in paragraph (2) shall exclude from the term  
9 ‘wages’ any amount which is required to be included in  
10 gross income under section 106(b).”

11 (4) WAGE WITHHOLDING.—Subsection (a) of  
12 section 3401 of such Code is amended by adding at  
13 the end thereof the following new sentence:  
14 “Nothing in the preceding provisions of this subsection  
15 shall exclude from the term ‘wages’ any amount which is  
16 required to be included in gross income under section  
17 106(b).”

18 **SEC. 203. HEALTH BENEFITS MAY NOT BE PROVIDED**  
19 **UNDER CAFETERIA PLANS.**

20 (a) GENERAL RULE.—Subsection (f) of section 125  
21 (defining qualified benefits) is amended by adding at the  
22 end thereof the following new sentence: “Such term shall  
23 not include any benefits or coverage (other than benefits  
24 or coverage described in paragraph (1), (2), (3), (4), or  
25 (5) of section 280I(e)) under an accident or health plan.”

1 (b) CONFORMING AMENDMENT.—Subsection (g) of  
2 section 125 is amended by striking paragraph (2) and re-  
3 designating paragraphs (3) and (4) as paragraphs (2) and  
4 (3), respectively.

5 **SEC. 204. EFFECTIVE DATE.**

6 (a) IN GENERAL.—The amendments made by this  
7 subtitle shall take effect on January 1, 1996.

8 (b) COLLECTIVELY BARGAINED PLANS.—In the case  
9 of a plan maintained pursuant to 1 or more collective bar-  
10 gaining agreements between employee representatives and  
11 1 or more employers ratified before March 15, 1994, the  
12 amendments made by this subtitle shall not apply to  
13 health coverage pursuant to such plan before the earlier  
14 of—

15 (1) the later of—

16 (A) January 1, 1997, or

17 (B) the date on which the last of such col-  
18 lective bargaining agreements terminates (de-  
19 termined without regard to any extension there-  
20 of after March 14, 1994), or

21 (2) January 1, 1999.

1 **Subtitle B—Credits for Contribu-**  
2 **tions to Medical Savings Ac-**  
3 **counts, for Purchase of High De-**  
4 **ductible Umbrella Insurance,**  
5 **and for Routine Preventive**  
6 **Care**

7 **SEC. 211. CREDIT FOR CONTRIBUTIONS TO MEDICAL SAV-**  
8 **INGS ACCOUNTS.**

9 (a) IN GENERAL.—Subpart A of part IV of sub-  
10 chapter A of chapter 1 of the Internal Revenue Code of  
11 1986 (relating to nonrefundable credits) is amended by  
12 inserting after section 22 the following new section:

13 **“SEC. 23. MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.**

14 “(a) EXCLUSION.—In the case of an eligible individ-  
15 ual, there shall be allowed as a credit against the tax im-  
16 posed by this chapter for the taxable year an amount equal  
17 to 31 percent of the medical savings account contributions  
18 of the individual for the taxable year.

19 “(b) LIMITATIONS.—

20 “(1) IN GENERAL.—The amount of medical  
21 savings account contributions by an eligible individ-  
22 ual which may be taken into account under sub-  
23 section (a) for any taxable year shall not exceed the  
24 excess of—

25 “(A) the lesser of—

1 “(i) the account limitation, or

2 “(ii) the excess health care tax benefit

3 limitation for the taxable year, over

4 “(B) the amount (if any) allowable as a  
5 credit under section 35 to the taxpayer for the  
6 taxable year.

7 “(2) ACCOUNT LIMITATION.—

8 “(A) IN GENERAL.—For purposes of para-  
9 graph (1), the account limitation is \$2,000.

10 “(B) HIGHER ACCOUNT LIMITATION IF  
11 TAXPAYER HAS DEPENDENTS.—The \$2,000  
12 amount in subparagraph (A) shall be increased  
13 by the lesser of—

14 “(i) \$500 for each other individual  
15 who is covered under the high deductible  
16 umbrella insurance plan (as defined in sec-  
17 tion 101 of the Health Savings and Secu-  
18 rity Act of 1994) by reason of such indi-  
19 vidual’s relationship to the taxpayer, or

20 “(ii) \$1,500.

21 In the case of a married individual (as defined  
22 in section 7703) who does not file a joint return  
23 with such individual’s spouse, the \$1,500  
24 amount in clause (ii) shall be divided equally

1           between such individual and spouse unless they  
2           agree on a different division of such amount.

3           “(C) PRORATION OF LIMITATION IF PART-  
4           YEAR ELIGIBILITY.—In the case of an individ-  
5           ual who is an eligible individual only for a por-  
6           tion (but not all) of the calendar year ending  
7           with or within the taxable year, the account  
8           limitation under this paragraph for such tax-  
9           able year shall be an amount which bears the  
10          same ratio to such limitation (determined with-  
11          out regard to this paragraph) as such portion  
12          bears to the entire calendar year.

13          “(3) EXCESS HEALTH CARE TAX BENEFIT LIM-  
14          TATION.—For purposes of paragraph (1), the excess  
15          health care tax benefit limitation for any taxable  
16          year is the excess (if any) of—

17                 “(A) the health care tax benefit limitation  
18                 under section 280I(d) for such taxable year,  
19                 over

20                 “(B) the amount excluded from the tax-  
21                 payer’s gross income by reason of subpara-  
22                 graphs (A) and (B) of section 106(b)(1) for  
23                 such taxable year.

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

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

8                   “(A) No contribution will be accepted un-  
9                   less it is in cash, and contributions will not be  
10                  accepted during any calendar year in excess of  
11                  the limitation under subsection (b).

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

18                  “(C) No part of the trust assets will be in-  
19                  vested in life insurance contracts.

20                  “(D) The assets of the trust will not be  
21                  commingled with other property except in a  
22                  common trust fund or common investment  
23                  fund.

24           “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
25           individual’ means any individual who is covered

1 under a high deductible umbrella insurance plan (as  
2 defined in section 101 of Health Savings and Secu-  
3 rity Act of 1994) other than—

4 “(A) an individual who is covered by—

5 “(i) part A or part B of the medicare  
6 program under title XVIII of the Social  
7 Security Act,

8 “(ii) the medicaid program under title  
9 XIX of the Social Security Act,

10 “(iii) the health care program for ac-  
11 tive military personnel under title 10,  
12 United States Code,

13 “(iv) the veterans health care program  
14 under chapter 17 of title 38, United States  
15 Code,

16 “(v) the Civilian Health and Medical  
17 Program of the Uniformed Services  
18 (CHAMPUS), as defined in section  
19 1073(4) of title 10, United States Code, or

20 “(vi) the Indian health service pro-  
21 gram under the Indian Health Care Im-  
22 provement Act (25 U.S.C. 1601 et seq.),

23 “(B) an individual with respect to whom a  
24 deduction under section 151 is allowable to an-  
25 other taxpayer for a taxable year beginning in

1 the calendar year in which the individual's tax-  
2 able year begins, and

3 “(C) an individual if the amendments  
4 made by subtitle A of title II of the Health Sav-  
5 ings and Security Act of 1994 do not apply to  
6 such individual's health coverage by reason of  
7 section 204(b) of such Act.

8 “(3) MEDICAL EXPENSES.—

9 “(A) IN GENERAL.—The term ‘medical ex-  
10 penses’ means, with respect to the account ben-  
11 efiary, the amount paid by such beneficiary  
12 for medical care (as defined in section 213(d))  
13 of such beneficiary and the spouse and depend-  
14 ents (as defined in section 152) of such bene-  
15 ficiary.

16 “(B) LIMITATION ON AMOUNTS PAID FOR  
17 HEALTH INSURANCE.—Such term shall include  
18 amounts paid for insurance only if—

19 “(i) the account beneficiary is not eli-  
20 gible to participate in any subsidized  
21 health plan maintained by any employer of  
22 such beneficiary or of the spouse of such  
23 beneficiary, and

24 “(ii) the insurance is a high deduct-  
25 ible umbrella insurance plan (as defined in

1 section 101 of the Health Savings and Se-  
2 curity Act of 1994.

3 “(4) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
4 TIONS.—The term ‘medical savings account con-  
5 tributions’ means any amount paid in cash for the  
6 taxable year by or on behalf of an individual to a  
7 medical savings account for such individual’s benefit.

8 “(5) ACCOUNT BENEFICIARY.—The term ‘ac-  
9 count beneficiary’ means the individual for whose  
10 benefit the medical savings account is established.

11 “(d) OTHER DEFINITIONS AND SPECIAL RULES.—

12 “(1) TIME WHEN CONTRIBUTIONS DEEMED  
13 MADE.—A contribution shall be deemed to be made  
14 on the last day of the preceding taxable year if the  
15 contribution is made on account of such taxable year  
16 and is made not later than the time prescribed by  
17 law for filing the return for such taxable year (not  
18 including extensions thereof).

19 “(2) MARRIED INDIVIDUALS.—The maximum  
20 credit under subsection (b) shall be computed sepa-  
21 rately for each individual.

22 “(3) EMPLOYER PAYMENTS.—For purposes of  
23 this title, any amount paid by an employer to a med-  
24 ical savings account shall be treated as a payment  
25 of compensation to the employee (other than a self-

1 employed individual who is an employee within the  
2 meaning of section 401(c)(1)) includible in his gross  
3 income for the taxable year for which the amount  
4 was contributed, whether or not a credit for such  
5 payment is allowable under this section to the  
6 employee.

7 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

8 “(1) IN GENERAL.—Any amount paid or dis-  
9 tributed out of a medical savings account shall be in-  
10 cluded in the gross income of the account beneficiary  
11 unless such amount is used exclusively to pay—

12 “(A) the medical expenses of such bene-  
13 ficiary or of the spouse and dependents (as de-  
14 fined in section 152) of such beneficiary, or

15 “(B) the expenses for long-term care (in-  
16 cluding long-term care insurance) for any of  
17 such individuals who have attained age 65 as of  
18 the date such expenses are paid.

19 “(2) EXCESS CONTRIBUTIONS RETURNED BE-  
20 FORE DUE DATE OF RETURN.—Paragraph (1) shall  
21 not apply to the distribution of any contribution paid  
22 during a taxable year to a medical savings account  
23 to the extent that such contribution exceeds the  
24 amount excludable under subsection (a) if—

1           “(A) such distribution is received by the  
2 individual on or before the last day prescribed  
3 by law (including extensions of time) for filing  
4 such individual’s return for such taxable year,  
5 and

6           “(B) such distribution is accompanied by  
7 the amount of net income attributable to such  
8 excess contribution.

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

12           “(3) ROLLOVERS TO INDIVIDUAL RETIREMENT  
13 PLANS.—Paragraph (1) shall not apply to any pay-  
14 ment or distribution to the account beneficiary if—

15           “(A) the payment or distribution is made  
16 on or after the date such beneficiary attains age  
17 65, and

18           “(B) the entire amount received (including  
19 money and other property) is paid into an indi-  
20 vidual retirement plan for the benefit of such  
21 beneficiary not later than the 60th day after  
22 the day on which the individual receives the  
23 payment or distribution.

1 The dollar limitation under section 408(a)(1) shall  
2 not apply to amounts paid under the preceding sen-  
3 tence.

4 “(4) PENALTY FOR DISTRIBUTIONS NOT USED  
5 FOR MEDICAL EXPENSES, ETC.—

6 “(A) IN GENERAL.—The tax imposed by  
7 this chapter for any taxable year in which there  
8 is a payment or distribution from a medical  
9 savings account which is includible in gross in-  
10 come under paragraph (1) shall be increased by  
11 10 percent of the amount which is so includible.

12 “(B) EXCEPTION FOR DISTRIBUTIONS  
13 AFTER AGE 65.—Subparagraph (A) shall not  
14 apply to any distribution or payment after the  
15 date on which the account beneficiary attains  
16 age 65.

17 “(C) DISABILITY OR DEATH CASES.—Sub-  
18 paragraph (A) shall not apply if the payment or  
19 distribution is made after the account bene-  
20 ficiary becomes disabled within the meaning of  
21 section 72(m)(7) or dies.

22 “(f) TAX TREATMENT OF ACCOUNTS.—

23 “(1) IN GENERAL.—A medical savings account  
24 is exempt from taxation under this subtitle, unless  
25 such account has ceased to be a medical savings ac-

1 count by reason of paragraph (2) or (3). Notwith-  
2 standing the preceding sentence, any such account is  
3 subject to the taxes imposed by section 511 (relating  
4 to imposition of tax on unrelated business income of  
5 charitable, etc., organizations).

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

8 “(A) IN GENERAL.—If, during any taxable  
9 year of the account beneficiary engages in any  
10 transaction prohibited by section 4975 with re-  
11 spect to the account, the account ceases to be  
12 a medical savings account as of the first day of  
13 that taxable year.

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

1           “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-  
2           RITY.—If, during any taxable year, the account ben-  
3           eficiary uses the account or any portion thereof as  
4           security for a loan, the portion so used is treated as  
5           distributed and not used to pay medical expenses.

6           “(g) INFLATION ADJUSTMENT.—In the case of any  
7           calendar year after 1996, each dollar amount in subsection  
8           (b) shall be increased by an amount equal to—

9                   “(1) such dollar amount, multiplied by

10                   “(2) the inflation adjustment (determined  
11           under section 280I(d)(3)) for such calendar year.

12           If any increase under the preceding sentence is not a mul-  
13           tiple of \$50, such increase shall be rounded to the nearest  
14           multiple of \$50.

15           “(h) CUSTODIAL ACCOUNTS.—For purposes of this  
16           section, a custodial account shall be treated as a trust if—

17                   “(1) the assets of such account are held by a  
18           bank (as defined in section 408(n)) or another per-  
19           son who demonstrates to the satisfaction of the Sec-  
20           retary that the manner in which he will administer  
21           the account will be consistent with the requirements  
22           of this section, and

23                   “(2) the custodial account would, except for the  
24           fact that it is not a trust, constitute a medical sav-  
25           ings account described in subsection (c).

1 For purposes of this title, in the case of a custodial ac-  
2 count treated as a trust by reason of the preceding sen-  
3 tence, the custodian of such account shall be treated as  
4 the trustee thereof.

5 “(i) REPORTS.—The trustee of a medical savings ac-  
6 count shall make such reports regarding such account to  
7 the Secretary and to the account beneficiary with respect  
8 to contributions, distributions, and such other matters as  
9 the Secretary may require under regulations. The reports  
10 required by this subsection shall be filed at such time and  
11 in such manner and furnished to such individuals at such  
12 time and in such manner as may be required by those reg-  
13 ulations.

14 “(j) OTHER DEFINITIONS.—For purposes of this sec-  
15 tion—

16 “(1) EMPLOYER.—The term ‘employer’ includes  
17 persons treated as an employer under section  
18 401(c)(4).

19 “(2) EMPLOYEE.—The term ‘employee’ includes  
20 an individual who is an employee within the meaning  
21 of section 401(c)(1).”

22 (b) EMPLOYER PAYMENTS EXCLUDED FROM EM-  
23 PLOYMENT TAX BASE.—

24 (1) SOCIAL SECURITY TAXES.—

1           (A) Subsection (a) of section 3121 of such  
2           Code is amended by striking “or” at the end of  
3           paragraph (20), by striking the period at the  
4           end of paragraph (21) and inserting “; or”, and  
5           by inserting after paragraph (21) the following  
6           new paragraph:

7           “(22) any payment made to or for the benefit  
8           of an employee if at the time of such payment it is  
9           reasonable to believe that the employee will be able  
10          to take such payment into account in determining  
11          the credit under section 23.”

12          (B) Subsection (a) of section 209 of the  
13          Social Security Act is amended by striking “or”  
14          at the end of paragraph (18), by striking the  
15          period at the end of paragraph (19) and insert-  
16          ing “; or”, and by inserting after paragraph  
17          (19) the following new paragraph:

18          “(20) any payment made to or for the benefit  
19          of an employee if at the time of such payment it is  
20          reasonable to believe that the employee will be able  
21          to take such payment into account in determining  
22          the credit under section 23 of the Internal Revenue  
23          Code of 1986.”

1           (2) RAILROAD RETIREMENT TAX.—Subsection  
2           (e) of section 3231 of such Code is amended by add-  
3           ing at the end the following new paragraph:

4           “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
5           TIONS.—The term ‘compensation’ shall not include  
6           any payment made to or for the benefit of an em-  
7           ployee if at the time of such payment it is reason-  
8           able to believe that the employee will be able to take  
9           such payment into account in determining the credit  
10          under section 23.”

11          (3) UNEMPLOYMENT TAX.—Subsection (b) of  
12          section 3306 of such Code is amended by striking  
13          “or” at the end of paragraph (15), by striking the  
14          period at the end of paragraph (16) and inserting “;  
15          or”, and by inserting after paragraph (16) the fol-  
16          lowing new paragraph:

17          “(17) any payment made to or for the benefit  
18          of an employee if at the time of such payment it is  
19          reasonable to believe that the employee will be able  
20          to take such payment into account in determining  
21          the credit under section 23.”

22          (4) WITHHOLDING TAX.—Subsection (a) of sec-  
23          tion 3401 of such Code is amended by striking “or”  
24          at the end of paragraph (19), by striking the period  
25          at the end of paragraph (20) and inserting “; or”,

1 and by inserting after paragraph (20) the following  
2 new paragraph:

3 “(21) any payment made to or for the benefit  
4 of an employee if at the time of such payment it is  
5 reasonable to believe that the employee will be able  
6 to take such payment into account in determining  
7 the credit under section 23.”

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

13 (1) by inserting “**MEDICAL SAVINGS AC-**  
14 **COUNTS,**” after “**ACCOUNTS,**” in the heading of  
15 such section,

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

19 “(2) a medical savings account (within the  
20 meaning of section 23(c)),”,

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

23 (4) by adding at the end thereof the following  
24 new subsection:

1       “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS  
2 ACCOUNTS.—For purposes of this section, in the case of  
3 a medical savings account (within the meaning of section  
4 23(c)), the term ‘excess contributions’ means the amount  
5 by which the amount contributed for the taxable year to  
6 the account exceeds the amount which may be taken into  
7 account in determining the credit under section 23 for  
8 such taxable year. For purposes of this subsection, any  
9 contribution which is distributed out of the medical sav-  
10 ings account in a distribution to which section 23(e)(2)  
11 applies shall be treated as an amount not contributed.”

12       (d) TAX ON PROHIBITED TRANSACTIONS.—Section  
13 4975 of such Code (relating to prohibited transactions)  
14 is amended—

15               (1) by adding at the end of subsection (c) the  
16 following new paragraph:

17               “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
18 COUNTS.—An individual for whose benefit a medical  
19 savings account (within the meaning of section  
20 23(c)) is established shall be exempt from the tax  
21 imposed by this section with respect to any trans-  
22 action concerning such account (which would other-  
23 wise be taxable under this section) if, with respect  
24 to such transaction, the account ceases to be a medi-

1 cal savings account by reason of the application of  
2 section 23(f)(2)(A) to such account.”, and

3 (2) by inserting “or a medical savings account  
4 described in section 23(c)” in subsection (e)(1) after  
5 “described in section 408(a)”.

6 (e) FAILURE TO PROVIDE REPORTS ON MEDICAL  
7 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat-  
8 ing to failure to provide reports on individual retirement  
9 account or annuities) is amended—

10 (1) by inserting “**OR ON MEDICAL SAVINGS**  
11 **ACCOUNTS**” after “**ANNUITIES**” in the heading of  
12 such section, and

13 (2) by adding at the end of subsection (a) the  
14 following: “The person required by section 23(i) to  
15 file a report regarding a medical savings account at  
16 the time and in the manner required by such section  
17 shall pay a penalty of \$50 for each failure unless it  
18 is shown that such failure is due to reasonable  
19 cause.”

20 (f) CLERICAL AMENDMENTS.—

21 (1) The table of sections for subpart A of part  
22 IV of subchapter A of chapter 1 of such Code is  
23 amended by inserting after the item relating to sec-  
24 tion 22:

“Sec. 23. Medical savings account contributions.”

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

“Sec. 4973. Tax on excess contributions to individual retirement  
accounts, medical savings accounts, certain 403(b)  
contracts, and certain individual retirement annu-  
ities.”

4           (3) The table of sections for subchapter B of  
5 chapter 68 of such Code is amended by inserting “or  
6 on medical savings accounts” after “annuities” in  
7 the item relating to section 6693.

8 **SEC. 212. REFUNDABLE CREDIT FOR PURCHASE OF COV-**  
9 **ERAGE UNDER TAX-QUALIFIED HEALTH**  
10 **CARE PLANS.**

11       (a) IN GENERAL.—Subpart C of part IV of sub-  
12 chapter A of chapter 1 of the Internal Revenue Code of  
13 1986 (relating to refundable credits) is amended by redес-  
14 ignating section 35 as section 36 and by inserting after  
15 section 34 the following new section:

16 **“SEC. 35. PURCHASE OF COVERAGE UNDER TAX-QUALIFIED**  
17 **HEALTH CARE PLANS.**

18       “(a) ALLOWANCE OF CREDIT.—In the case of an in-  
19 dividual, there shall be allowed as a credit against the tax  
20 imposed by this subtitle for the taxable year an amount  
21 equal to 31 percent of the amount paid by the taxpayer  
22 during the taxable year for coverage under a tax-qualified  
23 health care plan (as defined in section 101 of the Health

1 Savings and Security Act of 1994) for the taxpayer, the  
2 spouse of the taxpayer, and any dependent (as defined in  
3 section 152) of the taxpayer.

4 “(b) COVERAGE OF CERTAIN INDIVIDUALS NOT IN-  
5 CLUDED.—There shall not be taken into account under  
6 subsection (a) amounts paid for coverage for any individ-  
7 ual if—

8 “(1) such individual is covered by—

9 “(A) part A or part B of the medicare pro-  
10 gram under title XVIII of the Social Security  
11 Act,

12 “(B) the medicaid program under title  
13 XIX of the Social Security Act,

14 “(C) the health care program for active  
15 military personnel under title 10, United States  
16 Code,

17 “(D) the veterans health care program  
18 under chapter 17 of title 38, United States  
19 Code,

20 “(E) the Civilian Health and Medical Pro-  
21 gram of the Uniformed Services (CHAMPUS),  
22 as defined in section 1073(4) of title 10, United  
23 States Code, or

1           “(F) the Indian health service program  
2           under the Indian Health Care Improvement Act  
3           (25 U.S.C. 1601 et seq.), or

4           “(2) the amendments made by subtitle A of  
5           title II of the Health Savings and Security Act of  
6           1994 do not apply to such individual’s health cov-  
7           erage by reason of section 204(b) of such Act.

8           “(c) COORDINATION WITH HEALTH INSURANCE  
9           CREDIT CERTIFICATES.—

10           “(1) IN GENERAL.—If any health insurance  
11           credit certificate is used pursuant to section 212(b)  
12           of the Health Savings and Security Act of 1994 by  
13           the taxpayer to pay for coverage under a tax-quali-  
14           fied health care plan during any taxable year, then  
15           the tax imposed by this chapter for such taxable  
16           year shall be increased by the aggregate dollar  
17           amount of the certificates so used during such tax-  
18           able year.

19           “(2) RECONCILIATION OF CERTIFICATES AND  
20           CREDIT ALLOWED.—Any increase in tax under para-  
21           graph (1) shall not be treated as tax imposed by this  
22           chapter for purposes of determining the amount of  
23           any credit (other than the credit allowed by sub-  
24           section (a)) allowable under this subpart.”

1 (b) HEALTH INSURANCE CERTIFICATES FOR LOW-  
2 INCOME INDIVIDUALS ELIGIBLE FOR CREDIT.—

3 (1) IN GENERAL.—The Secretary of the Treas-  
4 ury shall establish a program under which individ-  
5 uals provide certificates to any provider of a tax-  
6 qualified health care plan (as defined in section 101  
7 of this Act) in full or partial payment of the provid-  
8 er's premium for the individual for the year. If an  
9 individual presents the provider with such a certifi-  
10 cate, the provider shall accept the certificate toward  
11 payment of the provider's premium for the individ-  
12 ual for the year.

13 (2) INDIVIDUALS ELIGIBLE FOR CERTIFI-  
14 CATES.—Under the program established pursuant to  
15 paragraph (1), certificates shall be available only to  
16 individuals—

17 (A) to whom a credit under section 35 of  
18 the Internal Revenue Code of 1986 (as added  
19 by subsection (a)) is allowable for the taxable  
20 year, and

21 (B) whose liability for tax under subtitle A  
22 of such Code (determined without regard to  
23 such credit) is likely (as determined by the Sec-  
24 retary) to be less than the amount of such cred-  
25 it allowable for such taxable year.

1           (3) AMOUNT OF CERTIFICATES.—The dollar  
2 amount of the certificates provided under such pro-  
3 gram to an individual for any taxable year shall not  
4 exceed the amount of the credit under such section  
5 35 that the Secretary estimates will be allowable to  
6 such individual for such taxable year.

7           (4) PAYMENT TO PROVIDERS.—

8           (A) AMOUNT.—Except as otherwise pro-  
9 vided in this paragraph, a provider of any tax-  
10 qualified health care plan shall be entitled, upon  
11 presentation to the Secretary (or his designee)  
12 of an individual's certificate and of information  
13 used by the provider to determine the individ-  
14 ual's applicable premium, to payment equal to  
15 the dollar amount of the certificate.

16           (B) PREMIUM LESS THAN CERTIFICATE  
17 DOLLAR AMOUNT.—If the certificate dollar  
18 amount is greater than the amount of the indi-  
19 vidual's applicable premium, the provider of the  
20 tax-qualified health care plan to the individual  
21 shall be entitled to payment under subpara-  
22 graph (A) only in the amount of the individual's  
23 applicable premium.

24           (C) OFFSETTING PAYMENTS.—If a pro-  
25 vider of a tax-qualified health care plan has re-

1           ceived prepayment of an individual's applicable  
2           premium for any period for which the individ-  
3           ual's certificate is in effect, the amount of the  
4           payment to which the provider is otherwise enti-  
5           tled under subparagraph (A) shall be reduced  
6           to the extent of such premium paid.

7           (D) ACCEPTANCE OF CERTAIN IMPROPER  
8           CERTIFICATES.—The Secretary may not deny  
9           payment under subparagraph (A) to a provider  
10          of a tax-qualified health care plan because a  
11          certificate presented for payment was invalid,  
12          unless the entity had knowledge of such invalid-  
13          ity at the time of its acceptance of the certifi-  
14          cate.

15          (5) HEALTH PLANS PROVIDED BY STATES.—In  
16          the case of a tax-qualified health care plan provided  
17          pursuant to a program described in section 1932 of  
18          the Social Security Act, the State shall be treated  
19          for purposes of this subsection as the provider of  
20          such plan.

21          (c) TECHNICAL AMENDMENTS.—

22                 (1) Subsection (l) of section 162 of such Code  
23                 is hereby repealed.

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

          “Sec. 35. Purchase of coverage under tax-qualified health care  
          plans.

          “Sec. 36. Overpayments of tax.”

4           (3) Paragraph (2) of section 1324(b) of title  
5           31, United States Code, is amended by inserting be-  
6           fore the period “or from section 35 of such Code”.

7   **SEC. 213. CREDIT FOR COST OF ROUTINE PREVENTIVE**  
8                           **CARE.**

9           (a) IN GENERAL.—Subpart A of part IV of sub-  
10          chapter A of chapter 1 of the Internal Revenue Code of  
11          1986 (relating to nonrefundable credits) is amended by  
12          inserting after section 23 the following new section:

13       **“SEC. 24. COST OF ROUTINE PREVENTIVE CARE.**

14           “(a) ALLOWANCE OF CREDIT.—In the case of an in-  
15          dividual, there shall be allowed as a credit against the tax  
16          imposed by this chapter for the taxable year an amount  
17          equal to 31 percent of the amount paid by the taxpayer  
18          during the taxable year for routine preventive care for the  
19          taxpayer, the spouse of the taxpayer, and any dependent  
20          (as defined in section 152) of the taxpayer.

21           “(b) CARE OF CERTAIN INDIVIDUALS NOT IN-  
22          CLUDED.—There shall not be taken into account under  
23          subsection (a) amounts paid for routine preventive care  
24          for—

1           “(1) any individual who is the beneficiary of a  
2           medical savings account (as defined in section 23(c))  
3           or the spouse or a dependent of such a beneficiary,

4           “(2) any individual who is covered under a  
5           managed health care plan (as defined in section 101  
6           of Health Savings and Security Act of 1994),

7           “(3) any individual who is covered by—

8                   “(A) part A or part B of the medicare pro-  
9                   gram under title XVIII of the Social Security  
10                  Act,

11                  “(B) the medicaid program under title  
12                  XIX of the Social Security Act,

13                  “(C) the health care program for active  
14                  military personnel under title 10, United States  
15                  Code,

16                  “(D) the veterans health care program  
17                  under chapter 17 of title 38, United States  
18                  Code,

19                  “(E) the Civilian Health and Medical Pro-  
20                  gram of the Uniformed Services (CHAMPUS),  
21                  as defined in section 1073(4) of title 10, United  
22                  States Code,

23                  “(F) the Indian health service program  
24                  under the Indian Health Care Improvement Act  
25                  (25 U.S.C. 1601 et seq.), and

1           “(4) any individual if the amendments made by  
2 subtitle A of title II of the Health Savings and Secu-  
3 rity Act of 1994 do not apply to such individual’s  
4 health coverage by reason of section 204(b) of such  
5 Act.

6           “(c) ROUTINE PREVENTIVE CARE.—For purposes of  
7 this section, the term ‘routine preventive care’ means any  
8 service provided in accordance with the recommended  
9 schedule of clinical preventive services of the United States  
10 Preventive Services Task Force.”

11           (b) CLERICAL AMENDMENT.—The table of sections  
12 for such subpart A is amended by inserting after the item  
13 relating to section 23 the following new item:

“Sec. 24. Cost of routine preventive care.”

14 **SEC. 214. EFFECTIVE DATE.**

15           The amendments made by this subtitle shall apply to  
16 taxable years beginning after December 31, 1995.

17           **Subtitle C—Repeal of Medical**  
18           **Expense Deduction**

19 **SEC. 221. REPEAL OF MEDICAL EXPENSE DEDUCTION.**

20           Section 213 of the Internal Revenue Code of 1986  
21 (relating to medical, dental, etc., expenses) is amended by  
22 adding at the end thereof the following new subsection:

23           “(f) TERMINATION.—No deduction shall be allowed  
24 under this section for any taxable year beginning after De-  
25 cember 31, 1995.”

1           **Subtitle D—Veterans Medical**  
 2           **Benefits and Services Unaffected**

3   **SEC. 231. VETERANS MEDICAL BENEFITS AND SERVICES**  
 4                           **UNAFFECTED.**

5           Nothing in this title or the amendments made by this  
 6 title shall affect the eligibility of any veteran (or spouse  
 7 or dependent thereof) for medical benefits and services  
 8 provided under title 38, United States Code.

9   **TITLE III—SAVINGS IN MEDI-**  
 10           **CARE AND MEDICAID PRO-**  
 11           **GRAMS**

12           **Subtitle A—Medicare Program**

13   **SEC. 301. INCREASE IN MEDICARE PART B PREMIUM FOR**  
 14                           **INDIVIDUALS WITH HIGH INCOME.**

15           (a) IN GENERAL.—Subchapter A of chapter 1 of the  
 16 Internal Revenue Code of 1986 is amended by adding at  
 17 the end thereof the following new part:

18   **“PART VIII—MEDICARE PART B PREMIUMS FOR**  
 19                           **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

20   **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

21           “(a) IMPOSITION OF TAX.—In the case of an individ-  
 22 ual to whom this section applies for the taxable year, there  
 23 is hereby imposed (in addition to any other tax imposed  
 24 by this subtitle) a tax for such taxable year equal to the

1 aggregate of the Medicare part B premium taxes for each  
2 of the months during such year that such individual is  
3 covered by Medicare part B.

4 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—  
5 This section shall apply to any individual for any taxable  
6 year if—

7 “(1) such individual is covered under Medicare  
8 part B for any month during such year, and

9 “(2) the modified adjusted gross income of the  
10 taxpayer for such taxable year exceeds the threshold  
11 amount.

12 “(c) MEDICARE PART B PREMIUM TAX FOR  
13 MONTH.—

14 “(1) IN GENERAL.—The Medicare part B pre-  
15 mium tax for any month is  $\frac{2}{3}$  the amount equal to  
16 the excess of—

17 “(A) 150 percent of the monthly actuarial  
18 rate for enrollees age 65 and over determined  
19 for that calendar year under section 1839(b) of  
20 the Social Security Act, over

21 “(B) the total monthly premium under sec-  
22 tion 1839 of the Social Security Act (deter-  
23 mined without regard to subsections (b) and (f)  
24 of section 1839 of such Act).

1           “(2) PHASEIN OF TAX.—If the modified ad-  
2           justed gross income of the taxpayer for any taxable  
3           years exceeds the threshold amount by less than  
4           \$50,000, the Medicare part B premium tax for any  
5           month during such taxable year shall be an amount  
6           which bears the same ratio to the amount deter-  
7           mined under paragraph (1) (without regard to this  
8           paragraph) as such excess bears to \$50,000. The  
9           preceding sentence shall not apply to any individual  
10          whose threshold amount is zero.

11          “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
12          For purposes of this section—

13                  “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
14                  old amount’ means—

15                          “(A) except as otherwise provided in this  
16                          paragraph, \$100,000,

17                          “(B) \$125,000 in the case of a joint re-  
18                          turn, and

19                          “(C) zero in the case of a taxpayer who—

20                                  “(i) is married at the close of the tax-  
21                                  able year but does not file a joint return  
22                                  for such year, and

23                                  “(ii) does not live apart from his  
24                                  spouse at all times during the taxable year.

1           “(2) MODIFIED ADJUSTED GROSS INCOME.—  
2           The term ‘modified adjusted gross income’ means  
3           adjusted gross income—

4                   “(A) determined without regard to sections  
5                   135, 911, 931, and 933, and

6                   “(B) increased by the amount of interest  
7                   received or accrued by the taxpayer during the  
8                   taxable year which is exempt from tax.

9           “(3) MEDICARE PART B COVERAGE.—An indi-  
10           vidual shall be treated as covered under Medicare  
11           part B for any month if a premium is paid under  
12           part B of title XVIII of the Social Security Act for  
13           the coverage of the individual under such part for  
14           the month.

15           “(4) MARRIED INDIVIDUAL.—The determina-  
16           tion of whether an individual is married shall be  
17           made in accordance with section 7703.”

18           (b) CLERICAL AMENDMENT.—The table of parts for  
19           subchapter A of chapter 1 of such Code is amended by  
20           adding at the end thereof the following new item:

                  “Part VIII. Medicare Part B Premiums For High-Income Individ-  
                  uals.”

21           (c) EFFECTIVE DATE.—The amendments made by  
22           this section shall apply to months after December 1993  
23           in taxable years ending after December 31, 1995.

1 **SEC. 302. IMPOSITION OF 20 PERCENT COINSURANCE ON**  
2 **CLINICAL LABORATORY SERVICES UNDER**  
3 **MEDICARE.**

4 (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of  
5 section 1833(a) of the Social Security Act (42 U.S.C.  
6 1395l(a)) are each amended—

7 (1) by striking “(or 100 percent” and all that  
8 follows through “the first opinion))”; and

9 (2) by striking “100 percent of such negotiated  
10 rate” and inserting “80 percent of such negotiated  
11 rate”.

12 (b) REPEAL OF MANDATORY ASSIGNMENT.—Section  
13 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amend-  
14 ed by striking subparagraphs (C) and (D).

15 (c) EFFECTIVE DATE.—The amendments made by  
16 subsections (a) and (b) shall apply to tests furnished on  
17 or after January 1, 1996.

18 **SEC. 303. ANNUAL INDEXING OF PART B DEDUCTIBLE.**

19 Section 1833(b) of the Social Security Act (42 U.S.C.  
20 1395l(b)) is amended by striking “1991 and subsequent  
21 years” and inserting the following: “calendar years 1991  
22 through 1995, and, for calendar year 1996 and each sub-  
23 sequent year, by a deductible equal to the deductible under  
24 this subsection for the previous year increased by the per-  
25 centage increase in the consumer price index for all urban

1 consumers (U.S. city average) for the 12-month period  
2 ending with June of the previous year”.

### 3 **Subtitle B—Medicaid Program**

#### 4 **PART 1—ACHIEVING SAVINGS IN PROGRAM**

##### 5 **SEC. 311. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE** 6 **MEDICAL SERVICES FURNISHED UNDER THE** 7 **MEDICAID PROGRAM.**

8 (a) IN GENERAL.—Title XIX of the Social Security  
9 Act (42 U.S.C. 1396 et seq.) is amended by redesignating  
10 section 1931 as section 1932 and by inserting after section  
11 1930 the following new section:

12 “CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL  
13 SERVICES

14 “SEC. 1931. (a) ANNUAL FEDERAL CAP.—Federal  
15 financial participation is not available under section  
16 1903(a)(1) for expenditures for acute medical services (as  
17 defined in subsection (c)) for a class of medicaid categor-  
18 ical individuals (as defined in subsection (c)(2)) for a  
19 State for a quarter in a fiscal year, to the extent such  
20 expenditures exceed  $\frac{1}{4}$  of the product of—

21 “(1) the per-capita limit determined under sub-  
22 section (b) for the State for such fiscal year for such  
23 class, multiplied by

24 “(2) the average number of medicaid categor-  
25 ical individuals in such class entitled to receive medi-

1 cal assistance under the State plan in any month in  
2 the quarter.

3 “(b) PER-CAPITA LIMIT.—

4 “(1) IN GENERAL.—For purposes of subsection  
5 (a), the per-capita limit for a class of medicaid cat-  
6 egorical individuals for a State for—

7 “(A) fiscal year 1996, is an amount equal  
8 to the base per-capita funding amount (as de-  
9 termined under paragraph (2)) for such class  
10 for such State, increased by 20 percent; and

11 “(B) fiscal year 1997 and each succeeding  
12 fiscal year, is an amount equal to the amount  
13 determined under this paragraph for the pre-  
14 vious fiscal year for the class updated by the  
15 applicable percentage for such fiscal year (de-  
16 scribed in paragraph (3)).

17 “(2) BASE PER-CAPITA FUNDING AMOUNT.—

18 “(A) IN GENERAL.—The base per-capita  
19 funding amount for a State for a class is an  
20 amount equal to the quotient of—

21 “(i) the gross amount of payments  
22 under the State plan under this title with  
23 respect to medical assistance furnished for  
24 acute medical services for individuals with-  
25 in such class for calendar quarters in fiscal

1 year 1994, but does not include such ex-  
2 penditures for which no Federal financial  
3 participation is provided under such plan;  
4 divided by

5 “(ii) the average total number of med-  
6 icaid categorical individuals in such class  
7 in the State in any month during fiscal  
8 year 1994.

9 “(B) DISPROPORTIONATE SHARE PAY-  
10 MENTS NOT INCLUDED.—In applying subpara-  
11 graph (A), payments made under section 1923  
12 shall not be counted in the gross amount of  
13 payments.

14 “(C) TREATMENT OF DISALLOWANCES.—  
15 The amount determined under this paragraph  
16 shall take into account amounts (or an estimate  
17 of amounts) disallowed.

18 “(3) APPLICABLE PERCENTAGE.—In paragraph  
19 (1), the applicable percentage for a fiscal year is  
20 equal to—

21 “(A) for fiscal year 1997, the greater of—

22 “(i) the estimated percentage change  
23 in the Consumer Price Index through the  
24 midpoint of fiscal year 1996, plus 3 per-  
25 centage points, or

1           “(ii) the medicare economic index re-  
2           ferred to in the fourth sentence of section  
3           1842(b)(3) applicable to services provided  
4           as of January 1 of the fiscal year, minus  
5           1 percentage point;

6           “(B) for fiscal year 1998, the greater of—

7           “(i) the estimated percentage change  
8           in the Consumer Price Index through the  
9           midpoint of fiscal year 1997, plus 2 per-  
10          centage points, or

11          “(ii) the medicare economic index re-  
12          ferred to in the fourth sentence of section  
13          1842(b)(3) applicable to services provided  
14          as of January 1 of the fiscal year, minus  
15          1 percentage point;

16          “(C) for fiscal year 1999, the greater of—

17          “(i) the estimated percentage change  
18          in the Consumer Price Index through the  
19          midpoint of fiscal year 1998, plus 1 per-  
20          centage point, or

21          “(ii) the medicare economic index re-  
22          ferred to in the fourth sentence of section  
23          1842(b)(3) applicable to services provided  
24          as of January 1 of the fiscal year, minus  
25          2 percentage points; and

1           “(D) for fiscal year 2000 and each suc-  
2           ceeding fiscal year, the greater of—

3                   “(i) the estimated percentage change  
4                   in the Consumer Price Index through the  
5                   midpoint of the previous fiscal year, or

6                   “(ii) the medicare economic index re-  
7                   ferred to in the fourth sentence of section  
8                   1842(b)(3) applicable to services provided  
9                   as of January 1 of the fiscal year, minus  
10                  2 percentage points.

11           “(4) ESTIMATIONS OF AND ADJUSTMENTS TO  
12           STATE TOTAL FUNDING AMOUNT.—The Secretary  
13           shall—

14                   “(A) establish a process for estimating the  
15                   limit on expenditures for acute medical services  
16                   applicable under subsection (a) at the beginning  
17                   of each fiscal year and adjusting such amount  
18                   during such fiscal year; and

19                   “(B) notifying each State of the esti-  
20                   mations and adjustments referred to in sub-  
21                   paragraph (A).

22           “(c) DEFINITIONS.—For purposes of this section and  
23           section 1931:

1           “(1) ACUTE MEDICAL SERVICES.—The term  
2           ‘acute medical services’ means items and services de-  
3           scribed in section 1905(a) other than the following:

4                   “(A) Nursing facility services (as defined  
5                   in section 1905(f)).

6                   “(B) Intermediate care facility for the  
7                   mentally retarded services (as defined in section  
8                   1905(d)).

9                   “(C) Personal care services (as described  
10                  in section 1905(a)(24)).

11                  “(D) Private duty nursing services (as re-  
12                  ferred to in section 1905(a)(8)).

13                  “(E) Home or community-based services  
14                  furnished under a waiver granted under sub-  
15                  section (c), (d), or (e) of section 1915.

16                  “(F) Home and community care furnished  
17                  to functionally disabled elderly individuals  
18                  under section 1929.

19                  “(G) Community supported living arrange-  
20                  ments services under section 1930.

21                  “(H) Case-management services (as de-  
22                  scribed in section 1915(g)(2)).

23                  “(I) Home health care services (as referred  
24                  to in section 1905(a)(7)), clinic services, and re-  
25                  habilitation services that are furnished to an in-

1           dividual who has a condition or disability that  
2           qualifies the individual to receive any of the  
3           services described in a previous subparagraph.

4           “(J) Hospice care.

5           “(2) MEDICAID CATEGORICAL INDIVIDUAL.—

6           The term ‘medicaid categorical individual’ means an  
7           individual described in section 1902(a)(10)(A).

8           “(3) CLASS OF MEDICAID CATEGORICAL INDI-  
9           VIDUALS.—The term ‘class’ means individuals within  
10          each of the following classes:

11          “(A) SSI-RELATED INDIVIDUALS.—Medic-  
12          aid categorical individuals—

13                 “(i) with respect to whom supple-  
14                 mental security income benefits are being  
15                 paid under title XVI of the Social Security  
16                 Act,

17                 “(ii) who receiving a supplementary  
18                 payment under section 1616 of such Act or  
19                 under section 212 of Public Law 93–66, or

20                 “(iii) who receiving monthly benefits  
21                 under section 1619(a) of such Act (wheth-  
22                 er or not pursuant to section 1616(c)(3) of  
23                 such Act).

1           “(B) OTHER INDIVIDUALS.—Medicaid cat-  
2           egorical individuals not described in subpara-  
3           graph (A).”.

4           (b) REQUIRING STATE MAINTENANCE OF EFFORT.—  
5           Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is  
6           amended—

7           (1) by striking “and” at the end of paragraph  
8           (61);

9           (2) by striking the period at the end of para-  
10          graph (62) and inserting “; and”; and

11          (3) by adding at the end the following new  
12          paragraph:

13          “(63) provide that the State will continue to  
14          make eligible for medical assistance under section  
15          1902(a)(10)(A) any class or category of individuals  
16          eligible for medical assistance under such section  
17          during fiscal year 1994.”.

18          (c) DISCONTINUATION OF REIMBURSEMENT STAND-  
19          ARDS FOR INPATIENT HOSPITAL SERVICES.—Section  
20          1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A))  
21          is amended—

22          (1) by striking “hospital services, nursing facil-  
23          ity services, and” and inserting “nursing facilities  
24          services and”;

1 (2) by striking “, in the case of hospitals,” and  
2 all that follows through “(v)(1)(G)) which”;

3 (3) by striking “and to assure” and all that fol-  
4 lows through “adequate quality”; and

5 (4) by striking “each hospital, nursing facility,  
6 and” and inserting “each nursing facility and”.

7 (d) EFFECTIVE DATE.—The amendments made by  
8 this section shall become effective on October 1, 1995.

9 **PART 2—OPTIONAL ENROLLMENT OF LOW-IN-**  
10 **COME INDIVIDUALS UNDER HIGH DEDUCT-**  
11 **IBLE UMBRELLA INSURANCE PLANS AND**  
12 **MANAGED HEALTH CARE PLANS**

13 **SEC. 321. OPTIONAL ENROLLMENT UNDER PLANS.**

14 (a) STATE OPTION.—Section 1902(a) of the Social  
15 Security Act (42 U.S.C. 1396a(a)) is amended—

16 (1) by striking “and” at the end of paragraph  
17 (61);

18 (2) by striking the period at the end of para-  
19 graph (62) and inserting “; and”; and

20 (3) by adding at the end the following new  
21 paragraph:

22 “(63) at the option of the State, provide that  
23 an individual eligible for medical assistance under  
24 the State plan has the option to receive medical as-  
25 sistance consisting of acute medical services (as de-

1        fined in section 1931(c)(1)) through enrollment with  
2        a high deductible umbrella insurance plan or a man-  
3        aged health care plan (as defined in section  
4        1932(f)(2)) under the program described in section  
5        1932, in accordance with the requirements of section  
6        1932.”.

7        (b) REQUIREMENTS DESCRIBED.—Title XIX of such  
8 Act (42 U.S.C. 1396 et seq.), as amended by section  
9 311(a)(1), is further amended by redesignating section  
10 1932 as section 1933 and by inserting after section 1931  
11 the following new section:

12        “OPTIONAL STATE PROGRAM TO ENROLL INDIVIDUALS IN  
13        HIGH DEDUCTIBLE UMBRELLA INSURANCE PLANS  
14        OR MANAGED HEALTH CARE PLANS

15        “SEC. 1932. (a) IN GENERAL.—For purposes of sec-  
16 tion 1902(a)(63), a program under this section is a pro-  
17 gram under which the State makes payments to high de-  
18 ductible umbrella insurance plans and managed health  
19 care plans for enrolling eligible individuals (as described  
20 in subsection (c)) for coverage of acute medical services  
21 under such plans, including all necessary payments of pre-  
22 miums, copayments, and deductibles applicable under such  
23 a plan on behalf of such an individual.

24        “(b) TREATMENT OF PAYMENTS AS MEDICAL AS-  
25 SISTANCE.—

1           “(1) IN GENERAL.—Subject to paragraph (3),  
2           for purposes of determining the amount of Federal  
3           financial participation for a State under section  
4           1903 in a quarter, any payments made by a State  
5           under the program under this section shall be treat-  
6           ed as expenditures for medical assistance under the  
7           State plan for such quarter, without regard to  
8           whether or not such payments are on behalf of indi-  
9           viduals who (but for this section) would not other-  
10          wise be eligible for medical assistance under the  
11          State plan under this title.

12           “(2) FEDERAL PAYMENT RESTRICTED TO  
13          ACUTE MEDICAL SERVICES.—No amounts expended  
14          under a qualified health plan on behalf of an individ-  
15          ual enrolled under such a plan pursuant to this sec-  
16          tion that are attributable to medical assistance for  
17          other than acute medical services shall be included  
18          in the total amount expended as medical assistance  
19          under the State plan under paragraph (1). No  
20          amounts expended for abortions or services directly  
21          related to the performance of abortions, except when  
22          necessary to prevent the death of the mother, shall  
23          be included in the total amount expended as medical  
24          assistance under the State plan under paragraph  
25          (1).

1           “(3) LIMITATION.—In no case shall this sub-  
2           section result in (A) the total Federal payments to  
3           the State for the quarter under this title (including  
4           payments attributable to this section and section  
5           1923), exceeding (B) the total Federal payments  
6           that the Secretary estimates would have been paid  
7           under this title to the State for the quarter if the  
8           State did not have a program under this section.

9           “(c) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE  
10          IN PROGRAM.—

11           “(1) AUTOMATIC ELIGIBILITY OF MEDICAID  
12           CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject  
13           to subsection (d), any individual to whom the State  
14           makes medical assistance available under the State  
15           plan under this title pursuant to clause (i) of section  
16           1902(a)(10)(A) shall be eligible to participate in the  
17           program under this section.

18           “(2) MANDATORY ELIGIBILITY OF INDIVIDUALS  
19           WITH INCOME UNDER THE POVERTY LEVEL.—

20           “(A) IN GENERAL.—Subject to subsection  
21           (e) and subparagraph (B), an individual law-  
22           fully residing in the State shall be eligible to  
23           participate in the program if the income of the  
24           individual’s family is equal to or less than 100  
25           percent of the official poverty line (as defined

1 by the Office of Management and Budget, and  
2 revised annually in accordance with section  
3 673(2) of the Omnibus Budget Reconciliation  
4 Act of 1991) applicable to a family of the size  
5 involved.

6 “(B) EXCEPTION.—If the application of  
7 subparagraph (A) would result in—

8 “(i) the total State expenditures for a  
9 quarter under this title (including expendi-  
10 tures attributable to this section and sec-  
11 tion 1923), exceeding

12 “(ii) the total State expenditures that  
13 the Secretary estimates would have been  
14 made under this title for the quarter if the  
15 State did not have a program under this  
16 section,

17 then there shall be substituted for 100 percent  
18 in subparagraph (A) such percent as would re-  
19 sult in the amount described in clause (i) equal-  
20 ing the amount described in clause (ii).

21 “(3) OPTIONAL ELIGIBILITY OF INDIVIDUALS  
22 WITH INCOME UP TO 160 PERCENT OF POVERTY  
23 LEVEL.—

24 “(A) IN GENERAL.—Subject to subsection  
25 (e), a State operating a program under this sec-

1           tion may make an individual lawfully residing  
2           in the State eligible to participate in the pro-  
3           gram if the income of the individual’s family is  
4           greater than 100 percent (but less than such  
5           percentage, not to exceed 160 percent, as the  
6           State may specify) of such official poverty line.

7           “(B) CONTRIBUTION MAY BE REQUIRED.—

8           In the case of an individual who is participating  
9           in the program pursuant to this paragraph, the  
10          program may require such an individual to con-  
11          tribute all (or a portion) of the premiums and  
12          cost-sharing of such a high deductible umbrella  
13          insurance plan or managed care health plan if  
14          the amount of such contribution is determined  
15          in accordance with a sliding scale based on the  
16          individual’s family income.

17          “(4) OPTIONAL ENROLLMENT OF OTHER INDI-  
18          VIDUALS.—

19          “(A) IN GENERAL.—Subject to subsection  
20          (e), a State operating a program under this sec-  
21          tion may make any individual (or class of indi-  
22          viduals) who is not described in paragraph (1),  
23          (2), or (3) and who is not otherwise offered cov-  
24          erage under a high deductible umbrella insur-

1           ance plan or managed care health plan eligible  
2           to participate in the program.

3           “(B) SPECIAL RULES.—

4                   “(i) CONTRIBUTION MAY BE RE-  
5                   QUIRED.—In the case of an individual who  
6                   is participating in the program pursuant to  
7                   this paragraph, the program may require  
8                   such an individual to contribute all (or a  
9                   portion) of the premiums and cost-sharing  
10                  of such a high deductible umbrella insur-  
11                  ance plan or managed health care plan.

12                  “(ii) NO FEDERAL MATCHING PAY-  
13                  MENTS.—For purposes of payment to  
14                  States under section 1903(a), no amounts  
15                  expended by the State under the program  
16                  during a fiscal year on behalf of an indi-  
17                  vidual enrolled pursuant to subparagraph  
18                  (A) may be included in the total amount  
19                  expended during the fiscal year as medical  
20                  assistance under the State plan.

21           “(5) OFFERING OF COVERAGE THROUGH  
22           OTHER PROGRAMS.—Nothing in this section shall be  
23           construed as preventing a State which—

24                   “(A) does not operate a State program  
25                   under this section from assuring that individ-

1           uals in the State who are not offered coverage  
2           under a high deductible umbrella insurance  
3           plan or managed health care plan are offered  
4           coverage under a health plan, or

5                   “(B) does operate such a program from as-  
6           suring that individuals in the State who are not  
7           described in paragraph (1), (2), or (3) and who  
8           are not offered coverage under a high deduct-  
9           ible umbrella insurance plan or managed health  
10          care plan are offered coverage under a health  
11          plan other than through such program.”.

12          “(d) EXCLUSION AND USE OF RESOURCE STAND-  
13          ARD.—

14                   “(1) EXCLUSION OF ELDERLY MEDICARE-ELIGI-  
15          BLE INDIVIDUALS.—No individual shall be eligible to  
16          participate in the program under this section if the  
17          individual is entitled to benefits under title XVIII of  
18          the Social Security Act pursuant to section 226 of  
19          such Act.

20                   “(2) USE OF RESOURCE STANDARD.—A State  
21          may require an individual to meet a resource stand-  
22          ard as a condition of eligibility to participate in the  
23          program only if the Secretary approves the State’s  
24          use of such a standard.

1       “(e) CONSTRUCTION.—No provision of any Federal  
2 law shall prevent a State from enrolling any employee or  
3 other individual in accordance with this section. The pre-  
4 vious sentence shall not be construed as permitting a State  
5 to require the employer of an individual participating in  
6 the program to contribute toward the individual’s pre-  
7 mium required for such participation.

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

9           “(1) ACUTE MEDICAL SERVICES.—The term  
10 ‘acute medical services’ means the care and services  
11 described in section 1932(c)(1).

12           “(2) HIGH DEDUCTIBLE UMBRELLA INSURANCE  
13 PLAN; MANAGED HEALTH CARE PLAN.—The terms  
14 ‘high deductible umbrella insurance plan’ and ‘man-  
15 aged health care plan’ have the meaning given such  
16 terms in section 101(a) of the Health Savings and  
17 Security Act of 1994.”.

18       (c) REDUCTION IN DISPROPORTIONATE SHARE HOS-  
19 PITAL PAYMENTS FOR PARTICIPATING STATES.—Section  
20 1923 of the Social Security Act (42 U.S.C. 1396r-4), as  
21 amended by section 13621(b)(1) of the Omnibus Budget  
22 Reconciliation Act of 1993, is amended by adding at the  
23 end the following new subsection:

24           “(h) REDUCTION IN PAYMENT ADJUSTMENTS FOR  
25 STATES ENROLLING INDIVIDUALS IN CERTAIN PRIVATE

1 HEALTH PLANS.—In the case of a State operating a pro-  
2 gram under section 1932 to make payments to enroll indi-  
3 viduals in high deductible umbrella insurance plans or  
4 managed health care plans in a fiscal year, the Secretary  
5 shall reduce the total payment adjustments made under  
6 this section for hospitals in the State for quarters in the  
7 year by such amount as the Secretary determines to be  
8 necessary to ensure that the total amount paid to the  
9 State under section 1903(a)(1) for the year does not ex-  
10 ceed the amount that would have been paid to the State  
11 under such section for the year if the State did not operate  
12 such a program.”.

13 **PART 3—INCREASING STATE FLEXIBILITY TO**  
14 **USE MANAGED CARE UNDER MEDICAID**  
15 **SEC. 331. MODIFICATION OF FEDERAL REQUIREMENTS TO**  
16 **ALLOW STATES MORE FLEXIBILITY IN CON-**  
17 **TRACTING FOR COORDINATED CARE SERV-**  
18 **ICES UNDER MEDICAID.**

19 (a) IN GENERAL.—

20 (1) PAYMENT PROVISIONS.—Section 1903(m)  
21 of the Social Security Act (42 U.S.C. 1396b(m)) is  
22 amended to read as follows:

23 “(m)(1) No payment shall be made under this title  
24 to a State with respect to expenditures incurred by such  
25 State for payment to an entity which is at risk (as defined

1 in section 1933(a)(4)) for services provided by such entity  
2 to individuals eligible for medical assistance under the  
3 State plan under this title, unless the entity is a risk con-  
4 tracting entity (as defined in section 1933(a)(3)) and the  
5 State and such entity comply with the applicable provi-  
6 sions of section 1933.

7 “(2) No payment shall be made under this title to  
8 a State with respect to expenditures incurred by such  
9 State for payment for services provided to an individual  
10 eligible for medical assistance under the State plan under  
11 this title if such payment by the State is contingent upon  
12 the individual receiving such services from a specified  
13 health care provider or subject to the approval of a speci-  
14 fied health care provider, unless the entity receiving pay-  
15 ment is a primary care case management entity (as de-  
16 fined in section 1933(a)(2)) and the State and such entity  
17 comply with the applicable provisions of section 1933.”.

18 (2) REQUIREMENTS FOR COORDINATED CARE  
19 SERVICES.—Title XIX of the Social Security Act (42  
20 U.S.C. 1396 et seq.), as amended by sections  
21 311(a)(1) and 321(b), is further amended by redesi-  
22 gnating section 1933 as section 1934 and by insert-  
23 ing after section 1932 the following new section:

24 “REQUIREMENTS FOR COORDINATED CARE SERVICES

25 “SEC. 1933. (a) DEFINITIONS.—For purposes of this  
26 title:

1           “(1) PRIMARY CARE CASE MANAGEMENT PRO-  
2           GRAM.—The term ‘primary care case management  
3           program’ means a program operated by a State  
4           agency under which such State agency enters into  
5           contracts with primary care case management enti-  
6           ties for the provision of health care items and serv-  
7           ices which are specified in such contracts and the  
8           provision of case management services to individuals  
9           who are—

10                   “(A) eligible for medical assistance under  
11                   the State plan,

12                   “(B) enrolled with such primary care case  
13                   management entities, and

14                   “(C) entitled to receive such specified  
15                   health care items and services and case man-  
16                   agement services only as approved and ar-  
17                   ranged for, or provided, by such entities.

18           “(2) PRIMARY CARE CASE MANAGEMENT EN-  
19           TITY.—The term ‘primary care case management  
20           entity’ means a health care provider which—

21                   “(A) must be a physician, group of physi-  
22                   cians, a Federally qualified health center, a  
23                   rural health clinic, or an entity employing or  
24                   having other arrangements with physicians op-  
25                   erating under a contract with a State to provide

1 services under a primary care case management  
2 program,

3 “(B) receives payment on a fee for service  
4 basis (or, in the case of a Federally qualified  
5 health center or a rural health clinic, on a rea-  
6 sonable cost per encounter basis) for the provi-  
7 sion of health care items and services specified  
8 in such contract to enrolled individuals,

9 “(C) receives an additional fixed fee per  
10 enrollee for a period specified in such contract  
11 for providing case management services (includ-  
12 ing approving and arranging for the provision  
13 of health care items and services specified in  
14 such contract on a referral basis) to enrolled in-  
15 dividuals, and

16 “(D) is not an entity that is at risk (as de-  
17 fined in paragraph (4)) for such case manage-  
18 ment services.

19 “(3) RISK CONTRACTING ENTITY.—The term  
20 ‘risk contracting entity’ means an entity which has  
21 a contract with the State agency (or a health insur-  
22 ing organization described in subsection (n)(2))  
23 under which the entity—

24 “(A) provides or arranges for the provision  
25 of health care items or services which are speci-

1           fied in such contract to individuals eligible for  
2           medical assistance under the State plan, and

3           “(B) is at risk (as defined in paragraph  
4           (4)) for part or all of the cost of such items or  
5           services furnished to individuals eligible for  
6           medical assistance under such plan.

7           “(4) AT RISK.—The term ‘at risk’ means an  
8           entity which—

9           “(A) has a contract with the State agency  
10          under which such entity is paid a fixed amount  
11          for providing or arranging for the provision of  
12          health care items or services specified in such  
13          contract to an individual eligible for medical as-  
14          sistance under the State plan and enrolled with  
15          such entity, regardless of whether such items or  
16          services are furnished to such individual, and

17          “(B) is liable for all or part of the cost of  
18          furnishing such items or services, regardless of  
19          whether such cost exceeds such fixed payment.

20          “(5) FEDERALLY QUALIFIED HEALTH CEN-  
21          TER.—The term ‘Federally qualified health center’  
22          means a Federally qualified health center as defined  
23          in section 1905(l)(2)(B).

1           “(6) RURAL HEALTH CLINIC.—The term ‘rural  
2 health clinic’ means a rural health clinic as defined  
3 in section 1905(l)(1).

4           “(b) GENERAL REQUIREMENTS FOR RISK CON-  
5 TRACTING ENTITIES.—

6           “(1) ORGANIZATION.—A risk contracting entity  
7 meets the requirements of this section only if such  
8 entity—

9                   “(A)(i) is a qualified health maintenance  
10 organization as defined in section 1310(d) of  
11 the Public Health Service Act, as determined by  
12 the Secretary pursuant to section 1312 of such  
13 Act; or

14                   “(ii) is described in subparagraph (C), (D),  
15 (E), (F), or (G) of subsection (e)(4);

16                   “(B) is a Federally qualified health center  
17 or a rural health clinic which has made ade-  
18 quate provision against the risk of insolvency  
19 (pursuant to the guidelines and regulations is-  
20 sued by the Secretary under this section), and  
21 ensures that individuals eligible for medical as-  
22 sistance under the State plan are not held liable  
23 for such entity’s debts in case of such entity’s  
24 insolvency; or

1           “(C) is an entity which meets all applicable  
2 State licensing requirements and has made ade-  
3 quate provision against the risk of insolvency  
4 (pursuant to the guidelines and regulations is-  
5 sued by the Secretary under this section), and  
6 ensures that individuals eligible for medical as-  
7 sistance under the State plan are not held liable  
8 for such entity’s debts in case of such entity’s  
9 insolvency.

10           “(2) GUARANTEES OF ENROLLEE ACCESS.—A  
11 risk contracting entity meets the requirements of  
12 this section only if—

13           “(A) the geographic locations, hours of op-  
14 eration, patient to staff ratios, and other rel-  
15 evant characteristics of such entity are suffi-  
16 cient to afford individuals eligible for medical  
17 assistance under the State plan access to such  
18 entities that is at least equivalent to the access  
19 to health care providers that would be available  
20 to such individuals if such individuals were not  
21 enrolled with such entity;

22           “(B) such entity has reasonable and ade-  
23 quate hours of operation, including 24-hour  
24 availability of—

1           “(i)(I) treatment for an unforeseen ill-  
2           ness, injury, or condition of an individual  
3           eligible for medical assistance under the  
4           State plan and enrolled with such entity;  
5           or

6           “(II) referral to other health care pro-  
7           viders for such treatment; and

8           “(ii) other information, as determined  
9           by the Secretary or the State; and

10          “(C) such entity complies with such other  
11          requirements relating to access to care as the  
12          Secretary or the State may impose.

13          “(3) CONTRACT WITH STATE AGENCY.—A risk  
14          contracting entity meets the requirements of this  
15          section only if such entity has a written contract  
16          with the State agency which provides—

17                 “(A) that the entity will comply with all  
18                 applicable provisions of this section, that the  
19                 State has the right to penalize the entity for  
20                 failure to comply with such requirements and to  
21                 terminate the contract in accordance with sub-  
22                 section (j), and that the entity will be subject  
23                 to penalties imposed by the Secretary under  
24                 subsection (i) for failure to comply with such  
25                 requirements;

1           “(B) for a payment methodology based on  
2 experience rating or another actuarially sound  
3 methodology approved by the Secretary, which  
4 guarantees (as demonstrated by such models or  
5 formulas as the Secretary may approve) that—

6           “(i) payments to the entity under the  
7 contract shall not exceed an amount equal  
8 to 100 percent of the costs (which shall in-  
9 clude administrative costs and which may  
10 include costs for inpatient hospital services  
11 that would have been incurred in the ab-  
12 sence of such contract) that would have  
13 been incurred by the State agency in the  
14 absence of the contract; and

15           “(ii) the financial risk for inpatient  
16 hospital services is limited to an extent es-  
17 tablished by the State;

18           “(C) that the Secretary and the State (or  
19 any person or organization designated by ei-  
20 ther) shall have the right to audit and inspect  
21 any books and records of the entity (and of any  
22 subcontractor) that pertain—

23           “(i) to the ability of the entity (or a  
24 subcontractor) to bear the risk of potential  
25 financial losses; or

1           “(ii) to services performed or deter-  
2           minations of amounts payable under the  
3           contract;

4           “(D) that in the entity’s enrollment,  
5           reenrollment, or disenrollment of individuals eli-  
6           gible for medical assistance under the State  
7           plan and eligible to enroll, reenroll, or disenroll  
8           with the entity pursuant to the contract, the en-  
9           tity will not discriminate among such individ-  
10          uals on the basis of such individuals’ health sta-  
11          tus or requirements for health care services;

12          “(E)(i) individuals eligible for medical as-  
13          sistance under the State plan who have enrolled  
14          with the entity are permitted to terminate such  
15          enrollment without cause as of the beginning of  
16          the first calendar month (or in the case of an  
17          entity described in subsection (e)(4), as of the  
18          beginning of the first enrollment period) follow-  
19          ing a full calendar month after a request is  
20          made for such termination;

21          “(ii) that when an individual has relocated  
22          outside the entity’s service area, and the entity  
23          has been notified of the relocation, services  
24          (within reasonable limits) furnished by a health  
25          care provider outside the service area will be re-

1           imbursed either by the entity or by the State  
2           agency; and

3           “(iii) for written notification of each such  
4           individual’s right to terminate enrollment,  
5           which shall be provided at the time of such indi-  
6           vidual’s enrollment, and, in the case of a child  
7           with special health care needs as defined in sub-  
8           section (e)(1)(B)(ii), at the time the entity iden-  
9           tifies such a child;

10          “(F) in the case of services immediately re-  
11          quired to treat an unforeseen illness, injury, or  
12          condition, of an individual eligible for medical  
13          assistance under the State plan and enrolled  
14          with the entity—

15                 “(i) that such services shall not be  
16                 subject to a preapproval requirement; and

17                 “(ii) where such services are furnished  
18                 by a health care provider other than the  
19                 entity, for reimbursement of such provider  
20                 either by the entity or by the State agency;

21          “(G) for disclosure of information in ac-  
22          cordance with subsection (h) and section 1124;

23          “(H) that any physician incentive plan op-  
24          erated by the entity meets the requirements of  
25          section 1876(i)(8);

1           “(I) for maintenance of sufficient patient  
2           encounter data to identify the physician who de-  
3           livers services to patients;

4           “(J) that the entity will comply with the  
5           requirement of section 1902(w) with respect to  
6           each enrollee;

7           “(K) that the entity will implement a  
8           grievance system, inform enrollees in writing  
9           about how to use such grievance system, ensure  
10          that grievances are addressed in a timely man-  
11          ner, and report grievances to the State at inter-  
12          vals to be determined by the State;

13          “(L) that contracts between the entity and  
14          each subcontractor of such entity will require  
15          each subcontractor—

16                 “(i) to cooperate with the entity in the  
17                 implementation of its internal quality as-  
18                 surance program under paragraph (4) and  
19                 adhere to the standards set forth in the  
20                 quality assurance program, including  
21                 standards with respect to access to care,  
22                 facilities in which patients receive care,  
23                 and availability, maintenance, and review  
24                 of medical records;

1           “(ii) to cooperate with the Secretary,  
2           the State agency and any contractor to the  
3           State in monitoring and evaluating the  
4           quality and appropriateness of care pro-  
5           vided to enrollees as required by Federal or  
6           State laws and regulations; and

7           “(iii) where applicable, to adhere to  
8           regulations and program guidance with re-  
9           spect to reporting requirements under sec-  
10          tion 1905(r);

11          “(M) that, where the State deems it nec-  
12          essary to ensure the timely provision to enroll-  
13          ees of the services listed in subsection  
14          (f)(2)(C)(ii), the State may arrange for the pro-  
15          vision of such services by health care providers  
16          other than the entity and may adjust its pay-  
17          ments to the entity accordingly;

18          “(N) that the entity and the State will  
19          comply with guidelines and regulations issued  
20          by the Secretary with respect to procedures for  
21          marketing and information that must be pro-  
22          vided to individuals eligible for medical assist-  
23          ance under the State plan;

24          “(O) that the entity must provide pay-  
25          ments to hospitals for inpatient hospital serv-

1           ices furnished to infants who have not attained  
2           the age of 1 year, and to children who have not  
3           attained the age of 6 years and who receive  
4           such services in a disproportionate share hos-  
5           pital, in accordance with paragraphs (2) and  
6           (3) of section 1902(s);

7           “(P) that the entity shall report to the  
8           State, at such time and in such manner as the  
9           State shall require, on the rates paid for hos-  
10          pital services (by type of hospital and type of  
11          service) furnished to individuals enrolled with  
12          the entity;

13          “(Q) detailed information regarding the  
14          relative responsibilities of the entity and the  
15          State, for providing (or arranging for the provi-  
16          sion of), and making payment for, the following  
17          items and services:

18                  “(i) immunizations;

19                  “(ii) the purchase of vaccines;

20                  “(iii) lead screening and treatment  
21          services;

22                  “(iv) screening and treatment for tu-  
23          berculosis;

24                  “(v) screening and treatment for, and  
25          preventive services related to, sexually

1 transmitted diseases, including HIV infec-  
2 tion;

3 “(vi) screening, diagnostic, and treat-  
4 ment services required under section  
5 1905(r);

6 “(vii) family planning services;

7 “(viii) services prescribed under—

8 “(I) an Individual Education  
9 Plan or Individualized Family Service  
10 Plan under part B or part H of the  
11 Individuals with Disabilities Edu-  
12 cation Act; and

13 “(II) any other individual plan of  
14 care or treatment developed under  
15 this title or title V;

16 “(ix) transportation needed to obtain  
17 services to which the enrollee is entitled  
18 under the State plan or pursuant to an in-  
19 dividual plan of care or treatment de-  
20 scribed in subclauses (I) and (II) of clause  
21 (viii); and

22 “(x) such other services as the Sec-  
23 retary may specify;

24 “(R) detailed information regarding the  
25 procedures for coordinating the relative respon-

1           sibilities of the entity and the State to ensure  
2           prompt delivery of, compliance with any appli-  
3           cable reporting requirements related to, and ap-  
4           propriate record keeping with respect to, the  
5           items and services described in subparagraph  
6           (Q); and

7           “(S) such other provisions as the Secretary  
8           may require.

9           “(4) INTERNAL QUALITY ASSURANCE.—A risk  
10          contracting entity meets the requirements of this  
11          section only if such entity has in effect a written in-  
12          ternal quality assurance program which includes a  
13          systematic process to achieve specified and measur-  
14          able goals and objectives for access to, and quality  
15          of, care, which—

16                 “(A) identifies the organizational units re-  
17                 sponsible for performing specific quality assur-  
18                 ance functions, and ensures that such units are  
19                 accountable to the governing body of the entity  
20                 and that such units have adequate supervision,  
21                 staff, and other necessary resources to perform  
22                 these functions effectively,

23                 “(B) if any quality assurance functions are  
24                 delegated to other entities, ensures that the risk  
25                 contracting entity remains accountable for all

1 quality assurance functions and has mecha-  
2 nisms to ensure that all quality assurance ac-  
3 tivities are carried out,

4 “(C) includes methods to ensure that phy-  
5 sicians and other health care professionals  
6 under contract with the entity are licensed or  
7 certified as required by State law, or are other-  
8 wise qualified to perform the services such phy-  
9 sicians and other professionals provide, and  
10 that these qualifications are ensured through  
11 appropriate credentialing and recredentialing  
12 procedures,

13 “(D) provides for continuous monitoring of  
14 the delivery of health care, through—

15 “(i) identification of clinical areas to  
16 be monitored, including immunizations,  
17 prenatal care, services required under sec-  
18 tion 1905(r), and other appropriate clinical  
19 areas, to reflect care provided to enrollees  
20 eligible for medical assistance under the  
21 State plan,

22 “(ii) use of quality indicators and  
23 standards for assessing the quality and ap-  
24 propriateness of care delivered, and the  
25 availability and accessibility of all services

1 for which the entity is responsible under  
2 such entity's contract with the State,

3 “(iii) use of epidemiological data or  
4 chart review, as appropriate, and patterns  
5 of care overall,

6 “(iv) patient surveys, spot checks, or  
7 other appropriate methods to determine  
8 whether—

9 “(I) enrollees are able to obtain  
10 timely appointments with primary  
11 care providers and specialists, and

12 “(II) enrollees are otherwise  
13 guaranteed access and care as pro-  
14 vided under paragraph (2),

15 “(v) provision of written information  
16 to health care providers and other person-  
17 nel on the outcomes, quality, availability,  
18 accessibility, and appropriateness of care,  
19 and

20 “(vi) implementation of corrective ac-  
21 tions,

22 “(E) includes standards for timely enrollee  
23 access to information and care which at a mini-  
24 mum shall incorporate standards used by the  
25 State or professional or accreditation bodies for

1 facilities furnishing perinatal and neonatology  
2 care and other forms of specialized medical and  
3 surgical care,

4 “(F) includes standards for the facilities in  
5 which patients receive care,

6 “(G) includes standards for managing and  
7 treating medical conditions prevalent among  
8 such entity’s enrollees eligible for medical as-  
9 sistance under the State plan,

10 “(H) includes mechanisms to ensure that  
11 enrollees eligible for medical assistance under  
12 the State plan receive services for which the en-  
13 tity is responsible under the contract which are  
14 consistent with standards established by the ap-  
15 plicable professional societies or government  
16 agencies,

17 “(I) includes standards for the availability,  
18 maintenance, and review of medical records  
19 consistent with generally accepted medical prac-  
20 tice,

21 “(J) provides for dissemination of quality  
22 assurance procedures to health care providers  
23 under contract with the entity, and

24 “(K) meets any other requirements pre-  
25 scribed by the Secretary or the State.

1       “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE  
2 CASE MANAGEMENT PROGRAMS.—A primary care case  
3 management program implemented by a State under this  
4 section shall—

5           “(1) provide that each primary care case man-  
6 agement entity participating in such program has a  
7 written contract with the State agency,

8           “(2) include methods for selection and monitor-  
9 ing of participating primary care case management  
10 entities to ensure—

11           “(A) that the geographic locations, hours  
12 of operation, patient to staff ratio, and other  
13 relevant characteristics of such entities are suf-  
14 ficient to afford individuals eligible for medical  
15 assistance under the State plan access to such  
16 entities that is at least equivalent to the access  
17 to health care providers that would be available  
18 to such individuals if such individuals were not  
19 enrolled with such entity,

20           “(B) that such entities and their profes-  
21 sional personnel are licensed as required by  
22 State law and qualified to provide case manage-  
23 ment services, through methods such as ongo-  
24 ing monitoring of compliance with applicable re-

1            requirements and providing information and tech-  
2            nical assistance, and

3            “(C) that such entities—

4                       “(i) provide timely and appropriate  
5            primary care to such enrollees consistent  
6            with standards established by applicable  
7            professional societies or governmental  
8            agencies, or such other standards pre-  
9            scribed by the Secretary or the State, and

10                       “(ii) where other items and services  
11            are determined to be medically necessary,  
12            give timely approval of such items and  
13            services and referral to appropriate health  
14            care providers,

15            “(3) provide that no preapproval shall be re-  
16            quired for emergency health care items or services,  
17            and

18            “(4) permit individuals eligible for medical as-  
19            sistance under the State plan who have enrolled with  
20            a primary care case management entity to terminate  
21            such enrollment without cause not later than the be-  
22            ginning of the first calendar month following a full  
23            calendar month after the request is made for such  
24            termination.

1       “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-  
2 MENTS.—A State plan may permit or require an individ-  
3 ual eligible for medical assistance under such plan to en-  
4 roll with a risk contracting entity or a primary care case  
5 management entity without regard to the requirements set  
6 forth in the following paragraphs of section 1902(a):

7           “(1) Paragraph (1) (concerning statewideness).

8           “(2) Paragraph (10)(B) (concerning com-  
9 parability of benefits), to the extent benefits not in-  
10 cluded in the State plan are provided.

11          “(3) Paragraph (23) (concerning freedom of  
12 choice of provider), except with respect to services  
13 described in section 1905(a)(4)(C) and except as re-  
14 quired under subsection (e).

15       “(e) STATE OPTIONS WITH RESPECT TO ENROLL-  
16 MENT AND DISENROLLMENT.—

17           “(1) MANDATORY ENROLLMENT.—

18           “(A) IN GENERAL.—Except as provided in  
19 subparagraph (B), a State plan may require an  
20 individual eligible for medical assistance under  
21 such plan to enroll with a risk contracting en-  
22 tity or a primary care case management entity  
23 only if the individual is permitted a choice with-  
24 in a reasonable service area (as defined by the  
25 State)—

1 “(i) between or among 2 or more risk  
2 contracting entities,

3 “(ii) among a risk contracting entity  
4 and a primary care case management pro-  
5 gram, or

6 “(iii) among primary care case man-  
7 agement entities.

8 “(B) SPECIAL NEEDS CHILDREN.—

9 “(i) IN GENERAL.—A State may not  
10 require a child with special health care  
11 needs (as defined in clause (ii)) to enroll  
12 with a risk contracting entity or a primary  
13 care case management entity.

14 “(ii) DEFINITION.—For purposes of  
15 this subparagraph, the term ‘child with  
16 special health care needs’ refers to an indi-  
17 vidual eligible for supplemental security in-  
18 come under title XVI, a child described  
19 under section 501(a)(1)(D), or a child de-  
20 scribed in section 1902(e)(3).

21 “(2) REENROLLMENT OF INDIVIDUALS WHO  
22 REGAIN ELIGIBILITY.—In the case of an individual  
23 who—

24 “(A) in a month is eligible for medical as-  
25 sistance under the State plan and enrolled with

1 a risk contracting entity with a contract under  
2 this section,

3 “(B) in the next month (or next 2 months)  
4 is not eligible for such medical assistance, but

5 “(C) in the succeeding month is again eli-  
6 gible for such benefits,

7 the State agency (subject to subsection (b)(3)(E))  
8 may enroll the individual for that succeeding month  
9 with such entity, if the entity continues to have a  
10 contract with the State agency under this sub-  
11 section.

12 “(3) DISENROLLMENT.—

13 “(A) RESTRICTIONS ON DISENROLLMENT  
14 WITHOUT CAUSE.—Except as provided in sub-  
15 paragraph (C), a State plan may restrict the  
16 period in which individuals enrolled with risk  
17 contracting entities described in paragraph (4)  
18 may terminate such enrollment without cause to  
19 the first month of each period of enrollment (as  
20 defined in subparagraph (B)), but only if the  
21 State provides notification, at least once during  
22 each such enrollment period, to individuals en-  
23 rolled with such entity of the right to terminate  
24 such enrollment and the restriction on the exer-  
25 cise of this right. Such restriction shall not

1 apply to requests for termination of enrollment  
2 for cause.

3 “(B) PERIOD OF ENROLLMENT.—For pur-  
4 poses of this paragraph, the term ‘period of en-  
5 rollment’ means—

6 “(i) a period not to exceed 6 months  
7 in duration, or

8 “(ii) a period not to exceed 1 year in  
9 duration, in the case of a State that, on  
10 the effective date of this paragraph, had in  
11 effect a waiver under section 1115 of re-  
12 quirements under this title under which  
13 the State could establish a 1-year mini-  
14 mum period of enrollment with risk con-  
15 tracting entities.

16 “(C) SPECIAL NEEDS CHILDREN.—A State  
17 may not restrict disenrollment of a child with  
18 special health care needs (as defined in para-  
19 graph (1)(B)(ii)).

20 “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT  
21 RESTRICTIONS.—A risk contracting entity described  
22 in this paragraph is—

23 “(A) a qualified health maintenance orga-  
24 nization as defined in section 1310(d) of the  
25 Public Health Service Act,

1           “(B) an eligible organization with a con-  
2           tract under section 1876,

3           “(C) an entity that is receiving (and has  
4           received during the previous 2 years) a grant of  
5           at least \$100,000 under section 329(d)(1)(A)  
6           or 330(d)(1) of the Public Health Service Act,

7           “(D) an entity that—

8                   “(i) received a grant of at least  
9                   \$100,000 under section 329(d)(1)(A) or  
10                  section 330(d)(1) of the Public Health  
11                  Service Act in the fiscal year ending June  
12                  30, 1976, and has been a grantee under ei-  
13                  ther such section for all periods after that  
14                  date, and

15                   “(ii) provides to its enrollees, on a  
16                   prepaid capitation or other risk basis, all  
17                   of the services described in paragraphs (1),  
18                   (2), (3), (4)(C), and (5) of section 1905(a)  
19                   (and the services described in section  
20                   1905(a)(7), to the extent required by sec-  
21                   tion 1902(a)(10)(D)),

22           “(E) an entity that is receiving (and has  
23           received during the previous 2 years) at least  
24           \$100,000 (by grant, subgrant, or subcontract)

1 under the Appalachian Regional Development  
2 Act of 1965,

3 “(F) a nonprofit primary health care en-  
4 tity located in a rural area (as defined by the  
5 Appalachian Regional Commission)—

6 “(i) which received in the fiscal year  
7 ending June 30, 1976, at least \$100,000  
8 (by grant, subgrant, or subcontract) under  
9 the Appalachian Regional Development Act  
10 of 1965, and

11 “(ii) which, for all periods after such  
12 date, either has been the recipient of a  
13 grant, subgrant, or subcontract under such  
14 Act or has provided services on a prepaid  
15 capitation or other risk basis under a con-  
16 tract with the State agency initially en-  
17 tered into during a year in which the entity  
18 was the recipient of such a grant,  
19 subgrant, or subcontract,

20 “(G) an entity that had contracted with  
21 the State agency prior to 1970 for the provi-  
22 sion, on a prepaid risk basis, of services (which  
23 did not include inpatient hospital services) to  
24 individuals eligible for medical assistance under  
25 the State plan,

1           “(H) a program pursuant to an undertak-  
2           ing described in subsection (n)(3) in which at  
3           least 25 percent of the membership enrolled on  
4           a prepaid basis are individuals who—

5                   “(i) are not insured for benefits under  
6                   part B of title XVIII or eligible for medical  
7                   assistance under the State plan, and

8                   “(ii) (in the case of such individuals  
9                   whose prepayments are made in whole or  
10                  in part by any government entity) had the  
11                  opportunity at the time of enrollment in  
12                  the program to elect other coverage of  
13                  health care costs that would have been  
14                  paid in whole or in part by any govern-  
15                  mental entity,

16                  “(I) an entity that, on the date of enact-  
17                  ment of this provision, had a contract with the  
18                  State agency under a waiver under section 1115  
19                  or 1915(b) and was not subject to a require-  
20                  ment under this title to permit disenrollment  
21                  without cause, or

22                  “(J) an entity that has a contract with the  
23                  State agency under a waiver under section  
24                  1915(b)(5).

25           “(f) STATE MONITORING AND EXTERNAL REVIEW.—

1           “(1) STATE GRIEVANCE PROCEDURE.—A State  
2           contracting with a risk contracting entity or a pri-  
3           mary care case management entity under this sec-  
4           tion shall provide for a grievance procedure for  
5           enrollees of such entity with at least the following  
6           elements:

7                   “(A) A toll-free telephone number for en-  
8                   rollee questions and grievances.

9                   “(B) Periodic notification of enrollees of  
10                  their rights with respect to such entity or  
11                  program.

12                  “(C) Periodic sample reviews of grievances  
13                  registered with such entity or program or with  
14                  the State.

15                  “(D) Periodic survey and analysis of en-  
16                  rollee satisfaction with such entity or program,  
17                  including interviews with individuals who  
18                  disenroll from the entity or program.

19           “(2) STATE MONITORING OF QUALITY AND AC-  
20           CESS.—

21                   “(A) RISK CONTRACTING ENTITIES.—A  
22                   State contracting with a risk contracting entity  
23                   under this section shall provide for ongoing  
24                   monitoring of such entity’s compliance with the  
25                   requirements of subsection (b), including com-

1           pliance with the requirements of such entity’s  
2           contract under subsection (b)(3), and shall un-  
3           dertake appropriate followup activities to ensure  
4           that any problems identified are rectified and  
5           that compliance with the requirements of sub-  
6           section (b) and the requirements of the contract  
7           under subsection (b)(3) is maintained.

8           “(B) PRIMARY CARE CASE MANAGEMENT  
9           ENTITIES.—A State electing to implement a  
10          primary care case management program shall  
11          provide for ongoing monitoring of the pro-  
12          gram’s compliance with the requirements of  
13          subsection (c) and shall undertake appropriate  
14          followup activities to ensure that any problems  
15          identified are rectified and that compliance with  
16          subsection (c) is maintained.

17          “(C) SERVICES.—

18                 “(i) IN GENERAL.—The State shall  
19                 establish procedures (in addition to those  
20                 required under subparagraphs (A) and  
21                 (B)) to ensure that the services listed in  
22                 clause (ii) are available in a timely manner  
23                 to an individual enrolled with a risk con-  
24                 tracting entity or a primary care case man-  
25                 agement entity. Where necessary to ensure

1 the timely provision of such services, the  
2 State shall arrange for the provision of  
3 such services by health care providers  
4 other than the risk contracting entity or  
5 the primary care case management entity  
6 in which an individual is enrolled.

7 “(ii) SERVICES LISTED.—The services  
8 listed in this clause are—

9 “(I) prenatal care;

10 “(II) immunizations;

11 “(III) lead screening and treat-  
12 ment;

13 “(IV) prevention, diagnosis and  
14 treatment of tuberculosis, sexually  
15 transmitted diseases (including HIV  
16 infection), and other communicable  
17 diseases; and

18 “(V) such other services as the  
19 Secretary may specify.

20 “(iii) REPORT.—The procedures re-  
21 ferred to in clause (i) shall be described in  
22 an annual report to the Secretary provided  
23 by the State.

24 “(3) EXTERNAL INDEPENDENT REVIEW.—

1           “(A) IN GENERAL.—Except as provided in  
2 paragraph (4), a State contracting with a risk  
3 contracting entity under this section shall pro-  
4 vide for an annual external independent review  
5 of the quality and timeliness of, and access to,  
6 the items and services specified in such entity’s  
7 contract with the State agency. Such review  
8 shall be conducted by a utilization control and  
9 peer review organization with a contract under  
10 section 1153 or another organization unaffili-  
11 ated with the State government or with any  
12 risk contracting entity and approved by the  
13 Secretary.

14           “(B) CONTENTS OF REVIEW.—An external  
15 independent review conducted under this para-  
16 graph shall include the following:

17                   “(i) A review of the entity’s medical  
18 care, through sampling of medical records  
19 or other appropriate methods, for indica-  
20 tions of quality of care and inappropriate  
21 utilization (including overutilization) and  
22 treatment.

23                   “(ii) A review of enrollee inpatient  
24 and ambulatory data, through sampling of  
25 medical records or other appropriate meth-

1           ods, to determine trends in quality and ap-  
2           propriateness of care.

3           “(iii) Notification of the entity and  
4           the State when the review under this para-  
5           graph indicates inappropriate care, treat-  
6           ment, or utilization of services (including  
7           overutilization).

8           “(iv) Other activities as prescribed by  
9           the Secretary or the State.

10          “(C) AVAILABILITY.—The results of each  
11          external independent review conducted under  
12          this paragraph shall be available to the public  
13          consistent with the requirements for disclosure  
14          of information contained in section 1160.

15          “(4) DEEMED COMPLIANCE WITH EXTERNAL  
16          INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-  
17          MENTS.—

18          “(A) IN GENERAL.—The Secretary may  
19          deem the State to have fulfilled the requirement  
20          for independent external review of quality of  
21          care with respect to an entity which has been  
22          accredited by an organization described in sub-  
23          paragraph (B) and approved by the Secretary.

1           “(B) ACCREDITING ORGANIZATION.—An  
2           accrediting organization described in this sub-  
3           paragraph must—

4                   “(i) exist for the primary purpose of  
5                   accrediting coordinated care organizations;

6                   “(ii) be governed by a group of indi-  
7                   viduals representing health care providers,  
8                   purchasers, regulators, and consumers (a  
9                   minority of which shall be representatives  
10                  of health care providers);

11                  “(iii) have substantial experience in  
12                  accrediting coordinated care organizations,  
13                  including an organization’s internal quality  
14                  assurance program;

15                  “(iv) be independent of health care  
16                  providers or associations of health care  
17                  providers;

18                  “(v) be a nonprofit organization; and

19                  “(vi) have an accreditation process  
20                  which meets requirements specified by the  
21                  Secretary.

22           “(5) FEDERAL MONITORING RESPONSIBIL-  
23           ITIES.—The Secretary shall review the external inde-  
24           pendent reviews conducted pursuant to paragraph  
25           (3) and shall monitor the effectiveness of the State’s

1 monitoring and followup activities required under  
2 subparagraph (A) of paragraph (2). If the Secretary  
3 determines that a State’s monitoring and followup  
4 activities are not adequate to ensure that the re-  
5 quirements of paragraph (2) are met, the Secretary  
6 shall undertake appropriate followup activities to en-  
7 sure that the State improves its monitoring and fol-  
8 lowup activities.

9 “(g) PARTICIPATION OF FEDERALLY QUALIFIED  
10 HEALTH CENTERS AND RURAL HEALTH CLINICS.—

11 “(1) IN GENERAL.—Each risk contracting en-  
12 tity shall, with respect to each electing essential  
13 community provider (as defined in paragraph (5))  
14 located within the plan’s service area, either—

15 “(A) enter into a written provider partici-  
16 pation agreement (described in paragraph (2))  
17 with the provider, or

18 “(B) enter into a written agreement under  
19 which the plan shall make payment to the pro-  
20 vider in accordance with paragraph (3).

21 “(2) PARTICIPATION AGREEMENT.—A partici-  
22 pation agreement between a risk contracting entity  
23 and an electing essential community provider under  
24 this subsection shall provide that the entity agrees to  
25 treat the provider in accordance with terms and con-

1 conditions at least as favorable as those that are appli-  
2 cable to other participating providers with the risk  
3 contracting entity with respect to each of the follow-  
4 ing:

5 “(A) The scope of services for which pay-  
6 ment is made by the entity to the provider.

7 “(B) The rate of payment for covered care  
8 and services.

9 “(C) The availability of financial incentives  
10 to participating providers.

11 “(D) Limitations on financial risk provided  
12 to other participating providers.

13 “(E) Assignment of enrollees to participat-  
14 ing providers.

15 “(F) Access by the provider’s patients to  
16 providers in medical specialties or subspecialties  
17 participating in the plan.

18 “(3) PAYMENTS FOR PROVIDERS WITHOUT PAR-  
19 TICIPATION AGREEMENTS.—Payment in accordance  
20 with this paragraph is payment based on payment  
21 methodologies and rates used under the applicable  
22 Medicare payment methodology and rates (or the  
23 most closely applicable methodology under such pro-  
24 gram as the Secretary of Health and Human Serv-  
25 ices specifies in regulations).

1 “(4) ELECTION.—

2 “(A) IN GENERAL.—In this subsection, the  
3 term ‘electing essential community provider’  
4 means, with respect to a risk contracting entity,  
5 an essential community provider that elects this  
6 subpart to apply to the entity.

7 “(B) FORM OF ELECTION.—An election  
8 under this paragraph shall be made in a form  
9 and manner specified by the Secretary, and  
10 shall include notice to the risk contracting en-  
11 tity involved. Such an election may be made an-  
12 nually with respect to an entity, except that the  
13 entity and provider may agree to make such an  
14 election on a more frequent basis.

15 “(5) PROVIDERS DESCRIBED.—The categories  
16 of providers and organizations described in this sub-  
17 section are as follows:

18 “(A) MIGRANT HEALTH CENTERS.—A re-  
19 cipient or subrecipient of a grant under section  
20 329 of the Public Health Service Act.

21 “(B) COMMUNITY HEALTH CENTERS.—A  
22 recipient or subrecipient of a grant under sec-  
23 tion 330 of the Public Health Service Act.

1           “(C) HOMELESS PROGRAM PROVIDERS.—A  
2 recipient or subrecipient of a grant under sec-  
3 tion 340 of the Public Health Service Act.

4           “(D) PUBLIC HOUSING PROVIDERS.—A re-  
5 cipient or subrecipient of a grant under section  
6 340A of the Public Health Service Act.

7           “(E) FAMILY PLANNING CLINICS.—A re-  
8 cipient or subrecipient of a grant under title X  
9 of the Public Health Service Act.

10           “(F) INDIAN HEALTH PROGRAMS.—A serv-  
11 ice unit of the Indian Health Service, a tribal  
12 organization, or an urban Indian program, as  
13 defined in the Indian Health Care Improvement  
14 Act.

15           “(G) AIDS PROVIDERS UNDER RYAN  
16 WHITE ACT.—A public or private nonprofit  
17 health care provider that is a recipient or sub-  
18 recipient of a grant under title XXIII of the  
19 Public Health Service Act.

20           “(H) MATERNAL AND CHILD HEALTH PRO-  
21 VIDERS.—A public or private nonprofit entity  
22 that provides prenatal care, pediatric care, or  
23 ambulatory services to children, including chil-  
24 dren with special health care needs, and that

1 receives funding for such care or services under  
2 title V of the Social Security Act.

3 “(I) FEDERALLY QUALIFIED HEALTH CEN-  
4 TER; RURAL HEALTH CLINIC.—A Federally-  
5 qualified health center or a rural health clinic  
6 (as such terms are defined in section 1861(aa)).

7 “(6) SUBRECIPIENT DEFINED.—In this sub-  
8 section, the term ‘subrecipient’ means, with respect  
9 to a recipient of a grant under a particular author-  
10 ity, an entity that—

11 “(A) is receiving funding from such a  
12 grant under a contract with the principal recipi-  
13 ent of such a grant, and

14 “(B) meets the requirements established to  
15 be a recipient of such a grant.

16 “(7) SUNSET OF REQUIREMENT.—The require-  
17 ments of this subsection shall only apply to risk con-  
18 tracting entities during calendar years 1995 through  
19 2000.

20 “(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

21 “(1) IN GENERAL.—Each risk contracting en-  
22 tity which is not a qualified health maintenance or-  
23 ganization (as defined in section 1310(d) of the  
24 Public Health Service Act) must report to the State  
25 and, upon request, to the Secretary, the Inspector

1 General of the Department of Health and Human  
2 Services, and the Comptroller General of the United  
3 States a description of transactions between the en-  
4 tity and a party in interest (as defined in section  
5 1318(b) of such Act), including the following trans-  
6 actions:

7 “(A) Any sale or exchange, or leasing of  
8 any property between the entity and such a  
9 party.

10 “(B) Any furnishing for consideration of  
11 goods, services (including management serv-  
12 ices), or facilities between the entity and such  
13 a party, but not including salaries paid to em-  
14 ployees for services provided in the normal  
15 course of their employment.

16 “(C) Any lending of money or other exten-  
17 sion of credit between the entity and such a  
18 party.

19 The State or the Secretary may require that infor-  
20 mation reported with respect to a risk contracting  
21 entity which controls, or is controlled by, or is under  
22 common control with, another entity be in the form  
23 of a consolidated financial statement for the risk  
24 contracting entity and such entity.

1           “(2) AVAILABILITY OF INFORMATION.—Each  
2 risk contracting entity shall make the information  
3 reported pursuant to paragraph (1) available to its  
4 enrollees upon reasonable request.

5           “(i) REMEDIES FOR FAILURE TO COMPLY.—

6           “(1) IN GENERAL.—If the Secretary determines  
7 that a risk contracting entity or a primary care case  
8 management entity—

9           “(A) fails substantially to provide services  
10 required under section 1905(r), when such an  
11 entity is required to do so, or provide medically  
12 necessary items and services that are required  
13 to be provided to an individual enrolled with  
14 such an entity, if the failure has adversely af-  
15 fected (or has substantial likelihood of adversely  
16 affecting) the individual;

17           “(B) imposes premiums on individuals en-  
18 rolled with such an entity in excess of the pre-  
19 miums permitted under this title;

20           “(C) acts to discriminate among individ-  
21 uals in violation of the provision of subsection  
22 (b)(3)(D), including expulsion or refusal to  
23 reenroll an individual or engaging in any prac-  
24 tice that would reasonably be expected to have  
25 the effect of denying or discouraging enrollment

1 (except as permitted by this section) by eligible  
2 individuals with the entity whose medical condi-  
3 tion or history indicates a need for substantial  
4 future medical services;

5 “(D) misrepresents or falsifies information  
6 that is furnished—

7 “(i) to the Secretary or the State  
8 under this section; or

9 “(ii) to an individual or to any other  
10 entity under this section; or

11 “(E) fails to comply with the requirements  
12 of section 1876(i)(8),

13 the Secretary may provide, in addition to any other  
14 remedies available under law, for any of the rem-  
15 edies described in paragraph (2).

16 “(2) ADDITIONAL REMEDIES.—The remedies  
17 described in this paragraph are—

18 “(A) civil money penalties of not more  
19 than \$25,000 for each determination under  
20 paragraph (1), or, with respect to a determina-  
21 tion under subparagraph (C) or (D)(i) of such  
22 paragraph, of not more than \$100,000 for each  
23 such determination, plus, with respect to a de-  
24 termination under paragraph (1)(B), double the  
25 excess amount charged in violation of such

1 paragraph (and the excess amount charged  
2 shall be deducted from the penalty and returned  
3 to the individual concerned), and plus, with re-  
4 spect to a determination under paragraph  
5 (1)(C), \$15,000 for each individual not enrolled  
6 as a result of a practice described in such para-  
7 graph, or

8 “(B) denial of payment to the State for  
9 medical assistance furnished by a risk contract-  
10 ing entity or a primary care case management  
11 entity under this section for individuals enrolled  
12 after the date the Secretary notifies the entity  
13 of a determination under paragraph (1) and  
14 until the Secretary is satisfied that the basis for  
15 such determination has been corrected and is  
16 not likely to recur.

17 The provisions of section 1128A (other than sub-  
18 sections (a) and(b)) shall apply to a civil money pen-  
19 alty under subparagraph (A) in the same manner as  
20 such provisions apply to a penalty or proceeding  
21 under section 1128A(a).

22 “(j) TERMINATION OF CONTRACT BY STATE.—Any  
23 State which has a contract with a risk contracting entity  
24 or a primary care case management entity may terminate

1 such contract if such entity fails to comply with the terms  
2 of such contract or any applicable provision of this section.

3 “(k) FAIR HEARING.—Nothing in this section shall  
4 affect the rights of an individual eligible to receive medical  
5 assistance under the State plan to obtain a fair hearing  
6 under section 1902(a)(3) or under applicable State law.

7 “(l) DISPROPORTIONATE SHARE HOSPITALS.—Noth-  
8 ing in this section shall affect any requirement on a State  
9 to comply with section 1923.

10 “(m) REFERRAL PAYMENTS.—For 1 year following  
11 the date on which individuals eligible for medical assist-  
12 ance under the State plan in a service area are required  
13 to enroll with a risk contracting entity or a primary care  
14 case management entity, Federally qualified health cen-  
15 ters and rural health centers located in such service area  
16 or providing care to such enrollees, shall receive a fee for  
17 educating such enrollees about the availability of services  
18 from the risk contracting entity or primary care case man-  
19 agement entity with which such enrollees are enrolled.

20 “(n) SPECIAL RULES.—

21 “(1) NONAPPLICABILITY OF CERTAIN PROVI-  
22 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—  
23 In the case of any risk contracting entity which—

1           “(A)(i) is an individual physician or a phy-  
2           sician group practice of less than 50 physicians,  
3           and

4           “(ii) is not described in paragraphs (A)  
5           and (B) of subsection (b)(1), and

6           “(B) is at risk only for the health care  
7           items and services directly provided by such en-  
8           tity,  
9           paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)  
10          of subsection (b), and paragraph (3) of subsection  
11          (f), shall not apply to such entity.

12          “(2) EXCEPTION FROM DEFINITION OF RISK  
13          CONTRACTING ENTITY.—For purposes of this sec-  
14          tion, the term ‘risk contracting entity’ shall not in-  
15          clude a health insuring organization which was used  
16          by a State before April 1, 1986, to administer a por-  
17          tion of the State plan of such State on a statewide  
18          basis.

19          “(3) NEW JERSEY.—The rules under section  
20          1903(m)(6) as in effect on the day before the effec-  
21          tive date of this section shall apply in the case of an  
22          undertaking by the State of New Jersey (as de-  
23          scribed in such section 1903(m)(6)).

24          “(o) CONTINUATION OF CERTAIN COORDINATED  
25          CARE PROGRAMS.—The Secretary may provide for the

1 continuation of any coordinated care program operating  
2 under section 1115 or 1915 without requiring compliance  
3 with any provision of this section which conflicts with the  
4 continuation of such program and without requiring any  
5 additional waivers under such sections 1115 and 1915 if  
6 the program has been successful in assuring quality and  
7 containing costs (as determining by the Secretary) and is  
8 likely to continue to be successful in the future.

9 “(p) GUIDELINES, REGULATIONS, AND MODEL CON-  
10 TRACT.—

11 “(1) GUIDELINES AND REGULATIONS ON SOL-  
12 VENCY.—At the earliest practicable time after the  
13 date of enactment of this section, the Secretary shall  
14 issue guidelines and regulations concerning solvency  
15 standards for risk contracting entities and sub-  
16 contractors of such risk contracting entities. Such  
17 guidelines and regulations shall take into account  
18 characteristics that may differ among risk contract-  
19 ing entities including whether such an entity is at  
20 risk for inpatient hospital services.

21 “(2) GUIDELINES AND REGULATIONS ON MAR-  
22 KETING.—At the earliest practicable time after the  
23 date of enactment of this section, the Secretary shall  
24 issue guidelines and regulations concerning—

1           “(A) marketing undertaken by any risk  
2           contracting entity or any primary care case  
3           management program to individuals eligible for  
4           medical assistance under the State plan, and

5           “(B) information that must be provided by  
6           States or any such entity to individuals eligible  
7           for medical assistance under the State plan  
8           with respect to—

9                   “(i) the options and rights of such in-  
10                   dividuals to enroll with, and disenroll from,  
11                   any such entity, as provided in this section,  
12                   and

13                   “(ii) the availability of services from  
14                   any such entity (including a list of services  
15                   for which such entity is responsible or  
16                   must approve and information on how to  
17                   obtain services for which such entity is not  
18                   responsible).

19           In developing the guidelines and regulations under  
20           this paragraph, the Secretary shall address the spe-  
21           cial circumstances of children with special health  
22           care needs (as defined in subsection (e)(1)(B)(ii))  
23           and other individuals with special health care needs.

24           “(3) MODEL CONTRACT.—The Secretary shall  
25           develop a model contract to reflect the requirements

1 of subsection (b)(3) and such other requirements as  
2 the Secretary determines appropriate.”.

3 (b) WAIVERS FROM REQUIREMENTS ON COORDI-  
4 NATED CARE PROGRAMS.—Section 1915(b) of the Social  
5 Security Act (42 U.S.C. 1396n) is amended—

6 (1) in the matter preceding paragraph (1), by  
7 striking “as may be necessary” and inserting “, and  
8 section 1933 as may be necessary”;

9 (2) in paragraph (1), by striking “a primary  
10 care case management system or”;

11 (3) by striking “and” at the end of paragraph  
12 (3);

13 (4) by striking the period at the end of para-  
14 graph (4) and inserting “, and”; and

15 (5) by inserting after paragraph (4) the follow-  
16 ing new paragraph:

17 “(5) to permit a risk contracting entity (as de-  
18 fined in section 1933(a)(3)) to restrict the period in  
19 which individuals enrolled with such entity may ter-  
20minate such enrollment without cause in accordance  
21 with section 1933(e)(3)(A).”.

22 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-  
23 BILITY.—Section 1902(e)(2) of such Act (42 U.S.C.  
24 1396a(e)(2)) is amended—

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

4 “(i) with a qualified health maintenance  
5 organization (as defined in title XIII of the  
6 Public Health Service Act) or with a risk con-  
7 tracting entity (as defined in section  
8 1933(a)(3)), or

9 “(ii) with any risk contracting entity (as  
10 defined in section 1933(a)(3)) in a State that,  
11 on the effective date of this provision, had in ef-  
12 fect a waiver under section 1115 of require-  
13 ments under this title under which the State  
14 could extend eligibility for medical assistance  
15 for enrollees of such entity, or

16 “(iii) with an eligible organization with a  
17 contract under section 1876,

18 and who would”,

19 (2) in subparagraph (B), by striking “organiza-  
20 tion or” each place it appears, and

21 (3) by adding at the end the following new sub-  
22 paragraph:

23 “(C) The State plan may provide, notwith-  
24 standing any other provision of this title, that  
25 an individual shall be deemed to continue to be

1 eligible for benefits under this title until the end  
2 of the month following the month in which such  
3 individual would (but for this paragraph) lose  
4 such eligibility because of excess income and re-  
5 sources, if the individual is enrolled with a risk  
6 contracting entity or primary care case manage-  
7 ment entity (as those terms are defined in sec-  
8 tion 1933(a)).”.

9 (d) ENHANCED MATCH RELATED TO QUALITY RE-  
10 VIEW.—Section 1903(a)(3)(C) of such Act (42 U.S.C.  
11 1396b(a)(3)(C)) is amended—

12 (1) by striking “organization or by” and insert-  
13 ing “organization, by”; and

14 (2) by striking “section 1152, as determined by  
15 the Secretary,” and inserting “section 1152, as de-  
16 termined by the Secretary, or by another organiza-  
17 tion approved by the Secretary which is unaffiliated  
18 with the State government or with any risk contract-  
19 ing entity (as defined in section 1933(a)(3)),”.

20 (e) ACCUMULATION OF RESERVES BY CERTAIN EN-  
21 TITIES.—Any organization referred to in section 329, 330,  
22 or 340, of the Public Health Service Act which has con-  
23 tracted with a State agency as a risk contracting entity  
24 under section 1933(g)(3)(A) of the Social Security Act  
25 may accumulate reserves with respect to payments made

1 to such organization under section 1933(g)(3)(C) of such  
2 Act.

3 (f) CONFORMING AMENDMENTS.—

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

8 (2) Section 1902(a)(23) of such Act (42 U.S.C.  
9 1396a(a)(23)) is amended by striking “primary  
10 care-case management system (described in section  
11 1915(b)(1)), a health maintenance organization,”  
12 and inserting “primary care case management pro-  
13 gram (as defined in section 1933(a)(1)), a risk con-  
14 tracting entity (as defined in section 1933(a)(3)),”.

15 (3) Section 1902(a)(30)(C) of such Act (42  
16 U.S.C. 1396a(a)(30)(C)) is amended by striking  
17 “use a utilization” and all that follows through  
18 “with the results” and inserting “provide for inde-  
19 pendent review and quality assurance of entities with  
20 contracts under section 1933, in accordance with  
21 subsection (f) of such section 1933, with the  
22 results”.

23 (4) Section 1902(a)(57) of such Act (42 U.S.C.  
24 1396a(a)(57)) is amended by striking “or health  
25 maintenance organization (as defined in section

1 1903(m)(1)(A))” and inserting “risk contracting en-  
2 tity, or primary care case management entity (as de-  
3 fined in section 1933(a))”.

4 (5) Section 1902(a) of such Act (42 U.S.C.  
5 1396a), as amended by section 321(a), is amend-  
6 ed—

7 (A) by striking “and” at the end of para-  
8 graph (62);

9 (B) by striking the period at the end of  
10 paragraph (63) and inserting “; and”; and

11 (C) by adding at the end the following new  
12 paragraphs:

13 “(64) at State option, provide for a primary  
14 care case management program in accordance with  
15 section 1933; and

16 “(65) at State option, provide for a program  
17 under which the State contracts with risk contract-  
18 ing entities in accordance with section 1933.”.

19 (6) Section 1902(p)(2) of such Act (42 U.S.C.  
20 1396a(p)(2)) is amended by striking “health mainte-  
21 nance organization (as defined in section 1903(m))”  
22 and inserting “risk contracting entity (as defined in  
23 section 1933(a)(3))”.

24 (7) Section 1902(w) of such Act (42 U.S.C.  
25 1396a(w)) is amended—

1 (A) in paragraph (1), by striking “section  
2 1903(m)(1)(A)” and inserting “section  
3 1933(a)(3)”, and

4 (B) in paragraph (2)(E)—

5 (i) by striking “health maintenance  
6 organization” and inserting “risk contract-  
7 ing entity”, and

8 (ii) by striking “organization” and in-  
9 serting “entity”.

10 (8) Section 1903(k) of such Act (42 U.S.C.  
11 1396b(k)) is amended by striking “health mainte-  
12 nance organization which meets the requirements of  
13 subsection (m) of this section” and inserting “risk  
14 contracting entity which meets the requirements of  
15 section 1933”.

16 (9) Section 1903(w)(7)(A)(viii) of such Act (42  
17 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking  
18 “health maintenance organizations (and other orga-  
19 nizations with contracts under section 1903(m))”  
20 and inserting “risk contracting entities with con-  
21 tracts under section 1933”.

22 (10) Section 1905(a) of such Act (42 U.S.C.  
23 1396d(a)) is amended, in the matter preceding  
24 clause (i), by inserting “(which may be on a prepaid  
25 capitation or other risk basis)” after “payment”.

1           (11) Section 1916(b)(2)(D) of such Act (42  
2 U.S.C. 1396o(b)(2)(D)) is amended by striking  
3 “health maintenance organization (as defined in sec-  
4 tion 1903(m))” and inserting “risk contracting en-  
5 tity (as defined in section 1933(a)(3))”.

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

8           (A) in the heading, by striking “**HMO**”  
9 and inserting “**RISK CONTRACTING ENTITY**”,

10           (B) by striking “health maintenance orga-  
11 nization (as defined in section 1903(m)(1)(A))”  
12 and inserting “risk contracting entity (as de-  
13 fined in section 1933(a)(3))”, and

14           (C) by striking “health maintenance orga-  
15 nization in accordance with section 1903(m)”  
16 and inserting “risk contracting entity in accord-  
17 ance with section 1933”.

18           (13) Paragraphs (1) and (2) of section 1926(a)  
19 of such Act (42 U.S.C. 1396r-7(a)) are each amend-  
20 ed by striking “health maintenance organizations  
21 under section 1903(m)” and inserting “risk con-  
22 tracting entities under section 1933”.

23           (14) Section 1927(j)(1) of such Act (42 U.S.C.  
24 1396r-8(j)(1)) is amended by striking “\* \* \*  
25 Health Maintenance Organizations, including those

1 organizations that contract under section 1903(m)”  
2 and inserting “risk contracting entities (as defined  
3 in section 1933(a)(3))”.

4 (g) EFFECTIVE DATE.—The amendments made by  
5 this section shall become effective with respect to calendar  
6 quarters beginning on or after January 1, 1995.

7 **PART 4—LIMITATIONS ON FUNDING OF**

8 **ABORTION SERVICES UNDER MEDICAID**

9 **SEC. 341. LIMITATIONS ON FUNDING OF ABORTION SERV-**

10 **ICES UNDER MEDICAID.**

11 Title XIX of the Social Security Act (42 U.S.C. 1396  
12 et seq.), as amended by sections 311(a)(1), 321(b), and  
13 331(a)(2), is further amended by redesignating section  
14 1934 as section 1935 and by inserting after section 1933  
15 the following new section:

16 “LIMITATIONS ON FUNDING OF ABORTION SERVICES

17 “SEC. 1934. (a) None of the funds authorized by this  
18 title may be used to provide abortions, except to prevent  
19 the death of the mother.

20 “(b) Nothing in this title shall be construed—

21 “(1) to require any State to pay for abortions,  
22 except those necessary to prevent the death of the  
23 mother, or

24 “(2) to require any health plan or other entity  
25 to provide abortions in order to participate in any  
26 program authorized by this title, or

1           “(3) to authorize any State to impose such a  
2           requirement for participation in any program au-  
3           thorized by this title.”.

4       **TITLE IV—CONTAINING HEALTH**  
5                                   **CARE COSTS**

6       **Subtitle A—Medical Malpractice**  
7                                   **Liability Reform**

8                                   **PART 1—GENERAL PROVISIONS**

9       **SEC. 401. FEDERAL REFORM OF MEDICAL MALPRACTICE**  
10                                   **LIABILITY ACTIONS.**

11           (a) **APPLICABILITY.**—This subtitle shall apply with  
12           respect to any medical malpractice liability claim and to  
13           any medical malpractice liability action brought in any  
14           State or Federal court, except that this subtitle—

15                           (1) shall not apply to a claim or action for dam-  
16                           ages arising from a vaccine-related injury or death  
17                           to the extent that title XXI of the Public Health  
18                           Service Act applies to the claim or action, and

19                           (2) it shall not apply to a claim or action for  
20                           damages brought pursuant to subtitle C of title VII.

21           (b) **PREEMPTION.**—The provisions of this subtitle  
22           shall preempt any State law to the extent such law is in-  
23           consistent with the limitations contained in such provi-  
24           sions. The provisions of this subtitle shall not preempt any  
25           State law that provides for defenses or places limitations

1 on a person's liability in addition to those contained in  
2 this subtitle or otherwise imposes greater restrictions than  
3 those provided in this subtitle.

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

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

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

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

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

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

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

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

3 **SEC. 402. DEFINITIONS.**

4 As used in this subtitle:

5 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
6 TEM; ADR.—The term “alternative dispute resolution  
7 system” or “ADR” means a system established  
8 under this subtitle that provides for the resolution of  
9 medical malpractice liability claims in a manner  
10 other than through medical malpractice liability ac-  
11 tions.

12 (2) CLAIMANT.—The term “claimant” means  
13 any person who alleges a medical malpractice liabil-  
14 ity claim, and any person on whose behalf such a  
15 claim is alleged, including the decedent in the case  
16 of an action brought through or on behalf of an  
17 estate.

18 (3) CLEAR AND CONVINCING EVIDENCE.—The  
19 term “clear and convincing evidence” is that meas-  
20 ure or degree of proof that will produce in the mind  
21 of the trier of fact a firm belief or conviction as to  
22 the truth of the allegations sought to be established,  
23 except that such measure or degree of proof is more  
24 than that required under preponderance of the evi-

1        dence, but less than that required for proof beyond  
2        a reasonable doubt.

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

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

13           (6) HEALTH CARE PROVIDER.—The term  
14       “health care provider” means any organization or  
15       institution that is engaged in the delivery of health  
16       care services in a State and that is required by the  
17       laws or regulations of the State to be licensed or cer-  
18       tified by the State to engage in the delivery of such  
19       services in the State.

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

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

1       tion” means a civil action brought in a State or Fed-  
2       eral court against a health care provider or health  
3       care professional in which the plaintiff alleges a  
4       medical malpractice liability claim, but does not in-  
5       clude any action in which the plaintiff’s sole allega-  
6       tion is an allegation of an intentional tort.

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

13           (10) MEDICAL PRODUCT.—

14           (A) IN GENERAL.—The term “medical  
15      product” means, with respect to the allegation  
16      of a claimant, a drug (as defined in section  
17      201(g)(1) of the Federal Food, Drug, and Cos-  
18      metic Act (21 U.S.C. 321(g)(1)) or a medical  
19      device (as defined in section 201(h) of the Fed-  
20      eral Food, Drug, and Cosmetic Act (21 U.S.C.  
21      321(h)) if—

22                   (i) such drug or device was subject to  
23                   premarket approval under section 505,  
24                   507, or 515 of the Federal Food, Drug,  
25                   and Cosmetic Act (21 U.S.C. 355, 357, or

1           360e) or section 351 of the Public Health  
2           Service Act (42 U.S.C. 262) with respect  
3           to the safety of the formulation or per-  
4           formance of the aspect of such drug or de-  
5           vice which is the subject of the claimant's  
6           allegation or the adequacy of the packag-  
7           ing or labeling of such drug or device, and  
8           such drug or device is approved by the  
9           Food and Drug Administration; or

10           (ii) the drug or device is generally rec-  
11           ognized as safe and effective under regula-  
12           tions issued by the Secretary of Health  
13           and Human Services under section 201(p)  
14           of the Federal Food, Drug, and Cosmetic  
15           Act (21 U.S.C. 321(p)).

16           (B) EXCEPTION IN CASE OF MISREPRE-  
17           SENTATION OR FRAUD.—Notwithstanding sub-  
18           paragraph (A), the term “medical product”  
19           shall not include any product described in such  
20           subparagraph if the claimant shows that the  
21           product is approved by the Food and Drug Ad-  
22           ministration for marketing as a result of with-  
23           held information, misrepresentation, or an ille-  
24           gal payment by manufacturer of the product.

1           (C) EXCEPTION IN THE CASE OF ABOR-  
2           TION-INDUCING DRUGS AND DEVICES.—Not-  
3           withstanding subparagraph (A), the term “med-  
4           ical product” shall not include any drug or de-  
5           vice which is used as a contraceptive or abor-  
6           tifacient and which has as one of its known ef-  
7           fects the interference with implantation of a  
8           fertilized human ovum or embryo or the termi-  
9           nation of pregnancy after implantation with in-  
10          tent other than to produce a live birth.

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

18          (12) PUNITIVE DAMAGES; EXEMPLARY DAM-  
19          AGES.—The terms “punitive damages” and “exem-  
20          plary damages” mean compensation, in addition to  
21          compensation for actual harm suffered, that is  
22          awarded for the purpose of punishing a person for  
23          conduct deemed to be malicious, wanton, willful, or  
24          excessively reckless.

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

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

7 **SEC. 403. EFFECTIVE DATE.**

8           (a) IN GENERAL.—Except as provided in subsection  
9 (b) and section 417(c), this subtitle shall apply with re-  
10 spect to claims accruing or actions brought on or after  
11 the expiration of the 3-year period that begins on the date  
12 of the enactment of this Act.

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

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

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

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

8 **PART 2—MEDICAL MALPRACTICE AND PRODUCT**  
9 **LIABILITY REFORM**

10 **SEC. 411. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**  
11 **TION THROUGH ALTERNATIVE DISPUTE RES-**  
12 **OLUTION.**

13 (a) IN GENERAL.—

14 (1) STATE CASES.—A medical malpractice li-  
15 ability action may not be brought in any State court  
16 during a calendar year unless the medical mal-  
17 practice liability claim that is the subject of the ac-  
18 tion has been initially resolved under an alternative  
19 dispute resolution system certified for the year by  
20 the Secretary under section 422(a), or, in the case  
21 of a State in which such a system is not in effect  
22 for the year, under the alternative Federal system  
23 established under section 422(b).

24 (2) FEDERAL DIVERSITY ACTIONS.—A medical  
25 malpractice liability action may not be brought in

1 any Federal court under section 1332 of title 28,  
2 United States Code, during a calendar year unless  
3 the medical malpractice liability claim that is the  
4 subject of the action has been initially resolved  
5 under the alternative dispute resolution system re-  
6 ferred to in paragraph (1) that applied in the State  
7 whose law applies in such action.

8 (3) CLAIMS AGAINST UNITED STATES.—

9 (A) ESTABLISHMENT OF PROCESS FOR  
10 CLAIMS.—The Attorney General shall establish  
11 an alternative dispute resolution process for the  
12 resolution of tort claims consisting of medical  
13 malpractice liability claims brought against the  
14 United States under chapter 171 of title 28,  
15 United States Code. Under such process, the  
16 resolution of a claim shall occur after the com-  
17 pletion of the administrative claim process ap-  
18 plicable to the claim under section 2675 of such  
19 title.

20 (B) REQUIREMENT FOR INITIAL RESOLU-  
21 TION UNDER PROCESS.—A medical malpractice  
22 liability action based on a medical malpractice  
23 liability claim described in subparagraph (A)  
24 may not be brought in any Federal court unless  
25 the claim has been initially resolved under the

1 alternative dispute resolution process estab-  
2 lished by the Attorney General under such sub-  
3 paragraph.

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

8 (A) the ADR reaches a decision on wheth-  
9 er the defendant is liable to the plaintiff for  
10 damages; and

11 (B) if the ADR determines that the de-  
12 fendant is liable, the ADR reaches a decision on  
13 the amount of damages assessed against the de-  
14 fendant.

15 (c) PROCEDURES FOR FILING ACTIONS.—

16 (1) NOTICE OF INTENT TO CONTEST DECI-  
17 SION.—Not later than 60 days after a decision is is-  
18 sued with respect to a medical malpractice liability  
19 claim under an alternative dispute resolution system,  
20 each party affected by the decision shall submit a  
21 sealed statement to a court of competent jurisdiction  
22 indicating whether or not the party intends to con-  
23 test the decision.

1           (2) DEADLINE FOR FILING ACTION.—A medical  
2 malpractice liability action may not be brought by a  
3 party unless—

4           (A) the party has filed the notice of intent  
5 required by paragraph (1); and

6           (B) the party files the action in a court of  
7 competent jurisdiction not later than 90 days  
8 after the decision resolving the medical mal-  
9 practice liability claim that is the subject of the  
10 action is issued under the applicable alternative  
11 dispute resolution system.

12           (3) COURT OF COMPETENT JURISDICTION.—  
13 For purposes of this subsection, the term “court of  
14 competent jurisdiction” means—

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

17           (B) with respect to actions filed in a Fed-  
18 eral court, the appropriate United States dis-  
19 trict court.

20           (d) LEGAL EFFECT OF UNCONTESTED ADR DECI-  
21 SION.—The decision reached under an alternative dispute  
22 resolution system shall, for purposes of enforcement by a  
23 court of competent jurisdiction, have the same status in  
24 the court as the verdict of a medical malpractice liability  
25 action adjudicated in a State or Federal trial court. The

1 previous sentence shall not apply to a decision that is con-  
2 tested by a party affected by the decision pursuant to sub-  
3 section (c)(1).

4 **SEC. 412. CALCULATION AND PAYMENT OF DAMAGES.**

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

13 (b) **TREATMENT OF PUNITIVE DAMAGES.**—

14 (1) **BASIS FOR RECOVERY.**—Punitive or exem-  
15 plary damages shall not be awarded in a medical  
16 malpractice liability action unless the claimant es-  
17 tablishes by clear and convincing evidence that the  
18 injury suffered was the direct result of conduct  
19 manifesting a malicious, wanton, willful, or exces-  
20 sively reckless disregard of the safety of others.

21 (2) **NO AWARD AGAINST MANUFACTURER OF**  
22 **MEDICAL PRODUCT.**—In the case of a medical mal-  
23 practice liability action in which the plaintiff alleges  
24 a claim against the manufacturer of a medical prod-

1 uct, no punitive or exemplary damages may be  
2 awarded against such manufacturer.

3 (3) PAYMENTS TO STATE FOR MEDICAL QUAL-  
4 ITY ASSURANCE ACTIVITIES.—

5 (A) IN GENERAL.—Any punitive or exem-  
6 plary damages awarded in a medical mal-  
7 practice liability action shall be paid to the  
8 State in which the action is brought or, in a  
9 case brought in Federal court, in the State in  
10 which the health care services that caused the  
11 injury that is the subject of the action were  
12 provided.

13 (B) ACTIVITIES DESCRIBED.—A State  
14 shall use amounts paid pursuant to subpara-  
15 graph (A) to carry out activities to assure the  
16 safety and quality of health care services pro-  
17 vided in the State, including (but not limited  
18 to)—

19 (i) licensing or certifying health care  
20 professionals and health care providers in  
21 the State;

22 (ii) operating alternative dispute reso-  
23 lution systems;

24 (iii) carrying out public education pro-  
25 grams relating to medical malpractice and

1 the availability of alternative dispute reso-  
2 lution systems in the State; and

3 (iv) carrying out programs to reduce  
4 malpractice-related costs for retired provid-  
5 ers or other providers volunteering to pro-  
6 vide services in medically underserved  
7 areas.

8 (C) MAINTENANCE OF EFFORT.—A State  
9 shall use any amounts paid pursuant to sub-  
10 paragraph (A) to supplement and not to replace  
11 amounts spent by the State for the activities  
12 described in subparagraph (B).

13 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

14 (1) GENERAL RULE.—In any medical mal-  
15 practice liability action in which the damages award-  
16 ed for future economic loss exceeds \$100,000, a de-  
17 fendant may not be required to pay such damages  
18 in a single, lump-sum payment, but shall be per-  
19 mitted to make such payments periodically based on  
20 when the damages are found likely to occur, as such  
21 payments are determined by the court.

22 (2) WAIVER.—A court may waive the applica-  
23 tion of paragraph (1) with respect to a defendant if  
24 the court determines that it is not in the best inter-

1       ests of the plaintiff to receive payments for damages  
2       on such a periodic basis.

3       **SEC. 413. REQUIRING PARTY CONTESTING ADR RULING TO**  
4                                   **PAY ATTORNEY'S FEES AND OTHER COSTS.**

5       (a) IN GENERAL.—The court in a medical mal-  
6       practice liability action shall require the party that (pursu-  
7       ant to section 411(c)(1)) contested the ruling of the alter-  
8       native dispute resolution system with respect to the medi-  
9       cal malpractice liability claim that is the subject of the  
10      action to pay to the opposing party the costs incurred by  
11      the opposing party under the action, including attorney's  
12      fees, fees paid to expert witnesses, and other litigation ex-  
13      penses (but not including court costs, filing fees, or other  
14      expenses paid directly by the party to the court, or any  
15      fees or costs associated with the resolution of the claim  
16      under the alternative dispute resolution system), but only  
17      if—

18               (1) in the case of an action in which the party  
19               that contested the ruling is the claimant, the amount  
20               of damages awarded to the party under the action  
21               does not exceed the amount of damages awarded to  
22               the party under the ADR system by at least 10 per-  
23               cent; and

24               (2) in the case of an action in which the party  
25               that contested the ruling is the defendant, the

1 amount of damages assessed against the party under  
2 the action is not at least 10 percent less than the  
3 amount of damages assessed under the ADR system.

4 (b) EXCEPTIONS.—Subsection (a) shall not apply  
5 if—

6 (1) the party contesting the ruling made under  
7 the previous alternative dispute resolution system  
8 shows that—

9 (A) the ruling was procured by corruption,  
10 fraud, or undue means,

11 (B) there was partiality or corruption  
12 under the system,

13 (C) there was other misconduct under the  
14 system that materially prejudiced the party's  
15 rights, or

16 (D) the ruling was based on an error of  
17 law;

18 (2) the party contesting the ruling made under  
19 the alternative dispute resolution system presents  
20 new evidence before the trier of fact that was not  
21 available for presentation under the ADR system;

22 (3) the medical malpractice liability action  
23 raised a novel issue of law; or

24 (4) the court finds that the application of such  
25 paragraph to a party would constitute an undue

1 hardship, and issues an order waiving or modifying  
2 the application of such paragraph that specifies the  
3 grounds for the court's decision.

4 (c) REQUIREMENT FOR PERFORMANCE BOND.—The  
5 court in a medical malpractice liability action shall require  
6 the party that (pursuant to section 411(c)(1)) contested  
7 the ruling of the alternative dispute resolution system with  
8 respect to the medical malpractice liability claim that is  
9 the subject of the action to post a performance bond (in  
10 such amount and consisting of such funds and assets as  
11 the court determines to be appropriate), except that the  
12 court may waive the application of such requirement to  
13 a party if the court determines that the posting of such  
14 a bond is not necessary to ensure that the party shall meet  
15 the requirements of this subsection to pay the opposing  
16 party the costs incurred by the opposing party under the  
17 action.

18 (d) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys'  
19 fees that are required to be paid under subsection (a) by  
20 the contesting party shall not exceed the amount of the  
21 attorneys' fees incurred by the contesting party in the ac-  
22 tion. If the attorneys' fees of the contesting party are  
23 based on a contingency fee agreement, the amount of at-  
24 torneys' fees for purposes of the preceding sentence shall  
25 not exceed the reasonable value of those services.

1 (e) RECORDS.—In order to receive attorneys’ fees  
2 under subsection (a), counsel of record in the medical mal-  
3 practice liability action involved shall maintain accurate,  
4 complete records of hours worked on the action, regardless  
5 of the fee arrangement with the client involved.

6 (f) CONTINGENCY FEE DEFINED.—As used in this  
7 section, the term “contingency fee” means any fee for pro-  
8 fessional legal services which is, in whole or in part, con-  
9 tingent upon the recovery of any amount of damages,  
10 whether through judgment or settlement.

11 **SEC. 414. JOINT AND SEVERAL LIABILITY FOR NON-**  
12 **ECONOMIC DAMAGES.**

13 A defendant may be held severally but not jointly lia-  
14 ble in a medical malpractice action for noneconomic dam-  
15 ages. A person found liable for such damages in any such  
16 action may be found liable, if at all, only for those dam-  
17 ages directly attributable to the person’s proportionate  
18 share of fault or responsibility for the injury, and may  
19 not be found liable for damages attributable to the propor-  
20 tionate share of fault or responsibility of any other person  
21 (without regard to whether that person is a party to the  
22 action) for the injury, including any person bringing the  
23 action.

1 **SEC. 415. STATUTE OF LIMITATIONS.**

2 A medical malpractice liability claim may not be  
3 brought after the expiration of the 7-year period that be-  
4 gins on the date the alleged injury that is the subject of  
5 the claim occurred. If the commencement of such an ac-  
6 tion is stayed or enjoined, the running of the statute of  
7 limitations under this section shall be suspended for the  
8 period of the stay or injunction.

9 **SEC. 416. UNIFORM STANDARD FOR DETERMINING NEG-**  
10 **LIGENCE.**

11 A defendant in a medical malpractice liability action  
12 may not be found to have acted negligently unless the de-  
13 fendant's conduct at the time of providing the health care  
14 services that are the subject of the action was not reason-  
15 able.

16 **SEC. 417. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
17 **SERVICES.**

18 (a) IMPOSITION OF HIGHER STANDARD OF PROOF.—  
19 In the case of a medical malpractice liability claim relating  
20 to services provided during labor or the delivery of a baby,  
21 if the health care professional against whom the claim is  
22 brought did not previously treat the individual alleged to  
23 have been injured for the pregnancy, the trier of fact may  
24 not find that the defendant committed malpractice and  
25 may not assess damages against the health care profes-

1 sional unless the malpractice is proven by clear and con-  
2 vincing evidence.

3 (b) APPLICABILITY TO GROUP PRACTICES OR  
4 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-  
5 section (a), a health care professional shall be considered  
6 to have previously treated an individual for a pregnancy  
7 if the professional is a member of a group practice whose  
8 members previously treated the individual for the preg-  
9 nancy or is providing services to the individual during  
10 labor or the delivery of a baby pursuant to an agreement  
11 with another health care professional.

12 (c) EFFECTIVE DATE.—This section shall apply with  
13 respect to claims accruing or actions brought on or after  
14 the expiration of the 2-year period that begins on the date  
15 of the enactment of this Act.

16 **PART 3—REQUIREMENTS FOR STATE ALTER-**  
17 **NATIVE DISPUTE RESOLUTION SYSTEMS**  
18 **(ADR)**

19 **SEC. 421. BASIC REQUIREMENTS.**

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

23 (1) applies to all medical malpractice liability  
24 claims under the jurisdiction of the courts of that  
25 State;

1           (2) requires that a written opinion resolving the  
2           dispute be issued not later than 6 months after the  
3           date by which each party against whom the claim is  
4           filed has received notice of the claim (other than in  
5           exceptional cases for which a longer period is re-  
6           quired for the issuance of such an opinion), and that  
7           the opinion contain—

8                   (A) findings of fact relating to the dispute,

9                   and

10                   (B) a description of the costs incurred in  
11                   resolving the dispute under the system (includ-  
12                   ing any fees paid to the individuals hearing and  
13                   resolving the claim), together with an appro-  
14                   priate assessment of the costs against any of  
15                   the parties;

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

20           (4) is approved by the State or by local govern-  
21           ments in the State;

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

1 (A) permits the parties to a dispute to se-  
2 lect the procedure to be used for the resolution  
3 of the dispute under the system, and

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

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

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

23 (b) APPLICATION OF MALPRACTICE LIABILITY  
24 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—  
25 The provisions of part 2 shall apply with respect to claims

1 brought under a State alternative dispute resolution sys-  
2 tem or the alternative Federal system in the same manner  
3 as such provisions apply with respect to medical mal-  
4 practice liability actions brought in the State.

5 **SEC. 422. CERTIFICATION OF STATE SYSTEMS; APPLICABIL-**  
6 **ITY OF ALTERNATIVE FEDERAL SYSTEM.**

7 (a) CERTIFICATION.—

8 (1) IN GENERAL.—Not later than October 1 of  
9 each year (beginning with 1995), the Secretary, in  
10 consultation with the Attorney General, shall deter-  
11 mine whether a State's alternative dispute resolution  
12 system meets the requirements of this part for the  
13 following calendar year.

14 (2) BASIS FOR CERTIFICATION.—The Secretary  
15 shall certify a State's alternative dispute resolution  
16 system under this subsection for a calendar year if  
17 the Secretary determines under paragraph (1) that  
18 the system meets the requirements of section 421.

19 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-  
20 TEM.—

21 (1) ESTABLISHMENT AND APPLICABILITY.—  
22 Not later than October 1, 1995, the Secretary, in  
23 consultation with the Attorney General, shall estab-  
24 lish by rule an alternative Federal ADR system for  
25 the resolution of medical malpractice liability claims

1 during a calendar year in States that do not have  
2 in effect an alternative dispute resolution system  
3 certified under subsection (a) for the year.

4 (2) REQUIREMENTS FOR SYSTEM.—Under the  
5 alternative Federal ADR system established under  
6 paragraph (1)—

7 (A) paragraphs (1), (2), (6), and (7) of  
8 section 421(a) shall apply to claims brought  
9 under the system;

10 (B) if the system provides for the resolu-  
11 tion of claims through arbitration, the claims  
12 brought under the system shall be heard and  
13 resolved by arbitrators appointed by the Sec-  
14 retary in consultation with the Attorney Gen-  
15 eral; and

16 (C) with respect to a State in which the  
17 system is in effect, the Secretary may (at the  
18 State's request) modify the system to take into  
19 account the existence of dispute resolution pro-  
20 cedures in the State that affect the resolution  
21 of medical malpractice liability claims.

22 (3) TREATMENT OF STATES WITH ALTER-  
23 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-  
24 eral ADR system established under this subsection is  
25 applied with respect to a State for a calendar year—

1 (A) the State shall reimburse the United  
2 States (at such time and in such manner as the  
3 Secretary may require) for the costs incurred  
4 by the United States during the year as a result  
5 of the application of the system with respect to  
6 the State; and

7 (B) notwithstanding any other provision of  
8 law, no funds may be paid to the State (or to  
9 any unit of local government in the State) or to  
10 any entity in the State pursuant to the Public  
11 Health Service Act.

12 **SEC. 423. REPORTS ON IMPLEMENTATION AND EFFECTIVE-**  
13 **NESS OF ALTERNATIVE DISPUTE RESOLU-**  
14 **TION SYSTEMS.**

15 (a) IN GENERAL.—Not later than 5 years after the  
16 date of the enactment of this Act, the Secretary shall pre-  
17 pare and submit to the Congress a report describing and  
18 evaluating State alternative dispute resolution systems op-  
19 erated pursuant to this part and the alternative Federal  
20 system established under section 422(b).

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

24 (1) information on—

1 (A) the effect of the alternative dispute  
2 resolution systems on the cost of health care  
3 within each State,

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

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

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

16 **PART 4—OTHER PROVISIONS RELATING TO**  
17 **MEDICAL MALPRACTICE LIABILITY**

18 **SEC. 431. PERMITTING STATE PROFESSIONAL SOCIETIES**  
19 **TO PARTICIPATE IN DISCIPLINARY ACTIVI-**  
20 **TIES.**

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

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

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

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

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

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

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

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

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

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

9 **SEC. 432. STUDY OF INCENTIVES TO ENCOURAGE VOL-**  
10 **UNTARY SERVICE BY PHYSICIANS.**

11 (a) STUDY.—The Secretary shall conduct a study  
12 analyzing the existence and effectiveness of incentives  
13 adopted by State and local governments, insurers, medical  
14 societies, and other entities to encourage physicians  
15 (whether practicing or retired) to volunteer to provide  
16 health care services in medically underserved areas.

17 (b) REPORTS.—(1) Not later than 1 year after the  
18 date of the enactment of this Act, the Secretary shall sub-  
19 mit an interim report to Congress on the study conducted  
20 under subsection (a), together with the Secretary's rec-  
21 ommendations for actions to increase the number of physi-  
22 cians volunteering to provide health care services in medi-  
23 cally underserved areas.

24 (2) Not later than 5 years after the date of the enact-  
25 ment of this Act, the Secretary shall submit a final report

1 to the Congress on the study conducted under subsection  
2 (a) (taking into account the effects of this subtitle on the  
3 incidence and costs of medical malpractice), together with  
4 the Secretary's recommendations for actions to increase  
5 the number of physicians volunteering to provide health  
6 care services in medically underserved areas.

7 **SEC. 433. REQUIREMENTS FOR RISK MANAGEMENT PRO-**  
8 **GRAMS.**

9 (a) **REQUIREMENTS FOR PROVIDERS.**—Each State  
10 shall require each health care professional and health care  
11 provider providing services in the State to participate in  
12 a risk management program to prevent and provide early  
13 warning of practices which may result in injuries to pa-  
14 tients or which otherwise may endanger patient safety.

15 (b) **REQUIREMENTS FOR INSURERS.**—Each State  
16 shall require each entity which provides health care profes-  
17 sional or provider liability insurance to health care profes-  
18 sionals and health care providers in the State to—

19 (1) establish risk management programs based  
20 on data available to such entity or sanction pro-  
21 grams of risk management for health care profes-  
22 sionals and health care providers provided by other  
23 entities; and

24 (2) require each such professional or provider,  
25 as a condition of maintaining insurance, to partici-

1       pate in one program described in paragraph (1) at  
2       least once in each 3-year period.

3       (c) EFFECTIVE DATE.—This section shall take effect  
4       2 years after the date of the enactment of this Act.

5       **SEC. 434. GRANTS FOR MEDICAL SAFETY PROMOTION.**

6       (a) RESEARCH ON MEDICAL INJURY PREVENTION  
7       AND COMPENSATION.

8               (1) IN GENERAL.—The Secretary shall make  
9       grants for the conduct of basic research in the pre-  
10      vention of and compensation for injuries resulting  
11      from health care professional or health care provider  
12      malpractice, and research of the outcomes of health  
13      care procedures.

14              (2) PREFERENCE FOR RESEARCH ON CERTAIN  
15      ACTIVITIES.—In making grants under paragraph  
16      (1), the Secretary shall give preference to applica-  
17      tions for grants to conduct research on the behavior  
18      of health care providers and health care profes-  
19      sionals in carrying out their professional duties and  
20      of other participants in systems for compensating in-  
21      dividuals injured by medical malpractice, the effects  
22      of financial and other incentives on such behavior,  
23      the determinants of compensation system outcomes,  
24      and the costs and benefits of alternative compensa-  
25      tion policy options.

1           (3) APPLICATION.—The Secretary may not  
2           make a grant under paragraph (1) unless an appli-  
3           cant submits an application to the Secretary at such  
4           time, in such form, in such manner, and containing  
5           such information as the Secretary may require.

6           (b) GRANTS FOR LICENSING AND DISCIPLINARY AC-  
7           TIVITIES.—

8           (1) IN GENERAL.—The Secretary shall make  
9           grants to States to assist States in improving the  
10          State’s ability to license and discipline health care  
11          professionals.

12          (2) USES FOR GRANTS.—A State may use a  
13          grant awarded under subsection (a) to develop and  
14          implement improved mechanisms for monitoring the  
15          practices of health care professionals or for conduct-  
16          ing disciplinary activities.

17          (3) TECHNICAL ASSISTANCE.—The Secretary  
18          shall provide technical assistance to States receiving  
19          grants under paragraph (1) to assist them in evalu-  
20          ating their medical practice acts and procedures and  
21          to encourage the use of efficient and effective early  
22          warning systems and other mechanisms for detecting  
23          practices which endanger patient safety and for dis-  
24          ciplining health care professionals.

1           (4) APPLICATIONS.—The Secretary may not  
2           make a grant under paragraph (1) unless the appli-  
3           cant submits an application to the Secretary at such  
4           time, in such form, in such manner, and containing  
5           such information as the Secretary shall require.

6           (c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

7           (1) IN GENERAL.—The Secretary shall make  
8           grants to States and to local governments, private  
9           nonprofit organizations, and health professional  
10          schools (as defined in paragraph (3)) for—

11                   (A) educating the general public about the  
12                   appropriate use of health care and realistic ex-  
13                   pectations of medical intervention;

14                   (B) educating the public about the re-  
15                   sources and role of health care professional li-  
16                   censing and disciplinary boards in investigating  
17                   claims of incompetence or health care mal-  
18                   practice; and

19                   (C) developing programs of faculty train-  
20                   ing and curricula for educating health care pro-  
21                   fessionals in quality assurance, risk manage-  
22                   ment, and medical injury prevention.

23          (2) APPLICATIONS.—The Secretary may not  
24          make a grant under paragraph (1) unless the appli-  
25          cant submits an application to the Secretary at such

1 time, in such form, in such manner, and containing  
2 such information as the Secretary shall require.

3 (3) HEALTH PROFESSIONAL SCHOOL DE-  
4 FINED.—In paragraph (1), the term “health profes-  
5 sional school” means a school of nursing (as defined  
6 in section 853(2) of the Public Health Service Act)  
7 or a school or program under section 799(1) of such  
8 Act.

9 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
10 are authorized to be appropriated not more than  
11 \$15,000,000 for each of the first 5 fiscal years beginning  
12 on or after the date of the enactment of this Act for grants  
13 under this section.

14 **Subtitle B—Treatment of Certain**  
15 **Activities Under the Antitrust**  
16 **Laws**

17 **SEC. 451. EXEMPTION FROM ANTITRUST LAWS FOR CER-**  
18 **TAIN COMPETITIVE AND COLLABORATIVE**  
19 **ACTIVITIES.**

20 (a) EXEMPTION DESCRIBED.—An activity relating to  
21 the provision of health care services shall be exempt from  
22 the antitrust laws if—

23 (1) the activity is within one of the categories  
24 of safe harbors described in section 452;

1           (2) the activity is within an additional safe har-  
2           bor designated by the Attorney General under sec-  
3           tion 453; or

4           (3) the activity is specified in and in compliance  
5           with the terms of a certificate of review issued by  
6           the Attorney General under section 454 and the ac-  
7           tivity occurs—

8                   (A) while the certificate is in effect, or

9                   (B) in the case of a certificate issued dur-  
10           ing the 2-year period beginning on the date of  
11           the enactment of this Act, at any time on or  
12           after the first day of the 2-year period that  
13           ends on the date the certificate takes effect.

14       (b) AWARD OF ATTORNEY'S FEES AND COSTS OF  
15       SUIT.—

16           (1) IN GENERAL.—If any person brings an ac-  
17           tion alleging a claim under the antitrust laws and  
18           the activity on which the claim is based is found by  
19           the court to be exempt from such laws under sub-  
20           section (a), the court shall, at the conclusion of the  
21           action—

22                   (A) award to a substantially prevailing  
23           claimant the cost of suit attributable to such  
24           claim, including a reasonable attorney's fee, or

1 (B) award to a substantially prevailing  
2 party defending against such claim the cost of  
3 such suit attributable to such claim, including  
4 reasonable attorney's fee, if the claim, or the  
5 claimant's conduct during litigation of the  
6 claim, was frivolous, unreasonable, without  
7 foundation, or in bad faith.

8 (2) OFFSET IN CASES OF BAD FAITH.—The  
9 court may reduce an award made pursuant to para-  
10 graph (1) in whole or in part by an award in favor  
11 of another party for any part of the cost of suit (in-  
12 cluding a reasonable attorney's fee) attributable to  
13 conduct during the litigation by any prevailing party  
14 that the court finds to be frivolous, unreasonable,  
15 without foundation, or in bad faith.

16 **SEC. 452. SAFE HARBORS.**

17 The following activities are safe harbors for purposes  
18 of section 451(a)(1):

19 (1) COMBINATIONS WITH MARKET SHARE  
20 BELOW THRESHOLD.—Activities relating to health  
21 care services of any combination of health care pro-  
22 viders if the number of each type or specialty of pro-  
23 vider in question does not exceed 20 percent of the  
24 total number of such type or specialty of provider in  
25 the relevant market area.

1           (2) ACTIVITIES OF MEDICAL SELF-REGULATORY  
2 ENTITIES.—

3           (A) IN GENERAL.—Subject to subpara-  
4 graph (B), any activity of a medical self-regu-  
5 latory entity relating to standard setting or  
6 standard enforcement activities that are de-  
7 signed to promote the quality of health care  
8 provided to patients.

9           (B) EXCEPTION.—No activity of a medical  
10 self-regulatory entity may be deemed to fall  
11 under the safe harbor established under this  
12 paragraph if the activity is conducted for pur-  
13 poses of financial gain.

14           (3) PARTICIPATION IN SURVEYS.—The partici-  
15 pation of a provider of health care services in a writ-  
16 ten survey of the prices of services, reimbursement  
17 levels, or the compensation and benefits of employ-  
18 ees and personnel, but only if—

19           (A) the survey is conducted by a third  
20 party, such as a purchaser of health care serv-  
21 ices, governmental entity, institution of higher  
22 education, or trade association;

23           (B) the information provided by partici-  
24 pants in the survey is based on prices charged,  
25 reimbursements received, or compensation and

1 benefits paid prior to the third month preceding  
2 the month in which the information is provided;  
3 and

4 (C) if the results of the survey are dissemi-  
5 nated, the results are aggregated in a manner  
6 that ensures that no recipient of the results  
7 may identify the prices charged, reimbursement  
8 received, or compensation and benefits paid by  
9 any particular provider.

10 (4) JOINT VENTURES FOR HIGH TECHNOLOGY  
11 AND COSTLY EQUIPMENT AND SERVICES.—Any ac-  
12 tivity of a health care cooperative venture relating to  
13 the purchase, operation, or marketing of high tech-  
14 nology or other expensive medical equipment, or the  
15 provision of high cost or complex services, but only  
16 if the number of participants in the venture does not  
17 exceed the lowest number needed to support the ven-  
18 ture. Other providers may be included in the ven-  
19 ture, but only if such other providers could not pur-  
20 chase, operate, or market such equipment or provide  
21 a competing service either alone or through the for-  
22 mation of a competing venture.

23 (5) HOSPITAL MERGERS.—Activities relating to  
24 a merger of 2 hospitals if, during the 3-year period  
25 preceding the merger, one of the hospitals had an

1 average of 150 or fewer operational beds and an av-  
2 erage daily inpatient census of less than 50 percent  
3 of such beds.

4 (6) JOINT PURCHASING ARRANGEMENTS.—Any  
5 joint purchasing arrangement among health care  
6 providers if—

7 (A) the purchases under the arrangement  
8 represent less than 35 percent of the total sales  
9 of the product or service purchased in the rel-  
10 evant market; and

11 (B) the cost of the products and services  
12 purchased jointly accounts for less than 20 per-  
13 cent of the total revenues from all products or  
14 services sold by each participant in the joint  
15 purchasing arrangement.

16 (7) NEGOTIATIONS.—Activities consisting of  
17 good faith negotiations to carry out any activity—

18 (A) described in this section,

19 (B) within an additional safe harbor des-  
20 ignated by the Attorney General under section  
21 453,

22 (C) that is the subject of an application for  
23 a certificate of review under section 454, or

24 (D) that is deemed a submission of a noti-  
25 fication under section 455(a)(2)(B),

1 without regard to whether such an activity is carried  
2 out.

3 **SEC. 453. DESIGNATION OF ADDITIONAL SAFE HARBORS.**

4 (a) IN GENERAL.—

5 (1) SOLICITATION OF PROPOSALS.—Not later  
6 than 30 days after the date of the enactment of this  
7 Act, the Attorney General shall publish a notice in  
8 the Federal Register soliciting proposals for addi-  
9 tional safe harbors.

10 (2) REVIEW AND REPORT ON PROPOSED SAFE  
11 HARBORS.—Not later than 180 days after the date  
12 of the enactment of this Act, the Attorney General  
13 (in consultation with the Secretary of Health and  
14 Human Services and the Chair of the Federal Trade  
15 Commission) shall—

16 (A) review the proposed safe harbors sub-  
17 mitted under paragraph (1); and

18 (B) submit a report to Congress describing  
19 the proposals to be included in the publication  
20 of additional safe harbors described in para-  
21 graph (3) and the proposals that are not to be  
22 so included, together with explanations there-  
23 fore.

24 (3) PUBLICATION OF ADDITIONAL SAFE HAR-  
25 BORS.—Not later than 180 days after the date of

1 the enactment of this Act, the Attorney General (in  
2 consultation with the Secretary of Health and  
3 Human Services and the Chair of the Federal Trade  
4 Commission) shall publish in the Federal Register  
5 proposed additional safe harbors for purposes of sec-  
6 tion 451(a)(2) for providers of health care services.  
7 Not later than 180 days after publishing such pro-  
8 posed safe harbors in the Federal Register, the At-  
9 torney General shall issue final rules establishing  
10 such safe harbors.

11 (b) CRITERIA FOR SAFE HARBORS.—In establishing  
12 safe harbors under subsection (a), the Attorney General  
13 shall take into account the following:

14 (1) The extent to which a competitive or col-  
15 laborative activity will accomplish any of the follow-  
16 ing:

17 (A) An increase in access to health care  
18 services.

19 (B) The enhancement of the quality of  
20 health care services.

21 (C) The establishment of cost efficiencies  
22 that will be passed on to consumers, including  
23 economies of scale and reduced transaction and  
24 administrative costs.

1           (D) An increase in the ability of health  
2 care facilities to provide services in medically  
3 underserved areas or to medically underserved  
4 populations.

5           (E) An improvement in the utilization of  
6 health care resources or the reduction in the in-  
7 efficient duplication of the use of such re-  
8 sources.

9           (2) Whether the designation of an activity as a  
10 safe harbor under subsection (a) will result in the  
11 following outcomes:

12           (A) Health plans and other health care in-  
13 surers, consumers of health care services, and  
14 health care providers will be better able to ne-  
15 gotiate payment and service arrangements  
16 which will reduce costs to consumers.

17           (B) Taking into consideration the charac-  
18 teristics of the particular purchasers and pro-  
19 viders involved, competition will not be unduly  
20 restricted.

21           (C) Equally efficient and less restrictive al-  
22 ternatives do not exist to meet the criteria de-  
23 scribed in paragraph (1).

1           (D) The activity will not unreasonably  
2           foreclose competition by denying competitors a  
3           necessary element of competition.

4 **SEC. 454. CERTIFICATES OF REVIEW.**

5           (a) ESTABLISHMENT OF PROGRAM.—In consultation  
6 with the Secretary and the Chair, the Attorney General  
7 shall (not later than 180 days after the date of the enact-  
8 ment of this Act) issue certificates of review in accordance  
9 with this section for providers of health care services and  
10 advise and assist any person with respect to applying for  
11 such a certificate of review.

12           (b) PROCEDURES FOR APPLICATION FOR CERTIFI-  
13 CATE.—

14           (1) FORM; CONTENT.—To apply for a certifi-  
15 cate of review, a person shall submit to the Attorney  
16 General a written application which—

17           (A) specifies the activities relating to the  
18 provision of health care services which satisfy  
19 the criteria described in section 453(b) and  
20 which will be included in the certificate; and

21           (B) is in a form and contains any informa-  
22 tion, including information pertaining to the  
23 overall market in which the applicant operates,  
24 required by rule or regulation promulgated  
25 under section 457.

1           (2) PUBLICATION OF NOTICE IN FEDERAL REG-  
2           ISTER.—Within 10 days after an application submit-  
3           ted under paragraph (1) is received by the Attorney  
4           General, the Attorney General shall publish in the  
5           Federal Register a notice that announces that an  
6           application for a certificate of review has been sub-  
7           mitted, identifies each person submitting the appli-  
8           cation, and describes the conduct for which the ap-  
9           plication is submitted.

10           (3) ESTABLISHMENT OF PROCEDURES FOR IS-  
11           SUANCE OF CERTIFICATE.—In consultation with the  
12           Chair and the Secretary, the Attorney General shall  
13           establish procedures to be used in applying for and  
14           in determining whether to approve an application for  
15           a certificate of review under this subtitle. Under  
16           such procedures the Attorney General shall approve  
17           an application if the Attorney General determines  
18           that the activities to be covered under the certificate  
19           will satisfy the criteria described in section 453(b)  
20           for additional safe harbors designated under such  
21           section and that the benefits of the issuance of the  
22           certificate will outweigh any disadvantages that may  
23           result from reduced competition.

24           (4) TIMING FOR DECISION ON APPLICATION.—

1 (A) IN GENERAL.—Within 90 days after  
2 the Attorney General receives an application for  
3 a certificate of review, the Attorney General  
4 shall determine whether the applicant’s health  
5 care market activities are in accordance with  
6 the procedures described in paragraph (3). If  
7 the Attorney General, with the concurrence of  
8 the Secretary, determines that such procedures  
9 are met, the Attorney General shall issue to the  
10 applicant a certificate of review. The certificate  
11 of review shall specify—

12 (i) the health care market activities to  
13 which the certificate applies,

14 (ii) the person to whom the certificate  
15 of review is issued, and

16 (iii) any terms and conditions the At-  
17 torney General or the Secretary deems nec-  
18 essary to assure compliance with the appli-  
19 cable procedures described in paragraph  
20 (3).

21 (B) APPLICATIONS DEEMED APPROVED.—  
22 If the Attorney General does not reject an ap-  
23 plication before the expiration of the 90-period  
24 beginning on the date the Attorney General re-  
25 ceives the application, the Attorney General

1 shall be deemed to have approved the applica-  
2 tion and to have issued a certificate of review  
3 relating to the applicant's health care market  
4 activities covered under the application.

5 (5) EXPEDITED ACTION.—If the applicant indi-  
6 cates a special need for prompt disposition, the At-  
7 torney General and the Secretary may expedite ac-  
8 tion on the application, except that no certificate of  
9 review may be issued within 30 days of publication  
10 of notice in the Federal Register under subsection  
11 (b)(2).

12 (6) ACTIONS UPON DENIAL.—

13 (A) NOTIFICATION.—If the Attorney Gen-  
14 eral denies in whole or in part an application  
15 for a certificate, the Attorney General shall no-  
16 tify the applicant of the Attorney General's de-  
17 termination and the reasons for it.

18 (B) REQUEST FOR RECONSIDERATION.—  
19 An applicant may, within 30 days of receipt of  
20 notification that the application has been denied  
21 in whole or in part, request the Attorney Gen-  
22 eral to reconsider the determination. The Attor-  
23 ney General, with the concurrence of the Sec-  
24 retary, shall notify the applicant of the deter-

1           mination upon reconsideration within 30 days  
2           of receipt of the request.

3           (C) RETURN OF DOCUMENTS.—If the At-  
4           torney General denies an application for the is-  
5           suaunce of a certificate of review and thereafter  
6           receives from the applicant a request for the re-  
7           turn of documents submitted by the applicant  
8           in connection with the application for the cer-  
9           tificate, the Attorney General and the Secretary  
10          shall return to the applicant, not later than 30  
11          days after receipt of the request, the documents  
12          and all copies of the documents available to the  
13          Attorney General and the Secretary, except to  
14          the extent that the information has been made  
15          public under an exception to the rule against  
16          public disclosure described in subsection  
17          (g)(2)(B).

18          (7) FRAUDULENT PROCUREMENT.—A certifi-  
19          cate of review shall be void ab initio with respect to  
20          any health care market activities for which the cer-  
21          tificate was procured by fraud.

22          (c) AMENDMENT AND REVOCATION OF CERTIFI-  
23          CATES.—

24                (1) NOTIFICATION OF CHANGES.—Any appli-  
25                cant who receives a certificate of review—

1 (A) shall promptly report to the Attorney  
2 General any change relevant to the matters  
3 specified in the certificate; and

4 (B) may submit to the Attorney General  
5 an application to amend the certificate to re-  
6 flect the effect of the change on the conduct  
7 specified in the certificate.

8 (2) AMENDMENT TO CERTIFICATE.—An appli-  
9 cation for an amendment to a certificate of review  
10 shall be treated as an application for the issuance of  
11 a certificate. The effective date of an amendment  
12 shall be the date on which the application for the  
13 amendment is submitted to the Attorney General.

14 (3) REVOCATION.—

15 (A) GROUNDS FOR REVOCATION.—In ac-  
16 cordance with this paragraph, the Attorney  
17 General may revoke in whole or in part a cer-  
18 tificate of review issued under this section. The  
19 following shall be considered grounds for the  
20 revocation of a certificate:

21 (i) After the expiration of the 2-year  
22 period beginning on the date a person's  
23 certificate is issued, the activities of the  
24 person have not substantially accomplished

1 the purposes for the issuance of the certifi-  
2 cate.

3 (ii) The person has failed to comply  
4 with any of the terms or conditions im-  
5 posed under the certificate by the Attorney  
6 General or the Secretary under subsection  
7 (b)(4).

8 (iii) The activities covered under the  
9 certificate no longer satisfy the criteria set  
10 forth in section 453(b).

11 (B) REQUEST FOR COMPLIANCE INFORMA-  
12 TION.—If the Attorney General or Secretary  
13 has reason to believe that any of the grounds  
14 for revocation of a certificate of review de-  
15 scribed in subparagraph (A) may apply to a  
16 person holding the certificate, the Attorney  
17 General shall request such information from  
18 such person as the Attorney General or the Sec-  
19 retary deems necessary to resolve the matter of  
20 compliance. Failure to comply with such request  
21 shall be grounds for revocation of the certificate  
22 under this paragraph.

23 (C) PROCEDURES FOR REVOCATION.—If  
24 the Attorney General or the Secretary deter-  
25 mines that any of the grounds for revocation of

1 a certificate of review described in subpara-  
2 graph (A) apply to a person holding the certifi-  
3 cate, or that such person has failed to comply  
4 with a request made under subparagraph (B),  
5 the Attorney General shall give written notice of  
6 the determination to such person. The notice  
7 shall include a statement of the circumstances  
8 underlying, and the reasons in support of, the  
9 determination. In the 60-day period beginning  
10 30 days after the notice is given, the Attorney  
11 General shall revoke the certificate or modify it  
12 as the Attorney General or the Secretary deems  
13 necessary to cause the certificate to apply only  
14 to activities that meet the procedures for the is-  
15 suance of certificates described in subsection  
16 (b)(2).

17 (D) INVESTIGATION AUTHORITY.—For  
18 purposes of carrying out this paragraph, the  
19 Attorney General may conduct investigations in  
20 the same manner as the Attorney General con-  
21 ducts investigations under section 3 of the Anti-  
22 trust Civil Process Act, except that no civil in-  
23 vestigative demand may be issued to a person  
24 to whom a certificate of review is issued if such  
25 person is the target of such investigation.

1 (d) REVIEW OF DETERMINATIONS.—

2 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-  
3 TIONS.—If the Attorney General denies, in whole or  
4 in part, an application for a certificate of review or  
5 for an amendment to a certificate, or revokes or  
6 modifies a certificate pursuant to paragraph (3), the  
7 applicant or certificate holder (as the case may be)  
8 may, within 30 days of the denial or revocation,  
9 bring an action in any appropriate district court of  
10 the United States to set aside the determination on  
11 the ground that such determination is erroneous  
12 based on the preponderance of the evidence.

13 (2) NO OTHER REVIEW PERMITTED.—Except  
14 as provided in paragraph (1), no action by the At-  
15 torney General or the Secretary pursuant to this  
16 subtitle shall be subject to judicial review.

17 (3) EFFECT OF REJECTED APPLICATION.—If  
18 the Attorney General denies, in whole or in part, an  
19 application for a certificate of review or for an  
20 amendment to a certificate, or revokes or amends a  
21 certificate, neither the negative determination nor  
22 the statement of reasons therefore shall be admissi-  
23 ble in evidence, in any administrative or judicial pro-  
24 ceeding, concerning any claim under the antitrust  
25 laws.

1 (e) PUBLICATION OF DECISIONS.—The Attorney  
2 General shall publish a notice in the Federal Register on  
3 a timely basis of each decision made with respect to an  
4 application for a certificate of review under this section  
5 or the amendment or revocation of such a certificate, in  
6 a manner that protects the confidentiality of any propri-  
7 etary information relating to the application.

8 (f) ANNUAL REPORTS.—Every person to whom a cer-  
9 tificate of review is issued shall submit to the Attorney  
10 General an annual report, in such form and at such time  
11 as the Attorney General may require, that contains any  
12 necessary updates to the information required under sub-  
13 section (b) and a description of the activities of the holder  
14 under the certificate during the preceding year.

15 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-  
16 TION.—

17 (1) WAIVER OF DISCLOSURE REQUIREMENTS  
18 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-  
19 mation submitted by any person in connection with  
20 the issuance, amendment, or revocation of a certifi-  
21 cate of review shall be exempt from disclosure under  
22 section 552 of title 5, United States Code.

23 (2) RESTRICTIONS ON DISCLOSURE OF COM-  
24 MERCIAL OR FINANCIAL INFORMATION.—

1           (A) IN GENERAL.—Except as provided in  
2           subparagraph (B), no officer or employee of the  
3           United States shall disclose commercial or fi-  
4           nancial information submitted in connection  
5           with the issuance, amendment, or revocation of  
6           a certificate of review if the information is priv-  
7           ileged or confidential and if disclosure of the in-  
8           formation would cause harm to the person who  
9           submitted the information.

10          (B) EXCEPTIONS.—Subparagraph (A)  
11          shall not apply with respect to information dis-  
12          closed—

13                 (i) upon a request made by the Con-  
14                 gress or any committee of the Congress,

15                 (ii) in a judicial or administrative pro-  
16                 ceeding, subject to appropriate protective  
17                 orders,

18                 (iii) with the consent of the person  
19                 who submitted the information,

20                 (iv) in the course of making a deter-  
21                 mination with respect to the issuance,  
22                 amendment, or revocation of a certificate  
23                 of review, if the Attorney General deems  
24                 disclosure of the information to be nec-

1           essary in connection with making the de-  
2           termination,

3                   (v) in accordance with any require-  
4           ment imposed by a statute of the United  
5           States, or

6                   (vi) in accordance with any rule or  
7           regulation promulgated under subsection  
8           (i) permitting the disclosure of the infor-  
9           mation to an agency of the United States  
10          or of a State on the condition that the  
11          agency will disclose the information only  
12          under the circumstances specified in  
13          clauses (i) through (v).

14           (3) PROHIBITION AGAINST USE OF INFORMA-  
15          TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-  
16          TRUST LAWS.—Any information disclosed in an ap-  
17          plication for a certificate of review under this section  
18          shall only be admissible into evidence in a judicial or  
19          administrative proceeding for the sole purpose of es-  
20          tablishing that a person is entitled to the protections  
21          provided by such a certificate.

1 **SEC. 455. NOTIFICATIONS PROVIDING REDUCTION IN CER-**  
2 **TAIN PENALTIES UNDER ANTITRUST LAW**  
3 **FOR HEALTH CARE COOPERATIVE VEN-**  
4 **TURES.**

5 (a) NOTIFICATIONS DESCRIBED.—

6 (1) SUBMISSION OF NOTIFICATION BY VEN-  
7 TURE.—Any party to a health care cooperative ven-  
8 ture, acting on such venture's behalf, may, not later  
9 than 90 days after entering into a written agreement  
10 to form such venture or not later than 90 days after  
11 the date of the enactment of this Act, whichever is  
12 later, file with the Attorney General a written notifi-  
13 cation disclosing—

14 (A) the identities of the parties to such  
15 venture,

16 (B) the nature and objectives of such ven-  
17 ture, and

18 (C) such additional information as the At-  
19 torney General may require by regulation.

20 (2) ACTIVITIES DEEMED SUBMISSION OF NOTI-  
21 FICATION.—The following health care cooperative  
22 ventures shall be deemed to have filed a written noti-  
23 fication with respect to the venture under paragraph  
24 (1):

25 (A) SUBMISSION OF APPLICATION FOR  
26 CERTIFICATE OF REVIEW.—Any health care co-

1           operative venture for which an application for a  
2           certificate of review is filed with the Attorney  
3           General under section 453.

4           (B) CERTAIN VENTURES.—Any health care  
5           cooperative venture meeting the following re-  
6           quirements:

7                   (i) The venture consists of a network  
8                   of non-institutional providers not greater  
9                   than—

10                           (I) in the case of a nonexclusive  
11                           network in which the participating  
12                           members are permitted to create or  
13                           join other competing networks, 50  
14                           percent of the providers of health care  
15                           services in the relevant geographic  
16                           area and 50 percent of the members  
17                           of the provider specialty group in the  
18                           relevant market; or

19                           (II) in the case of an exclusive  
20                           network in which the participating  
21                           members are not permitted to create  
22                           or join other competing networks, 35  
23                           percent of the providers of health care  
24                           services in the relevant geographic  
25                           area and 35 percent of the members

1 of the provider specialty group in the  
2 relevant market.

3 (ii) Each member of the venture as-  
4 sumes substantial financial risk for the op-  
5 eration of the venture through risk-sharing  
6 arrangements, including (but not limited  
7 to)—

8 (I) the acceptance of capitation  
9 contracts;

10 (II) the acceptance of contracts  
11 with fee withholding mechanisms re-  
12 lating to the ability to meet estab-  
13 lished goals for utilization review and  
14 management; and

15 (III) the holding by members of  
16 significant ownership or equity inter-  
17 ests in the venture, where the capital  
18 contributed by the members is used to  
19 fund the operational costs of the ven-  
20 ture such as administration, market-  
21 ing, and computer-operated medical  
22 information, if the venture develops  
23 and operates comprehensive programs  
24 for utilization management and qual-  
25 ity assurance that include controls

1 over the use of institutional, special-  
2 ized, and ancillary medical services.

3 (3) SUBMISSION OF ADDITIONAL INFORMA-  
4 TION.—

5 (A) REQUEST OF ATTORNEY GENERAL.—

6 At any time after receiving a notification filed  
7 under paragraph (1), the Attorney General may  
8 require the submission of additional information  
9 or documentary material relevant to the pro-  
10 posed health care cooperative venture.

11 (B) PARTIES TO VENTURE.—Any party to  
12 a health care cooperative venture may submit  
13 such additional information on the venture's be-  
14 half as may be appropriate to ensure that the  
15 venture will receive the protections provided  
16 under subsection (b).

17 (C) REQUIRED SUBMISSION OF INFORMA-  
18 TION ON CHANGES TO VENTURE.—A health  
19 care cooperative venture for which a notification  
20 is in effect under this section shall submit infor-  
21 mation on any change in the membership of the  
22 venture not later than 90 days after such  
23 change occurs.

24 (4) PUBLICATION OF NOTIFICATION.—

1           (A) INFORMATION MADE PUBLICLY AVAIL-  
2 ABLE.—Not later than 30 days after receiving  
3 a notification with respect to a venture under  
4 paragraph (1), the Attorney General shall pub-  
5 lish in the Federal Register a notice with re-  
6 spect to the venture that identifies the parties  
7 to the venture and generally describes the pur-  
8 pose and planned activity of the venture. Prior  
9 to its publication, the contents of the notice  
10 shall be made available to the parties to the  
11 venture.

12           (B) RESTRICTION ON DISCLOSURE OF  
13 OTHER INFORMATION.—All information and  
14 documentary material submitted pursuant to  
15 this section and all information obtained by the  
16 Attorney General in the course of any investiga-  
17 tion or case with respect to a potential violation  
18 of the antitrust laws by the health care coopera-  
19 tive venture (other than information and mate-  
20 rial described in subparagraph (A)) shall be ex-  
21 empt from disclosure under section 552 of title  
22 5, United States Code, and shall not be made  
23 publicly available by any agency of the United  
24 States to which such section applies except in

1 a judicial proceeding in which such information  
2 and material is subject to any protective order.

3 (5) WITHDRAWAL OF NOTIFICATION.—Any per-  
4 son who files a notification pursuant to this section  
5 may withdraw such notification before a publication  
6 by the Attorney General pursuant to paragraph (4).  
7 Any person who is deemed to have filed a notifica-  
8 tion under paragraph (2)(A) shall be deemed to have  
9 withdrawn the notification if the certificate of review  
10 in question is revoked or withdrawn under section  
11 454.

12 (6) NO JUDICIAL REVIEW PERMITTED.—Any  
13 action taken or not taken by the Attorney General  
14 with respect to notifications filed pursuant to this  
15 subsection shall not be subject to judicial review.

16 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-  
17 TIFICATION.—

18 (1) IN GENERAL.—

19 (A) PROTECTIONS DESCRIBED.—The pro-  
20 visions of paragraphs (2), (3), (4), and (5) shall  
21 apply with respect to any action under the anti-  
22 trust laws challenging conduct within the scope  
23 of a notification which is in effect pursuant to  
24 subsection (a)(1).

1 (B) TIMING OF PROTECTIONS.—The pro-  
2 tections described in this subsection shall apply  
3 to the venture that is the subject of a notifica-  
4 tion under subsection (a)(1) as of the earlier  
5 of—

6 (i) the date of the publication in the  
7 Federal Register of the notice published  
8 with respect to the notification; or

9 (ii) if such notice is not published dur-  
10 ing the period required under subsection  
11 (a)(4), the expiration of the 30-day period  
12 that begins on the date the Attorney Gen-  
13 eral receives any necessary information re-  
14 quired to be submitted under subsection  
15 (a)(1) or any additional information re-  
16 quired by the Attorney General under sub-  
17 section (a)(3)(A).

18 (2) APPLICABILITY OF RULE OF REASON  
19 STANDARD.—In any action under the antitrust laws,  
20 the conduct of any person which is within the scope  
21 of a notification filed under subsection (a) shall not  
22 be deemed illegal per se, but shall be judged on the  
23 basis of its reasonableness, taking into account all  
24 relevant factors affecting competition, including, but

1 not limited to, effects on competition in relevant  
2 markets.

3 (3) LIMITATION ON RECOVERY TO ACTUAL  
4 DAMAGES AND INTEREST.—Notwithstanding section  
5 4 of the Clayton Act, any person who is entitled to  
6 recovery under the antitrust laws for conduct that is  
7 within the scope of a notification filed under sub-  
8 section (a) shall recover the actual damages sus-  
9 tained by such person and interest calculated at the  
10 rate specified in section 1961 of title 28, United  
11 States Code, for the period beginning on the earliest  
12 date for which injury can be established and ending  
13 on the date of judgment, unless the court finds that  
14 the award of all or part of such interest is unjust  
15 under the circumstances.

16 (4) AWARD OF ATTORNEY'S FEES AND COSTS  
17 OF SUIT.—

18 (A) IN GENERAL.—In any action under the  
19 antitrust laws brought against a health care co-  
20 operative venture for conduct that is within the  
21 scope of a notification filed under subsection  
22 (a), the court shall, at the conclusion of the ac-  
23 tion—

24 (i) award to a substantially prevailing  
25 claimant the cost of suit attributable to

1 such claim, including a reasonable attorney's fee, or  
2

3 (ii) award to a substantially prevailing  
4 party defending against such claim the  
5 cost of such suit attributable to such claim,  
6 including reasonable attorney's fee, if the  
7 claim, or the claimant's conduct during  
8 litigation of the claim, was frivolous, un-  
9 reasonable, without foundation, or in bad  
10 faith.

11 (B) OFFSET IN CASES OF BAD FAITH.—

12 The court may reduce an award made pursuant  
13 to subparagraph (A) in whole or in part by an  
14 award in favor of another party for any part of  
15 the cost of suit (including a reasonable attorney's  
16 fee) attributable to conduct during the  
17 litigation by any prevailing party that the court  
18 finds to be frivolous, unreasonable, without  
19 foundation, or in bad faith.

20 (5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—  
21

22 (A) IN GENERAL.—Any information disclosed  
23 in a notification submitted under subsection  
24 (a)(1) and the fact of the publication of  
25 a notification by the Attorney General under

1 subsection (a)(4) shall only be admissible into  
2 evidence in a judicial or administrative proceed-  
3 ing for the sole purpose of establishing that a  
4 party to a health care cooperative venture is en-  
5 titled to the protections described in this sub-  
6 section.

7 (B) ACTIONS OF ATTORNEY GENERAL.—  
8 No action taken by the Attorney General pursu-  
9 ant to this section shall be admissible into evi-  
10 dence in any judicial or administrative proceed-  
11 ing for the purpose of supporting or answering  
12 any claim under the antitrust laws.

13 **SEC. 456. REVIEW AND REPORTS ON SAFE HARBORS AND**  
14 **CERTIFICATES OF REVIEW.**

15 (a) IN GENERAL.—The Attorney General (in con-  
16 sultation with the Secretary and the Chair) shall periodi-  
17 cally review the safe harbors described in section 452, the  
18 additional safe harbors designated under section 453, and  
19 the certificates of review issued under section 454, and—

20 (1) with respect to the safe harbors described in  
21 section 452, submit such recommendations to Con-  
22 gress as the Attorney General considers appropriate  
23 for modifications of such safe harbors;

24 (2) with respect to the additional safe harbors  
25 under designated under section 453, issue proposed

1 revisions to such activities and publish the revisions  
2 in the Federal Register; and

3 (3) with respect to the certificates of review,  
4 submit a report to Congress on the issuance of such  
5 certificates, and shall include in the report a descrip-  
6 tion of the effect of such certificates on increasing  
7 access to high quality health care services at reduced  
8 costs.

9 (b) RECOMMENDATIONS FOR LEGISLATION.—The  
10 Attorney General shall include in the reports submitted  
11 under subsection (a)(3) any recommendations of the At-  
12 torney General for legislation to improve the program for  
13 the issuance of certificates of review established under this  
14 subtitle.

15 **SEC. 457. RULES, REGULATIONS, AND GUIDELINES.**

16 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-  
17 TIONS.—The Attorney General, with the concurrence of  
18 the Secretary, shall promulgate such rules, regulations,  
19 and guidelines as are necessary to carry out sections 452,  
20 453, 454, and 455, including guidelines defining or relat-  
21 ing to relevant geographic and product markets for health  
22 care services and providers of health care services.

23 (b) GUIDANCE FOR PROVIDERS.—

24 (1) IN GENERAL.—To promote greater cer-  
25 tainty regarding the application of the antitrust laws

1 to activities in the health care market, the Attorney  
2 General, in consultation with the Secretary and the  
3 Chair, shall (not later than 1 year after the date of  
4 the enactment of this Act), taking into account the  
5 criteria used to designate additional safe harbors  
6 under section 453 and grant certificates of review  
7 under section 454, publish guidelines—

8 (A) to assist providers of health care serv-  
9 ices in analyzing whether the activities of such  
10 providers may be subject to a safe harbor under  
11 sections 452 or 453; and

12 (B) describing specific types of activities  
13 which would meet the requirements for a cer-  
14 tificate of review under section 454, and sum-  
15 marizing the factual and legal bases on which  
16 the activities would meet the requirements.

17 (2) PERIODIC UPDATE.—The Attorney General  
18 shall periodically update the guidelines published  
19 under paragraph (1) as the Attorney General consid-  
20 ers appropriate.

21 (3) WAIVER OF ADMINISTRATIVE PROCEDURE  
22 ACT.—Section 553 of title 5, United States Code,  
23 shall not apply to the issuance of guidelines under  
24 paragraph (1).

1 **SEC. 458. ESTABLISHMENT OF HHS OFFICE OF HEALTH**  
2 **CARE COMPETITION POLICY.**

3 (a) IN GENERAL.—There is established within the  
4 Department of Health and Human Services an Office to  
5 be known as the Office of Health Care Competition Policy  
6 (hereafter in this section referred to as the “Office”). The  
7 Office shall be headed by a director, who shall be ap-  
8 pointed by the Secretary.

9 (b) DUTIES.—The Office shall coordinate the respon-  
10 sibilities of the Secretary under this subtitle and otherwise  
11 assist the Secretary in developing policies relating to the  
12 competitive and collaborative activities of providers of  
13 health care services.

14 **SEC. 459. DEFINITIONS.**

15 In this subtitle, the following definitions shall apply:

16 (1) The term “antitrust laws”—

17 (A) has the meaning given it in subsection  
18 (a) of the first section of the Clayton Act (15  
19 U.S.C. 12(a)), except that such term includes  
20 section 5 of the Federal Trade Commission Act  
21 (15 U.S.C. 45) to the extent such section ap-  
22 plies to unfair methods of competition; and

23 (B) includes any State law similar to the  
24 laws referred to in subparagraph (A).

25 (2) The term “Chair” means the Chair of the  
26 Federal Trade Commission.

1           (3) The term “health care cooperative venture”  
2 means any activities, including attempts to enter  
3 into or perform a contract or agreement, carried out  
4 by 2 or more persons for the purpose of providing  
5 health care services.

6           (4) The term “health care services” means any  
7 services for which payment may be made under a  
8 health plan, including services related to the delivery  
9 or administration of such services.

10          (5) The term “medical self-regulatory entity”  
11 means a medical society or association, a specialty  
12 board, a recognized accrediting agency, or a hospital  
13 medical staff, and includes the members, officers,  
14 employees, consultants, and volunteers or commit-  
15 tees of such an entity.

16          (6) The term “person” includes a State or unit  
17 of local government.

18          (7) The term “provider of health care services”  
19 means any individual or entity that is engaged in the  
20 delivery of health care services in a State and that  
21 is required by State law or regulation to be licensed  
22 or certified by the State to engage in the delivery of  
23 such services in the State.

24          (8) The term “specialty group” means a medi-  
25 cal specialty or subspecialty in which a provider of

1 health care services may be licensed to practice by  
2 a State (as determined by the Secretary in consulta-  
3 tion with the certification boards for such specialties  
4 and subspecialties).

5 (9) The term “standard setting and enforce-  
6 ment activities” means—

7 (A) accreditation of health care practition-  
8 ers, health care providers, medical education in-  
9 stitutions, or medical education programs,

10 (B) technology assessment and risk man-  
11 agement activities,

12 (C) the development and implementation of  
13 practice guidelines or practice parameters, or

14 (D) official peer review proceedings under-  
15 taken by a hospital medical staff (or committee  
16 thereof) or a medical society or association for  
17 purposes of evaluating the professional conduct  
18 or quality of health care provided by a medical  
19 professional.

1 **TITLE V—SPECIAL ASSISTANCE**  
2 **FOR FRONTIER, RURAL, AND**  
3 **URBAN UNDERSERVED AREAS**  
4 **Subtitle A—Frontier, Rural, and**  
5 **Urban Underserved Areas**

6 **SEC. 501. ESTABLISHMENT OF PROGRAM TO MAKE COMMU-**  
7 **NITY-BASED PRIMARY HEALTH GRANTS AND**  
8 **HEALTH SERVICE ACCESS GRANTS FOR FED-**  
9 **ERALLY-QUALIFIED HEALTH CENTERS.**

10 (a) IN GENERAL.—Subpart I of part D of title III  
11 of the Public Health Service Act (42 U.S.C. 254b et seq.)  
12 is amended by adding at the end the following new section:

13 **“SEC. 330A. GRANTS FOR EXPANDED ACCESS TO PRIMARY**  
14 **HEALTH SERVICES.**

15 “(a) COMMUNITY-BASED PRIMARY HEALTH CARE  
16 GRANT PROGRAM.—

17 “(1) ESTABLISHMENT.—The Secretary shall es-  
18 tablish and administer a program to provide allot-  
19 ments to states to enable such states to provide  
20 grants for the creation or enhancement of commu-  
21 nity-based primary health care entities that provide  
22 services to low-income or medically underserved  
23 populations.

24 “(2) ALLOTMENTS TO STATES.—

1           “(A) IN GENERAL.—From the amount  
2 available for allotment under subsection (c) for  
3 a fiscal year, the Secretary shall allot to each  
4 State an amount equal to the product of the  
5 grant share of the State (as determined under  
6 subparagraph (B)) multiplied by such amount  
7 available.

8           “(B) GRANT SHARE.—

9           “(i) IN GENERAL.—For purposes of  
10 subparagraph (A), the grant share of a  
11 State shall be the product of the need-ad-  
12 justed population of the State (as deter-  
13 mined under clause (ii)) multiplied by the  
14 Federal matching percentage of the State  
15 (as determined under clause (iii)), ex-  
16 pressed as a percentage of the sum of the  
17 products of such factors for all States.

18           “(ii) NEED-ADJUSTED POPULATION.—

19           “(I) IN GENERAL.—For purposes  
20 of clause (i), the need-adjusted popu-  
21 lation of a State shall be the product  
22 of the total population of the State  
23 (as estimated by the Secretary of  
24 Commerce) multiplied by the need

1 index of the State (as determined  
2 under subclause (B)).

3 “(II) NEED INDEX.—For pur-  
4 poses of subclause (I), the need index  
5 of a State shall be the ratio of—

6 “(aa) the weighted sum of  
7 the geographic percentage of the  
8 State (as determined under  
9 subclause (III)), the poverty per-  
10 centage of the State (as deter-  
11 mined under subclause (IV)), and  
12 the multiple grant percentage of  
13 the State (as determined under  
14 subclause (V)); to

15 “(bb) the general population  
16 percentage of the State (as deter-  
17 mined under subclause (VI)).

18 “(III) GEOGRAPHIC PERCENT-  
19 AGE.—For purposes of subclause  
20 (II)(a), the geographic percentage of  
21 the State shall be the estimated popu-  
22 lation of the State that is residing in  
23 nonurbanized areas expressed as a  
24 percentage of the total nonurbanized  
25 population of all States. For purposes

1 of the preceding sentence, the esti-  
2 mated population of the State that is  
3 residing in nonurbanized areas shall  
4 be one minus the urbanized popu-  
5 lation of the State (as determined  
6 using the most recent decennial cen-  
7 sus), expressed as a percentage of the  
8 total population of the State (as de-  
9 termined using the most recent decen-  
10 nial census), multiplied by the current  
11 estimated population of the State.

12 “(IV) POVERTY PERCENTAGE.—  
13 For purposes of subclause (II)(aa),  
14 the poverty percentage of the State  
15 shall be the estimated number of peo-  
16 ple residing in the State with incomes  
17 below 160 percent of the income offi-  
18 cial poverty line (as adjusted for ac-  
19 tual costs and incomes in each State  
20 and as determined by the Office of  
21 Management and Budget) expressed  
22 as a percentage of the total number of  
23 such people residing in all States.

24 “(V) MULTIPLE GRANT PER-  
25 CENTAGE.—For purposes of subclause

1 (II)(aa), the multiple grant percentage  
2 of the State shall be the amount of  
3 Federal funding received by the State  
4 under grants awarded under sections  
5 329, 330, and 340, expressed as a  
6 percentage of the total amounts re-  
7 ceived under such grants by all  
8 States. With respect to a State, such  
9 percentage shall not exceed twice the  
10 general population percentage of the  
11 State under subclause (VI) or be less  
12 than one-half of the States general  
13 population percentage.

14 “(VI) GENERAL POPULATION  
15 PERCENTAGE.—For purposes of  
16 subclause (II)(bb), the general popu-  
17 lation percentage of the State shall be  
18 the total population of the State (as  
19 determined by the Secretary of Com-  
20 merce) expressed as a percentage of  
21 the total population of all States.

22 “(iii) FEDERAL MATCHING PERCENT-  
23 AGE.—

24 “(I) IN GENERAL.—For purposes  
25 of clause (i), the Federal matching

1 percentage of the State shall be equal  
2 to one, less the State matching per-  
3 centage (as determined under  
4 subclause (B)).

5 “(II) STATE MATCHING PER-  
6 CENTAGE.—For purposes of clause  
7 (i), the State matching percentage of  
8 the State shall be 0.50 multiplied by  
9 the ratio of the total taxable resource  
10 percentage (as determined under  
11 subclause (III)) to the need-adjusted  
12 population of the State (as determined  
13 under clause (ii)).

14 “(III) TOTAL TAXABLE RE-  
15 SOURCE PERCENTAGE.—For purposes  
16 of subclause (II), the total taxable re-  
17 sources percentage of the State shall  
18 be the total taxable resources of a  
19 State (as determined by the Secretary  
20 of the Treasury) expressed as a per-  
21 centage of the sum of the total tax-  
22 able resources of all States.

23 “(C) ANNUAL ESTIMATES.—

24 “(i) IN GENERAL.—If the Secretary of  
25 Commerce does not produce the annual es-

1 estimates required under subparagraph  
2 (B)(ii)(IV), such estimates shall be deter-  
3 mined by multiplying the percentage of the  
4 population of the State that is below 160  
5 percent of the income official poverty line  
6 as determined using the most recent decen-  
7 nial census by the most recent estimate of  
8 the total population of the State. Except as  
9 provided in clause (ii), the calculations re-  
10 quired under this clause shall be made  
11 based on the most recent 3-year average of  
12 the total taxable resources of individuals  
13 within the State.

14 “(ii) DISTRICT OF COLUMBIA.—Not-  
15 withstanding clause (i), the calculations re-  
16 quired under such clause with respect to  
17 the District of Columbia shall be based on  
18 the most recent 3-year average of the per-  
19 sonal income of individuals residing within  
20 the District as a percentage of the personal  
21 income for all individuals residing within  
22 the District, as determined by the Sec-  
23 retary of Commerce.

24 “(iii) STATE OF ALASKA.—Notwith-  
25 standing clause (i), the calculations re-

1           required under such clause with respect to  
2           the State of Alaska shall be based on the  
3           quotient of—

4                   “(I) the most recent 3-year aver-  
5                   age of the per capita income of indi-  
6                   viduals residing in the State; divided  
7                   by

8                   “(II) 1.25.

9                   “(D) MATCHING REQUIREMENT.—A State  
10                  that receives an allotment under this subsection  
11                  shall make available State resources (either di-  
12                  rectly or indirectly) to carry out this subsection  
13                  in an amount that shall equal the State match-  
14                  ing percentage for the State (as determined  
15                  under subparagraph (B)(iii)(II)) divided by the  
16                  Federal matching percentage (as determined  
17                  under subparagraph (B)(iii)).

18                  “(3) APPLICATION.—

19                   “(A) IN GENERAL.—To be eligible to re-  
20                   ceive an allotment under this subsection, a  
21                   State shall prepare and submit an application  
22                   to the Secretary at such time, in such manner,  
23                   and containing such information as the Sec-  
24                   retary may by regulation require.

1           “(B) ASSURANCES.—A State application  
2 submitted under subparagraph (A) shall contain  
3 an assurance that—

4                   “(i) the State will use amounts re-  
5 ceived under its allotment consistent with  
6 the requirements of this subsection; and

7                   “(ii) the State will provide, from non-  
8 Federal sources, the amounts required  
9 under paragraph (2)(D).

10          “(4) USE OF FUNDS.—

11               “(A) IN GENERAL.—The State shall use  
12 amounts received under this subsection to  
13 award grants to eligible public and nonprofit  
14 private entities, or consortia of such entities,  
15 within the State to enable such entities or con-  
16 sortia to provide services of the type described  
17 in paragraph (2) of section 329(h) to low-in-  
18 come or medically underserved populations.

19               “(B) ELIGIBILITY.—To be eligible to re-  
20 ceive a grant under subparagraph (A), an entity  
21 or consortium shall—

22                   “(i) prepare and submit to the admin-  
23 istering entity of the State, an application  
24 at such time, in such manner, and contain-  
25 ing such information as such administering

1 entity may require, including a plan for the  
2 provision of services of the type described  
3 in subparagraph (C);

4 “(ii) provide assurances that services  
5 will be provided under the grant at fee  
6 rates established or determined in accord-  
7 ance with section 330(e)(3)(F); and

8 “(iii) provide assurances that in the  
9 case of services provided to individuals  
10 with health insurance, such insurance shall  
11 be used as the primary source of payment  
12 for such services.

13 “(C) SERVICES.—The services to be pro-  
14 vided under a grant awarded under subpara-  
15 graph (A) shall include—

16 “(i) one or more of the types of pri-  
17 mary health services described in section  
18 330(b)(1);

19 “(ii) one or more of the types of sup-  
20 plemental health services described in sec-  
21 tion 330(b)(2); and

22 “(iii) any other services determined  
23 appropriate by the administering entity of  
24 the State.

1           “(D) TARGET POPULATIONS.—Entities or  
2 consortia receiving grants under subparagraph  
3 (A) shall, in providing the services described in  
4 subparagraph (C), substantially target popu-  
5 lations of low-income or medically underserved  
6 populations within the State who reside in  
7 medically underserved or health professional  
8 shortage areas, areas certified as underserved  
9 under the rural health clinic program, or other  
10 areas determined appropriate by the admin-  
11 istering entity of the State, within the State.

12           “(E) PRIORITY.—In awarding grants  
13 under subparagraph (A), the State shall—

14           “(i) give priority to entities or consor-  
15 tia that can demonstrate through the plan  
16 submitted under subparagraph (B) that—

17           “(I) the services provided under  
18 the grant will expand the availability  
19 of primary care services to the maxi-  
20 mum number of low-income or medi-  
21 cally underserved populations who  
22 have no access to such care on the  
23 date of the grant award; and

1                   “(II) the delivery of services  
2                   under the grant will be cost-effective;  
3                   and

4                   “(ii) ensure that an equitable distribu-  
5                   tion of funds is achieved among urban and  
6                   rural entities or consortia.

7                   “(5) REPORTS AND AUDITS.—Each State shall  
8                   prepare and submit to the Secretary annual reports  
9                   concerning the State’s activities under this sub-  
10                  section which shall be in such form and contain such  
11                  information as the Secretary determines appropriate.  
12                  Each such State shall establish fiscal control and  
13                  fund accounting procedures as may be necessary to  
14                  assure that amounts received under this subsection  
15                  are being disbursed properly and are accounted for,  
16                  and include the results of audits conducted under  
17                  such procedures in the reports submitted under this  
18                  paragraph.

19                  “(6) PAYMENTS.—

20                  “(A) ELIGIBILITY.—Each State for which  
21                  an application has been approved by the Sec-  
22                  retary under this subsection shall be eligible to  
23                  receive payments under this subsection for each  
24                  fiscal year in an amount not to exceed the  
25                  State’s allotment under paragraph (2) to be ex-

1           pended by the State in accordance with the  
2           terms of the application for the fiscal year for  
3           which the allotment is to be made.

4           “(B) METHOD OF PAYMENTS.—The Sec-  
5           retary may make payments to a State in install-  
6           ments, and in advance or by way of reimburse-  
7           ment, with necessary adjustments on account of  
8           overpayments or underpayments, as the Sec-  
9           retary may determine.

10          “(C) STATE SPENDING OF PAYMENTS.—  
11          Payments to a State from the allotment under  
12          paragraph (2) for any fiscal year must be ex-  
13          pended by the State in that fiscal year or in the  
14          succeeding fiscal year.

15          “(7) DEFINITION.—As used in this subsection,  
16          the term ‘administering entity of the State’ means  
17          the agency or official designated by the chief execu-  
18          tive officer of the State to administer the amounts  
19          provided to the State under this section.

20          “(b) HEALTH SERVICES ACCESS GRANTS.—

21          “(1) ESTABLISHMENT OF PROGRAM.—From  
22          amounts appropriated under this subsection, the  
23          Secretary shall, acting through the Bureau of  
24          Health Care Delivery Assistance, award grants  
25          under this subsection to Federally Qualified Health

1 Centers (hereinafter referred to in this subsection as  
2 ‘FQHC’s’) and other entities and organizations sub-  
3 mitting applications under this subsection (as de-  
4 scribed in paragraph (3)) for the purpose of provid-  
5 ing access to services for medically underserved pop-  
6 ulations (as defined in section 330(b)(3)) or in high  
7 impact areas (as defined in section 329(a)(5)) not  
8 currently being served by a FQHC.

9 “(2) ELIGIBILITY FOR GRANTS.—

10 “(A) IN GENERAL.—The Secretary shall  
11 award grants under this subsection to entities  
12 or organizations described in this subparagraph  
13 and subparagraph (B) which have submitted a  
14 proposal to the Secretary to expand such enti-  
15 ties or organizations operations (including ex-  
16 pansions to new sites (as determined necessary  
17 by the Secretary)) to serve medically under-  
18 served populations or high impact areas not  
19 currently served by a FQHC and which—

20 “(i) have as of January 1, 1991, been  
21 certified by the Secretary as a FQHC  
22 under section 1905(l)(2)(B) of the Social  
23 Security Act; or

1           “(ii) have submitted applications to  
2 the Secretary to qualify as FQHC’s under  
3 such section 1905(l)(2)(B); or

4           “(iii) have submitted a plan to the  
5 Secretary which provides that the entity  
6 will meet the requirements to qualify as a  
7 FQHC when operational.

8           “(B) NON FQHC ENTITIES.—

9           “(i) ELIGIBILITY.—The Secretary  
10 shall also make grants under this sub-  
11 section to public or private nonprofit agen-  
12 cies, health care entities or organizations  
13 which meet the requirements necessary to  
14 qualify as a FQHC except, the requirement  
15 that such entity have a consumer majority  
16 governing board and which have submitted  
17 a proposal to the Secretary to provide  
18 those services provided by a FQHC as de-  
19 fined in section 1905(l)(2)(B) of the Social  
20 Security Act and which are designed to  
21 promote access to primary care services or  
22 to reduce reliance on hospital emergency  
23 rooms or other high cost providers of pri-  
24 mary health care services, provided such  
25 proposal is developed by the entity or orga-

1 nizations (or such entities or organizations  
2 acting in a consortium in a community)  
3 with the review and approval of the Gov-  
4 ernor of the State in which such entity or  
5 organization is located.

6 “(ii) LIMITATION.—The Secretary  
7 shall provide in making grants to entities  
8 or organizations described in this subpara-  
9 graph that no more than 10 percent of the  
10 funds provided for grants under this sub-  
11 section shall be made available for grants  
12 to such entities or organizations.

13 “(3) APPLICATION REQUIREMENTS.—

14 “(A) IN GENERAL.—In order to be eligible  
15 to receive a grant under this subsection, a  
16 FQHC or other entity or organization must  
17 submit an application in such form and at such  
18 time as the Secretary shall prescribe and which  
19 meets the requirements of this paragraph.

20 “(B) REQUIREMENTS.—An application  
21 submitted under this subsection must provide—

22 “(i)(I) for a schedule of fees or pay-  
23 ments for the provision of the services pro-  
24 vided by the entity designed to cover its  
25 reasonable costs of operations; and

1           “(II) for a corresponding schedule of  
2 discounts to be applied to such fees or pay-  
3 ments, based upon the patient’s ability to  
4 pay (determined by using a sliding scale  
5 formula based on the income of the  
6 patient);

7           “(ii) assurances that the entity or or-  
8 ganization provides services to persons who  
9 are eligible for benefits under title XVIII  
10 of the Social Security Act, for medical as-  
11 sistance under title XIX of such Act or for  
12 assistance for medical expenses under any  
13 other public assistance program or private  
14 health insurance program; and

15           “(iii) assurances that the entity or or-  
16 ganization has made and will continue to  
17 make every reasonable effort to collect re-  
18 imbursement for services—

19                   “(I) from persons eligible for as-  
20 sistance under any of the programs  
21 described in clause (ii); and

22                   “(II) from patients not entitled  
23 to benefits under any such programs.

24           “(4) LIMITATIONS ON USE OF FUNDS.—

1           “(A) IN GENERAL.—From the amounts  
2 awarded to an entity or organization under this  
3 subsection, funds may be used for purposes of  
4 planning but may only be expended for the  
5 costs of—

6                   “(i) assessing the needs of the popu-  
7 lations or proposed areas to be served;

8                   “(ii) preparing a description of how  
9 the needs identified will be met; and

10                   “(iii) development of an implementa-  
11 tion plan that addresses—

12                           “(I) recruitment and training of  
13 personnel; and

14                           “(II) activities necessary to  
15 achieve operational status in order to  
16 meet FQHC requirements under  
17 1905(l)(2)(B) of the Social Security  
18 Act.

19           “(B) RECRUITING, TRAINING AND COM-  
20 PENSATION OF STAFF.—From the amounts  
21 awarded to an entity or organization under this  
22 subsection, funds may be used for the purposes  
23 of paying for the costs of recruiting, training  
24 and compensating staff (clinical and associated  
25 administrative personnel (to the extent such

1 costs are not already reimbursed under title  
2 XIX of the Social Security Act or any other  
3 State or Federal program)) to the extent nec-  
4 essary to allow the entity to operate at new or  
5 expended existing sites.

6 “(C) FACILITIES AND EQUIPMENT.—From  
7 the amounts awarded to an entity or organiza-  
8 tion under this subsection, funds may be ex-  
9 pended for the purposes of acquiring facilities  
10 and equipment but only for the cost of—

11 “(i) construction of new buildings (to  
12 the extent that new construction is found  
13 to be the most cost-efficient approach by  
14 the Secretary);

15 “(ii) acquiring, expanding, and mod-  
16 ernizing of existing facilities;

17 “(iii) purchasing essential (as deter-  
18 mined by the Secretary) equipment; and

19 “(iv) amortization of principal and  
20 payment of interest on loans obtained for  
21 purposes of site construction, acquisition,  
22 modernization, or expansion, as well as  
23 necessary equipment.

24 “(D) SERVICES.—From the amounts  
25 awarded to an entity or organization under this

1 subsection, funds may be expanded for the pay-  
2 ment of services but only for the costs of—

3 “(i) providing or arranging for the  
4 provision of all services through the entity  
5 necessary to qualify such entity as a  
6 FQHC under section 1905(l)(2)(B) of the  
7 Social Security Act;

8 “(ii) providing or arranging for any  
9 other service that a FQHC may provide  
10 and be reimbursed for under title XIX of  
11 such Act; and

12 “(iii) providing any unreimbursed  
13 costs of providing services as described in  
14 section 330(a) to patients.

15 “(5) PRIORITIES IN THE AWARDING OF  
16 GRANTS.—

17 “(A) CERTIFIED FQHC’S.—The Secretary  
18 shall give priority in awarding grants under this  
19 subsection to entities which have, as of January  
20 1, 1991, been certified as a FQHC under sec-  
21 tion 1905(l)(2)(B) of the Social Security Act  
22 and which have submitted a proposal to the  
23 Secretary to expand their operations (including  
24 expansion to new sites) to serve medically un-  
25 derserved populations for high impact areas not

1 currently served by a FQHC. The Secretary  
2 shall give first priority in awarding grants  
3 under this subsection to those FQHCs or other  
4 entities which propose to serve populations with  
5 the highest degree of unmet need, and which  
6 can demonstrate the ability to expand their op-  
7 erations in the most efficient manner.

8 “(B) QUALIFIED FQHC’S.—The Secretary  
9 shall give second priority in awarding grants to  
10 entities which have submitted applications to  
11 the Secretary which demonstrate that the entity  
12 will qualify as a FQHC under section  
13 1905(l)(2)(B) of the Social Security Act before  
14 it provides or arranges for the provision of serv-  
15 ices supported by funds awarded under this  
16 subsection, and which are serving or proposing  
17 to serve medically underserved populations or  
18 high impact areas which are not currently  
19 served (or proposed to be served) by a FQHC.

20 “(C) EXPANDED SERVICES AND  
21 PROJECTS.—The Secretary shall give third pri-  
22 ority in awarding grants in subsequent years to  
23 those FQHCs or other entities which have pro-  
24 vided for expanded services and project and are  
25 able to demonstrate that such entity will incur

1 significant unreimbursed costs in providing  
2 such expanded services.

3 “(6) RETURN OF FUNDS TO SECRETARY FOR  
4 COSTS REIMBURSED FROM OTHER SOURCES.—To  
5 the extent that an entity or organization receiving  
6 funds under this subsection is reimbursed from an-  
7 other source for the provision of services to an indi-  
8 vidual, and does not use such increased reimburse-  
9 ment to expand services furnished, areas served, to  
10 compensate for costs of unreimbursed services pro-  
11 vided to patients, or to promote recruitment, train-  
12 ing, or retention of personnel, such excess revenues  
13 shall be returned to the Secretary.

14 “(7) TERMINATION OF GRANTS.—

15 “(A) FAILURE TO MEET FQHC REQUIRE-  
16 MENTS.—

17 “(A) IN GENERAL.—With respect to  
18 any entity that is receiving funds awarded  
19 under this subsection and which subse-  
20 quently fails to meet the requirements to  
21 qualify as a FQHC under section  
22 1905(l)(2)(B) or is an entity that is not  
23 required to meet the requirements to qual-  
24 ify as a FQHC under section  
25 1905(l)(2)(B) of the Social Security Act

1 but fails to meet the requirements of this  
2 subsection, the Secretary shall terminate  
3 the award of funds under this subsection  
4 to such entity.

5 “(ii) NOTICE.—Prior to any termi-  
6 nation of funds under this subsection to an  
7 entity, the entities shall be entitled to 60  
8 days prior notice of termination and, as  
9 provided by the Secretary in regulations,  
10 an opportunity to correct any deficiencies  
11 in order to allow the entity to continue to  
12 receive funds under this subsection.

13 “(B) REQUIREMENTS.—Upon any termi-  
14 nation of funding under this subsection, the  
15 Secretary may (to the extent practicable)—

16 “(i) sell any property (including  
17 equipment) acquired or constructed by the  
18 entity using funds made available under  
19 this subsection or transfer such property to  
20 another FQHC, provided, that the Sec-  
21 retary shall reimburse any costs which  
22 were incurred by the entity in acquiring or  
23 constructing such property (including  
24 equipment) which were not supported by  
25 grants under this subsection; and

1                   “(ii) recoup any funds provided to an  
2                   entity terminated under this subsection.

3           “(c) AUTHORIZATION OF APPROPRIATIONS; ALLOCA-  
4   TION AMONG PROGRAMS.—

5                   “(1) AUTHORIZATION.—There are authorized to  
6           be appropriated to carry out this section,  
7           \$400,000,000 for fiscal year 1995, \$800,000,000 for  
8           fiscal year 1996, \$1,200,000,000 for fiscal year  
9           1997, \$1,600,000,000 for fiscal year 1998, and  
10          \$1,600,000,000 for fiscal year 1999.

11                   “(2) ALLOCATION.—Of the amounts appro-  
12           priated pursuant to the authorization described in  
13           paragraph (1) to carry out this section in a fiscal  
14           year, 50 percent shall be allocated for grants under  
15           subsection (a) and 50 percent shall be allocated for  
16           grants under subsection (b).”.

17          (b) STUDY AND REPORT ON SERVICES PROVIDED BY  
18   COMMUNITY HEALTH CENTERS AND HOSPITALS.—

19                   (1) IN GENERAL.—The Secretary of Health and  
20           Human Services (hereinafter referred to in this sub-  
21           section as the “Secretary”) shall provide for a study  
22           to examine the relationship and interaction between  
23           community health centers and hospitals in providing  
24           services to individuals residing in medically under-  
25           served areas. The Secretary shall ensure that the

1 National Rural Research Centers participate in such  
2 study.

3 (2) REPORT.—The Secretary shall provide to  
4 the appropriate committees of Congress a report  
5 summarizing the findings of the study within 90  
6 days of the end of each project year and shall in-  
7 clude in such report recommendations on methods to  
8 improve the coordination of and provision of services  
9 in medically underserved areas by community health  
10 centers and hospitals.

11 (3) AUTHORIZATION.—There are authorized to  
12 be appropriated to carry out the study provided for  
13 in this subsection \$150,000 for each of fiscal years  
14 1995 and 1996.

15 **SEC. 502. TAX INCENTIVES FOR PRACTICE IN FRONTIER,**  
16 **RURAL, AND URBAN UNDERSERVED AREAS.**

17 (a) NONREFUNDABLE CREDIT FOR CERTAIN PRI-  
18 MARY HEALTH SERVICES PROVIDERS.—

19 (1) IN GENERAL.—Subpart A of part IV of sub-  
20 chapter A of chapter 1 of the Internal Revenue Code  
21 of 1986 (relating to nonrefundable personal credits)  
22 is amended by inserting after section 25 the follow-  
23 ing new section:

1 **“SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.**

2 “(a) ALLOWANCE OF CREDIT.—In the case of a  
3 qualified primary health services provider, there is allowed  
4 as a credit against the tax imposed by this chapter for  
5 any taxable year in a mandatory service period an amount  
6 equal to the product of—

7 “(1) the lesser of—

8 “(A) the number of months of such period  
9 occurring in such taxable year, or

10 “(B) 36 months, reduced by the number of  
11 months taken into account under this para-  
12 graph with respect to such provider for all pre-  
13 ceding taxable years (whether or not in the  
14 same mandatory service period), multiplied by

15 “(2) \$1,000 (\$500 in the case of a qualified  
16 primary health services provider who is a physician  
17 assistant or a nurse practitioner).

18 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-  
19 VIDER.—For purposes of this section, the term ‘qualified  
20 primary health services provider’ means any physician,  
21 physician assistant, or nurse practitioner who for any  
22 month during a mandatory service period is certified by  
23 the Bureau to be a primary health services provider who—

24 “(1) is providing primary health services—

25 “(A) full time, and

1           “(B) to individuals at least 80 percent of  
2           whom reside in a health professional shortage  
3           area (as defined in subsection (d)(2)),

4           “(2) is not receiving during such year a scholar-  
5           ship under the National Health Service Corps Schol-  
6           arship Program or a loan repayment under the  
7           National Health Service Corps Loan Repayment  
8           Program,

9           “(3) is not fulfilling service obligations under  
10          such Programs, and

11          “(4) has not defaulted on such obligations.

12          “(c) MANDATORY SERVICE PERIOD.—For purposes  
13          of this section, the term ‘mandatory service period’ means  
14          the period of 60 consecutive calendar months beginning  
15          with the first month the taxpayer is a qualified primary  
16          health services provider.

17          “(d) DEFINITIONS AND SPECIAL RULES.—For pur-  
18          poses of this section—

19                  “(1) BUREAU.—The term ‘Bureau’ means the  
20                  Bureau of Health Care Delivery and Assistance,  
21                  Health Resources and Services Administration of the  
22                  United States Public Health Service.

23                  “(2) HEALTH PROFESSIONAL SHORTAGE  
24                  AREA.—The term ‘health professional shortage area’  
25                  means—

1           “(A) a geographic area in which there are  
2           6 or fewer individuals residing per square mile,

3           “(B) a health professional shortage area  
4           (as defined in section 332(a)(1)(A) of the Pub-  
5           lic Health Service Act),

6           “(C) an area which is determined by the  
7           Secretary of Health and Human Services as  
8           equivalent to an area described in subparagraph  
9           (A) and which is designated by the Bureau of  
10          the Census as not urbanized, or

11          “(D) a community that is certified as un-  
12          derserved by the Secretary for purposes of par-  
13          ticipation in the rural health clinic program  
14          under title XVIII of the Social Security Act.

15          “(3) PHYSICIAN.—The term ‘physician’ has the  
16          meaning given to such term by section 1861(r) or  
17          the Social Security Act.

18          “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-  
19          TIONER.—The terms ‘physician assistant’ and ‘nurse  
20          practitioner’ have the meanings given to such terms  
21          by section 1861(aa)(5) of the Social Security Act.

22          “(5) PRIMARY HEALTH SERVICES PROVIDER.—  
23          The term ‘primary health services provider’ means a  
24          provider of primary health services (as defined in  
25          section 330(b)(1) of the Public Health Service Act).

1 “(e) RECAPTURE OF CREDIT.—

2 “(1) IN GENERAL.—If, during any taxable year,  
 3 there is a recapture event, then the tax of the tax-  
 4 payer under this chapter for such taxable year shall  
 5 be increased by an amount equal to the product of—

6 “(A) the applicable percentage, and

7 “(B) the aggregate unrecaptured credits  
 8 allowed to such taxpayer under this section for  
 9 all prior taxable years.

10 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

11 “(A) IN GENERAL.—For purposes of this  
 12 subsection, the applicable recapture percentage  
 13 shall be determined from the following table:

<b>“If the recapture event occurs during:</b>	<b>The applicable recapture percentage is:</b>
Months 1–24 .....	100
Months 25–36 .....	75
Months 37–48 .....	50
Months 49–60 .....	25
Months 61 and thereafter .....	0.

14 “(B) TIMING.—For purposes of subpara-  
 15 graph (A), month 1 shall begin on the first day  
 16 of the mandatory service period.

17 “(3) RECAPTURE EVENT DEFINED.—

18 “(A) IN GENERAL.—For purposes of this  
 19 subsection, the term ‘recapture event’ means  
 20 the failure of the taxpayer to be a qualified pri-

1           mary health services provider for any month  
2           during any mandatory service period.

3           “(B) CESSATION OF DESIGNATION.—The  
4           cessation of the designation of any area as a  
5           rural health professional shortage area after the  
6           beginning of the mandatory service period for  
7           any taxpayer shall not constitute a recapture  
8           event.

9           “(C) SECRETARIAL WAIVER.—The Sec-  
10          retary may waive any recapture event caused by  
11          extraordinary circumstances.

12          “(4) NO CREDITS AGAINST TAX.—Any increase  
13          in tax under this subsection shall not be treated as  
14          a tax imposed by this chapter for purposes of deter-  
15          mining the amount of any credit under subpart A,  
16          B, or D of this part.”.

17          (2) CLERICAL AMENDMENT.—The table of sec-  
18          tions for subpart A of part IV of subchapter A of  
19          chapter 1 of such Code is amended by inserting  
20          after the item relating to section 25 the following  
21          new item:

            “Sec. 25A. Primary health services providers.”.

22          (3) EFFECTIVE DATE.—The amendments made  
23          by this subsection shall apply to taxable years begin-  
24          ning after the date of the enactment of this Act.

1 (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-  
2 PAYMENTS EXCLUDED FROM GROSS INCOME.—

3 (1) IN GENERAL.—Part III of subchapter B of  
4 chapter 1 of the Internal Revenue Code of 1986 (re-  
5 lating to items specifically excluded from gross in-  
6 come) is amended by redesignating section 137 as  
7 section 138 and by inserting after section 136 the  
8 following new section:

9 **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-  
10 PAYMENTS.**

11 “(a) GENERAL RULE.—Gross income shall not in-  
12 clude any qualified loan repayment.

13 “(b) QUALIFIED LOAN REPAYMENT.—For purposes  
14 of this section, the term ‘qualified loan repayment’ means  
15 any payment made on behalf of the taxpayer by the Na-  
16 tional Health Service Corps Loan Repayment Program  
17 under section 338B(g) of the Public Health Service Act.”.

18 (2) CONFORMING AMENDMENT.—Paragraph (3)  
19 of section 338B(g) of the Public Health Service Act  
20 is amended by striking “Federal, State, or local”  
21 and inserting “State or local”.

22 (3) CLERICAL AMENDMENT.—The table of sec-  
23 tions for part III of subchapter B of chapter 1 of  
24 the Internal Revenue Code of 1986 is amended by

1 striking the item relating to section 136 and insert-  
2 ing the following:

“Sec. 137. National Health Service Corps loan repayments.  
“Sec. 138. Cross references to other Acts.”.

3 (4) EFFECTIVE DATE.—The amendments made  
4 by this subsection shall apply to payments made  
5 under section 338B(g) of the Public Health Service  
6 Act after the date of the enactment of this Act.

7 (c) EXPENSING OF MEDICAL EQUIPMENT.—

8 (1) IN GENERAL.—Section 179 of the Internal  
9 Revenue Code of 1986 (relating to election to ex-  
10 pense certain depreciable business assets) is amend-  
11 ed—

12 (A) by striking paragraph (1) of subsection  
13 (b) and inserting the following:

14 “(1) DOLLAR LIMITATION.—

15 “(A) GENERAL RULE.—The aggregate cost  
16 which may be taken into account under sub-  
17 section (a) for any taxable year shall not exceed  
18 \$17,500.

19 “(B) RURAL HEALTH CARE PROPERTY.—  
20 In the case of rural health care property, the  
21 aggregate cost which may be taken into account  
22 under subsection (a) for any taxable year shall  
23 not exceed \$32,500, reduced by the amount

1 otherwise taken into account under subsection  
2 (a) for such year.”; and

3 (B) by adding at the end of subsection (d)  
4 the following new paragraph:

5 “(11) RURAL HEALTH CARE PROPERTY.—For  
6 purposes of this section, the term ‘rural health care  
7 property’ means section 179 property—

8 “(A) which is medical equipment used in  
9 the screening, monitoring, observation, diag-  
10 nosis, or treatment of patients in a laboratory,  
11 medical, or hospital environment,

12 “(B) which is owned (directly or indirectly)  
13 and used by a physician (as defined in section  
14 1861(r) of the Social Security Act) in the active  
15 conduct of such physician’s full-time trade or  
16 business of providing primary health services  
17 (as defined in section 330(b)(1) of the Public  
18 Health Service Act) in a rural health profes-  
19 sional shortage area (as defined in section  
20 25A(d)(5)), and

21 “(C) substantially all the use of which is in  
22 such area.”.

23 (2) EFFECTIVE DATE.—The amendments made  
24 by this subsection shall apply to property placed in

1 service in taxable years beginning after the date of  
2 enactment of this Act.

3 (d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY  
4 MEDICAL PROFESSIONALS PRACTICING IN RURAL  
5 AREAS.—

6 (1) INTEREST ON STUDENT LOANS NOT TREAT-  
7 ED AS PERSONAL INTEREST.—Section 163(h)(2) of  
8 the Internal Revenue Code of 1986 (defining per-  
9 sonal interest) is amended by striking “and” at the  
10 end of subparagraph (D), by striking the period at  
11 the end of subparagraph (E) and inserting “, and”,  
12 and by adding at the end thereof the following new  
13 subparagraph:

14 “(F) any qualified medical education interest  
15 (within the meaning of subsection (k)).”.

16 (2) QUALIFIED MEDICAL EDUCATION INTEREST  
17 DEFINED.—Section 163 of such Code (relating to in-  
18 terest expenses) is amended by redesignating sub-  
19 section (k) as subsection (l) and by inserting after  
20 subsection (j) the following new subsection:

21 “(k) QUALIFIED MEDICAL EDUCATION INTEREST OF  
22 MEDICAL PROFESSIONALS PRACTICING IN RURAL  
23 AREAS.—

24 “(1) IN GENERAL.—For purposes of subsection  
25 (h)(2)(F), the term ‘qualified medical education in-

1       terest' means an amount which bears the same ratio  
2       to the interest paid on qualified educational loans  
3       during the taxable year by an individual performing  
4       services under a qualified rural medical practice  
5       agreement as—

6               “(A) the number of months during the tax-  
7               able year during which such services were per-  
8               formed, bears to

9               “(B) the number of months in the taxable  
10              year.

11             “(2) DOLLAR LIMITATION.—The aggregate  
12             amount which may be treated as qualified medical  
13             education interest for any taxable year with respect  
14             to an individual shall not exceed \$5,000.

15             “(3) QUALIFIED RURAL MEDICAL PRACTICE  
16             AGREEMENT.—For purposes of this subsection—

17               “(A) IN GENERAL.—The term ‘qualified  
18               rural medical practice agreement’ means a writ-  
19               ten agreement between an individual and an ap-  
20               plicable rural community under which the indi-  
21               vidual agrees—

22                   “(i) in the case of a medical doctor,  
23                   upon completion of the individual’s resi-  
24                   dency (or internship if no residency is re-  
25                   quired), or

1           “(ii) in the case of a registered nurse,  
2           nurse practitioner, or physician’s assistant,  
3           upon completion of the education to which  
4           the qualified education loan relates, to per-  
5           form full-time services as such a medical  
6           professional in the applicable rural commu-  
7           nity for a period of 24 consecutive months.  
8           An individual and an applicable rural com-  
9           munity may elect to have the agreement  
10          apply for 36 consecutive months rather  
11          than 24 months.

12          “(B) SPECIAL RULE FOR COMPUTING PE-  
13          RIODS.—An individual shall be treated as meet-  
14          ing the 24- or 36-consecutive month require-  
15          ment under subparagraph (A) if, during each  
16          12-consecutive month period within either such  
17          period, the individual performs full-time services  
18          as a medical doctor, registered nurse, nurse  
19          practitioner, or physician’s assistant, whichever  
20          applies, in the applicable rural community dur-  
21          ing 9 of the months in such 12-consecutive  
22          month period. For purposes of this subsection,  
23          an individual meeting the requirements of the  
24          preceding sentence shall be treated as perform-  
25          ing services during the entire 12-month period.

1           “(C) APPLICABLE RURAL COMMUNITY.—

2           The term ‘applicable rural community’ means—

3                   “(i) any political subdivision of a  
4                   State which—

5                           “(I) has a population of 5,000 or  
6                           less, and

7                           “(II) has a per capita income of  
8                           \$15,000 or less, or

9                           “(ii) an Indian reservation which has  
10                           a per capita income of \$15,000 or less.

11           “(4) QUALIFIED EDUCATIONAL LOAN.—The  
12           term ‘qualified educational loan’ means any indebt-  
13           edness to pay qualified higher education expenses  
14           (within the meaning of section 135(c)(2)) and rea-  
15           sonable living expenses—

16                   “(A) which are paid or incurred—

17                           “(i) as a candidate for a degree as a  
18                           medical doctor at an educational institu-  
19                           tion described in section 170(b)(1)(A)(ii),  
20                           or

21                           “(ii) in connection with courses of in-  
22                           struction at such an institution necessary  
23                           for certification as a registered nurse,  
24                           nurse practitioner, or physician’s assistant,  
25                           and

1           “(B) which are paid or incurred within a  
2           reasonable time before or after such indebted-  
3           ness is incurred.

4           “(5) RECAPTURE.—If an individual fails to  
5           carry out a qualified rural medical practice agree-  
6           ment during any taxable year, then—

7                   “(A) no deduction with respect to such  
8                   agreement shall be allowable by reason of sub-  
9                   section (h)(2)(F) for such taxable year and any  
10                  subsequent taxable year, and

11                   “(B) there shall be included in gross in-  
12                   come for such taxable year the aggregate  
13                   amount of the deductions allowable under this  
14                   section (by reason of subsection (h)(2)(F)) for  
15                   all preceding taxable years.

16           “(6) DEFINITIONS.—For purposes of this sub-  
17           section, the terms ‘registered nurse’, ‘nurse practi-  
18           tioner’, and ‘physician’s assistant’ have the meaning  
19           given such terms by section 1861 of the Social Secu-  
20           rity Act.”.

21           (3) DEDUCTION ALLOWED IN COMPUTING AD-  
22           JUSTED GROSS INCOME.—Section 62(a) of such  
23           Code, as amended by sections 2002(c)(3) and  
24           2003(b), is amended by inserting after paragraph  
25           (17) the following new paragraph:

1           “(18) INTEREST ON STUDENT LOANS OF RURAL  
2 HEALTH PROFESSIONALS.—The deduction allowable  
3 by reason of section 163(h)(2)(F) (relating to stu-  
4 dent loan payments of medical professionals practic-  
5 ing in rural areas).”.

6           (4) EFFECTIVE DATE.—The amendments made  
7 by this subsection shall apply to taxable years begin-  
8 ning after the date of the enactment of this Act.

9 **SEC. 503. RURAL EMERGENCY ACCESS CARE HOSPITALS.**

10       (a) RURAL EMERGENCY ACCESS CARE HOSPITALS  
11 DESCRIBED.—Section 1861 of the Social Security Act (42  
12 U.S.C. 1395x) is amended by adding at the end the follow-  
13 ing new subsection:

14           “Rural Emergency Access Care Hospital; Rural  
15           Emergency Access Care Hospital Services

16           “(oo)(1) The term ‘rural emergency access care hos-  
17 pital’ means, for a fiscal year, a facility with respect to  
18 which the Secretary finds the following:

19           “(A) The facility is located in a rural area (as  
20 defined in section 1886(d)(2)(D)).

21           “(B) The facility was a hospital under this title  
22 at any time during the 5-year period that ends on  
23 the date of the enactment of this subsection.

24           “(C) The facility is in danger of closing due to  
25 low inpatient utilization rates and negative operating

1 losses, and the closure of the facility would limit the  
2 access of individuals residing in the facility's service  
3 area to emergency services.

4 “(D) The facility has entered into (or plans to  
5 enter into) an agreement with a hospital with a par-  
6 ticipation agreement in effect under section 1866(a),  
7 and under such agreement the hospital shall accept  
8 patients transferred to the hospital from the facility  
9 and receive data from and transmit data to the  
10 facility.

11 “(E) There is a practitioner who is qualified to  
12 provide advanced cardiac life support services (as de-  
13 termined by the State in which the facility is lo-  
14 cated) on-site at the facility on a 24-hour basis.

15 “(F) A physician is available on-call to provide  
16 emergency medical services on a 24-hour basis.

17 “(G) The facility meets such staffing require-  
18 ments as would apply under section 1861(e) to a  
19 hospital located in a rural area, except that—

20 “(i) the facility need not meet hospital  
21 standards relating to the number of hours dur-  
22 ing a day, or days during a week, in which the  
23 facility must be open, except insofar as the fa-  
24 cility is required to provide emergency care on

1 a 24-hour basis under subparagraphs (E) and  
2 (F); and

3 “(ii) the facility may provide any services  
4 otherwise required to be provided by a full-time,  
5 on-site dietician, pharmacist, laboratory techni-  
6 cian, medical technologist, or radiological tech-  
7 nologist on a part-time, off-site basis.

8 “(H) The facility meets the requirements appli-  
9 cable to clinics and facilities under subparagraphs  
10 (C) through (J) of paragraph (2) of section  
11 1861(aa) and of clauses (ii) and (iv) of the second  
12 sentence of such paragraph (or, in the case of the  
13 requirements of subparagraph (E), (F), or (J) of  
14 such paragraph, would meet the requirements if any  
15 reference in such subparagraph to a ‘nurse practi-  
16 tioner’ or to ‘nurse practitioners’ was deemed to be  
17 a reference to a ‘nurse practitioner or nurse’ or to  
18 ‘nurse practitioners or nurses’), except that in deter-  
19 mining whether a facility meets the requirements of  
20 this subparagraph, subparagraphs (E) and (F) of  
21 that paragraph shall be applied as if any reference  
22 to a ‘physician’ is a reference to a physician as de-  
23 fined in section 1861(r)(1).

1       “(2) The term ‘rural emergency access care hospital  
2 services’ means medical and other health services fur-  
3 nished by a rural emergency access care hospital.”.

4       (b) COVERAGE OF AND PAYMENT FOR SERVICES.—  
5 Section 1832(a)(2) of the Social Security Act (42 U.S.C.  
6 1395k(a)(2)) is amended—

7           (1) by striking “and” at the end of subpara-  
8 graph (I);

9           (2) by striking the period at the end of sub-  
10 paragraph (J) and inserting “; and”; and

11           (3) by adding at the end the following new sub-  
12 paragraph:

13                   “(K) rural emergency access care hospital  
14 services (as defined in section 1861(oo)(2)).”.

15       (c) PAYMENT BASED ON PAYMENT FOR OUTPATIENT  
16 RURAL PRIMARY CARE HOSPITAL SERVICES.—

17           (1) IN GENERAL.—Section 1833(a)(6) of the  
18 Social Security Act (42 U.S.C. 1395l(a)(6)) is  
19 amended by striking “services,” and inserting “serv-  
20 ices and rural emergency access care hospital serv-  
21 ices,”.

22           (2) PAYMENT METHODOLOGY DESCRIBED.—  
23 Section 1834(g) of such Act (42 U.S.C. 1395m(g))  
24 is amended—

1 (A) in the heading, by striking “SERV-  
2 ICES” and inserting “SERVICES AND RURAL  
3 EMERGENCY ACCESS CARE HOSPITAL SERV-  
4 ICES”;

5 (B) in paragraph (1), by striking “during  
6 a year before 1993” and inserting “during a  
7 year before the prospective payment system de-  
8 scribed in paragraph (2) is in effect”;

9 (C) in paragraph (1), by adding at the end  
10 the following: “The amount of payment shall be  
11 determined under either method without regard  
12 to the amount of the customary or other  
13 charge.”;

14 (D) in paragraph (2), by striking “Janu-  
15 ary 1, 1993,” and inserting “January 1,  
16 1996,”; and

17 (E) by adding at the end the following new  
18 paragraph:

19 “(3) APPLICATION OF METHODS TO PAYMENT  
20 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL  
21 SERVICES.—The amount of payment for rural emer-  
22 gency access care hospital services provided during  
23 a year shall be determined using the applicable  
24 method provided under this subsection for determin-

1       ing payment for outpatient rural primary care hos-  
2       pital services during the year.”.

3       (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to fiscal years beginning on or  
5 after October 1, 1994.

6       **SEC. 504. GRANTS TO STATES REGARDING AIRCRAFT FOR**  
7                               **TRANSPORTING RURAL VICTIMS OF MEDICAL**  
8                               **EMERGENCIES.**

9       Part E of title XII of the Public Health Service Act  
10 (42 U.S.C. 300d–51 et seq.) is amended by adding at the  
11 end thereof the following new section:

12       **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**  
13                               **VICTIMS OF MEDICAL EMERGENCIES.**

14       “(a) IN GENERAL.—The Secretary shall make grants  
15 to States to assist such States in the creation or enhance-  
16 ment of air medical transport systems that provide victims  
17 of medical emergencies in rural areas with access to treat-  
18 ments for the injuries or other conditions resulting from  
19 such emergencies.

20       “(b) APPLICATION AND PLAN.—

21               “(1) APPLICATION.—To be eligible to receive a  
22 grant under subsection (a), a State shall prepare  
23 and submit to the Secretary an application in such  
24 form, made in such manner, and containing such  
25 agreements, assurances, and information, including

1 a State plan as required in paragraph (2), as the  
2 Secretary determines to be necessary to carry out  
3 this section.

4 “(2) STATE PLAN.—An application submitted  
5 under paragraph (1) shall contain a State plan that  
6 shall—

7 “(A) describe the intended uses of the  
8 grant proceeds and the geographic areas to be  
9 served;

10 “(B) demonstrate that the geographic  
11 areas to be served, as described under subpara-  
12 graph (A), are rural in nature;

13 “(C) demonstrate that there is a lack of  
14 facilities available and equipped to deliver ad-  
15 vanced levels of medical care in the geographic  
16 areas to be served;

17 “(D) demonstrate that in utilizing the  
18 grant proceeds for the establishment or en-  
19 hancement of air medical services the State  
20 would be making a cost-effective improvement  
21 to existing ground-based or air emergency medi-  
22 cal service systems;

23 “(E) demonstrate that the State will not  
24 utilize the grant proceeds to duplicate the capa-  
25 bilities of existing air medical systems that are

1 effectively meeting the emergency medical needs  
2 of the populations they serve;

3 “(F) demonstrate that in utilizing the  
4 grant proceeds the State is likely to achieve a  
5 reduction in the morbidity and mortality rates  
6 of the areas to be served, as determined by the  
7 Secretary;

8 “(G) demonstrate that the State, in utiliz-  
9 ing the grant proceeds, will—

10 “(i) maintain the expenditures of the  
11 State for air and ground medical transport  
12 systems at a level equal to not less than  
13 the level of such expenditures maintained  
14 by the State for the fiscal year preceding  
15 the fiscal year for which the grant is re-  
16 ceived; and

17 “(ii) ensure that recipients of direct  
18 financial assistance from the State under  
19 such grant will maintain expenditures of  
20 such recipients for such systems at a level  
21 at least equal to the level of such expendi-  
22 tures maintained by such recipients for the  
23 fiscal year preceding the fiscal year for  
24 which the financial assistance is received;

1           “(H) demonstrate that persons experienced  
2           in the field of air medical service delivery were  
3           consulted in the preparation of the State plan;  
4           and

5           “(I) contain such other information as the  
6           Secretary may determine appropriate.

7           “(c) CONSIDERATIONS IN AWARDING GRANTS.—In  
8           determining whether to award a grant to a State under  
9           this section, the Secretary shall—

10           “(1) consider the rural nature of the areas to  
11           be served with the grant proceeds and the services  
12           to be provided with such proceeds, as identified in  
13           the State plan submitted under subsection (b); and

14           “(2) give preference to States with State plans  
15           that demonstrate an effective integration of the pro-  
16           posed air medical transport systems into a com-  
17           prehensive network or plan for regional or statewide  
18           emergency medical service delivery.

19           “(d) STATE ADMINISTRATION AND USE OF  
20           GRANT.—

21           “(1) IN GENERAL.—The Secretary may not  
22           make a grant to a State under subsection (a) unless  
23           the State agrees that such grant will be adminis-  
24           tered by the State agency with principal responsibil-  
25           ity for carrying out programs regarding the provi-

1 sion of medical services to victims of medical emer-  
2 gencies or trauma.

3 “(2) PERMITTED USES.—A State may use  
4 amounts received under a grant awarded under this  
5 section to award subgrants to public and private en-  
6 tities operating within the State.

7 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—  
8 The Secretary may not make a grant to a State  
9 under subsection (a) unless that State agrees that,  
10 in developing and carrying out the State plan under  
11 subsection (b)(2), the State will provide public notice  
12 with respect to the plan (including any revisions  
13 thereto) and facilitate comments from interested  
14 persons.

15 “(e) NUMBER OF GRANTS.—The Secretary shall  
16 award grants under this section to not less than 7 States.

17 “(f) REPORTS.—

18 “(1) REQUIREMENT.—A State that receives a  
19 grant under this section shall annually (during each  
20 year in which the grant proceeds are used) prepare  
21 and submit to the Secretary a report that shall con-  
22 tain—

23 “(A) a description of the manner in which  
24 the grant proceeds were utilized;

1           “(B) a description of the effectiveness of  
2           the air medical transport programs assisted  
3           with grant proceeds; and

4           “(C) such other information as the Sec-  
5           retary may require.

6           “(2) TERMINATION OF FUNDINGS.—In review-  
7           ing reports submitted under paragraph (1), if the  
8           Secretary determines that a State is not using  
9           amounts provided under a grant awarded under this  
10          section in accordance with the State plan submitted  
11          by the State under subsection (b), the Secretary may  
12          terminate the payment of amounts under such grant  
13          to the State until such time as the Secretary deter-  
14          mines that the State comes into compliance with  
15          such plan.

16          “(g) DEFINITION.—As used in this section, the term  
17          ‘rural areas’ means geographic areas that are located out-  
18          side of standard metropolitan statistical areas, as identi-  
19          fied by the Secretary.

20          “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
21          are authorized to be appropriated to make grants under  
22          this section, \$15,000,000 for fiscal year 1995, and such  
23          sums as may be necessary for each for fiscal years 1996  
24          and 1997.”.

1 **SEC. 505. DEMONSTRATION PROJECTS TO ENCOURAGE THE**  
2 **DEVELOPMENT AND OPERATION OF RURAL**  
3 **HEALTH NETWORKS.**

4 (a) IN GENERAL.—

5 (1) ESTABLISHMENT.—

6 (A) IN GENERAL.—The Secretary may  
7 conduct a demonstration project under which  
8 public and private entities may apply for waiv-  
9 ers of any of the provisions of title XVIII and  
10 XIX of the Social Security Act in order to oper-  
11 ate rural health networks (as defined in sub-  
12 section (d)(1)) which—

13 (i) improve the access of medicare  
14 beneficiaries (as defined in subsection  
15 (d)(2)) and medicaid beneficiaries (as de-  
16 fined in subsection (d)(3)) to health care  
17 services;

18 (ii) improve the quality of health care  
19 services furnished to such beneficiaries;  
20 and

21 (iii) improve the outcomes of health  
22 care services furnished to such bene-  
23 ficiaries.

24 (B) NUMBER OF WAIVERS.—The Secretary  
25 may grant waivers to operate rural health net-  
26 works under the demonstration project con-

1 ducted under this section to a number of public  
2 and private entities determined appropriate by  
3 the Secretary.

4 (2) APPLICATIONS.—

5 (A) IN GENERAL.—In order to participate  
6 in the demonstration project conducted under  
7 this subsection, a public or private entity desir-  
8 ing to operate a rural health network shall sub-  
9 mit an application to the Secretary which meets  
10 the requirements of subparagraph (B). Such  
11 application shall be submitted in such manner  
12 and at such time as the Secretary shall require.

13 (B) REQUIREMENTS.—An application sub-  
14 mitted by a public or private entity under this  
15 subsection must provide—

16 (i) a description of the health care  
17 providers participating in the rural health  
18 network;

19 (ii) a description of the geographic  
20 area served by the rural health networks;

21 (iii) information demonstrating that  
22 the public or private entity has consulted  
23 with interested parties with respect to the  
24 operation of the rural health network, in-

1 including local government entities and com-  
2 munity groups;

3 (iv) a description of the operational  
4 structure of the rural health network, in-  
5 cluding whether the network is a managed  
6 care entity or a fee-for-service provider;

7 (v) a proposal for how payments  
8 should be made to the rural health network  
9 under titles XVIII and XIX of the Social  
10 Security Act, including a statement as to  
11 whether such payments should be made  
12 pursuant to the provisions of such titles or  
13 pursuant to an alternative payment meth-  
14 odology described in the application;

15 (vi) assurances that medicare bene-  
16 ficiaries served by the rural health network  
17 will receive care and services of the same  
18 quality as the care and services received by  
19 other beneficiaries under title XVIII of the  
20 Social Security Act;

21 (vii) assurances that medicaid bene-  
22 ficiaries served by the rural health network  
23 will receive care and services of the same  
24 quality as the care and services received by

1 other beneficiaries under title XIX of the  
2 Social Security Act;

3 (viii) a description of how the rural  
4 health network plans to handle any situa-  
5 tion in which a medicare beneficiary or  
6 medicaid beneficiary served by the network  
7 receives health care services from providers  
8 outside the network;

9 (ix) assurances that the rural health  
10 network is furnishing health care services  
11 to a significant number of individuals who  
12 are not receiving benefits under titles  
13 XVIII and XIX of the Social Security Act;

14 (x) assurances that through sharing  
15 of facilities, land, and equipment, the rural  
16 health network will result in a reduction of  
17 total capital costs for the area served by  
18 the network;

19 (xi) a plan for cooperation in service  
20 delivery by health care providers partici-  
21 pating in the rural health network that  
22 demonstrates the elimination of unneces-  
23 sary duplication and, when appropriate,  
24 the consolidation of specialized services  
25 within the area served by the network;

1 (xii) evidence that the rural health  
2 network furnishes services which address  
3 the special access needs of the medicare  
4 beneficiaries and medicaid beneficiaries  
5 served by the network;

6 (xiii) evidence of capability and exper-  
7 tise in network planning and management;  
8 and

9 (xiv) such additional information as  
10 the Secretary determines appropriate.

11 (C) APPROVAL OF APPLICATION.—

12 (i) INITIAL REVIEW.—Within 60 days  
13 after an application is submitted by a pub-  
14 lic or private entity under this subsection,  
15 the Secretary shall review and approve  
16 such application or provide the entity with  
17 a list of the modifications that are nec-  
18 essary for such application to be approved.

19 (ii) ADDITIONAL REVIEW.—Within 60  
20 days after a public or private entity resub-  
21 mits any application under this subsection,  
22 the Secretary shall review and approve  
23 such application or provide the entity with  
24 a summary of which items included on the  
25 list provided to the State under clause (i)

1           remain unsatisfied. An entity may resub-  
2           mit an application under this subpara-  
3           graph as many times as necessary to gain  
4           approval.

5           (3) COORDINATION WITH OTHER PROGRAMS.—

6           The Secretary shall coordinate the demonstration  
7           project conducted under this subsection with any  
8           other relevant Federal or State programs in order to  
9           prevent duplication and improve the quality and de-  
10          livery of health care services to medicare bene-  
11          ficiaries and medicaid beneficiaries.

12          (4) PAYMENTS TO NETWORKS.—

13           (A) IN GENERAL.—The Secretary shall de-  
14           termine the amount of payments to be made  
15           under titles XVIII and XIX to a rural health  
16           network participating in a demonstration  
17           project under this subsection based on historic  
18           costs adjusted based on population and geo-  
19           graphic area as the Secretary determines appro-  
20           priate to take into account the costs of furnish-  
21           ing health care services in the area served by  
22           the network.

23           (B) BUDGET NEUTRALITY.—The Secretary  
24           shall provide that in carrying out the dem-  
25           onstration project under this section, the aggre-

1           gate payments under titles XVIII and XIX of  
2           the Social Security Act to providers participat-  
3           ing in a rural health network shall be no great-  
4           er or lesser than what such payments would  
5           have been if such providers were not participat-  
6           ing in such network.

7           (5) DURATION OF WAIVERS.—Any waiver  
8           granted under the demonstration project conducted  
9           under this subsection shall be granted for a period  
10          determined appropriate by the Secretary. The Sec-  
11          retary may terminate such a waiver at any time if  
12          the Secretary determines that the rural health net-  
13          work has failed to furnish health care services in ac-  
14          cordance with the terms of the waiver.

15          (6) REPORTS.—

16                (A) IN GENERAL.—Each public or private  
17                entity receiving a waiver to operate a rural  
18                health network under the demonstration project  
19                conducted under this subsection shall, through  
20                an independent entity, evaluate the network and  
21                submit interim and final reports to the Sec-  
22                retary at such times and containing such infor-  
23                mation as the Secretary shall require.

24                (B) REPORT TO CONGRESS.—Not later  
25                than 60 days after the receipt of a final report

1 by a rural health network under subparagraph  
2 (A) the Secretary shall submit a report to  
3 Congress.

4 (b) GRANTS FOR THE DEVELOPMENT OF RURAL  
5 HEALTH NETWORKS.—

6 (1) IN GENERAL.—The Secretary shall award  
7 grants to public and private entities which have re-  
8 ceived a waiver under the demonstration project con-  
9 ducted under subsection (a) for the purpose of plan-  
10 ning and developing rural health networks.

11 (2) APPLICATION PROCESS.—

12 (A) SUBMISSION OF APPLICATION.—Each  
13 public or private entity desiring to receive a  
14 grant under this subsection shall submit an ap-  
15 plication to the Secretary at such time and con-  
16 taining such information as the Secretary deter-  
17 mines appropriate.

18 (B) CONSIDERATION OF APPLICATIONS.—  
19 The Secretary shall develop a system for deter-  
20 mining the priority for distributing grants  
21 under this subsection and such grants shall be  
22 distributed in accordance with such system.

23 (3) USE OF GRANT FUNDS.—A State that is  
24 awarded grant funds under this subsection may use  
25 such funds for all costs associated with assisting

1 public or private entities in planning and developing  
2 rural health networks.

3 (4) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated such sums  
5 as may be necessary for the purposes of awarding  
6 grants under this subsection.

7 (c) GRANTS FOR THE OPERATION OF RURAL  
8 HEALTH NETWORKS.—

9 (1) IN GENERAL.—The Secretary shall award  
10 grants to public and private entities which have re-  
11 ceived a waiver under the demonstration project con-  
12 ducted under subsection (a) for the operation of  
13 rural health networks.

14 (2) APPLICATION PROCESS.—

15 (A) SUBMISSION OF APPLICATION.—Any  
16 public or private entity which desires to receive  
17 a grant under this subsection shall submit an  
18 application to the Secretary at such time and  
19 containing such information as the Secretary  
20 determines appropriate.

21 (B) CONSIDERATION OF APPLICATIONS.—

22 The Secretary shall develop a system for deter-  
23 mining the priority for distributing grants  
24 under this subsection and such grants shall be  
25 distributed in accordance with such priority.

1           (3) USE OF GRANT FUNDS.—A public or pri-  
2       vate entity that is awarded grant funds under this  
3       subsection may use such funds for all costs associ-  
4       ated with operating a rural health network.

5           (4) AUTHORIZATION OF APPROPRIATIONS.—  
6       There are authorized to be appropriated such sums  
7       as may be necessary for the purposes of awarding  
8       grants under this subsection.

9       (d) DEFINITIONS.—For purposes of this section:

10           (1) RURAL HEALTH NETWORK.—The term  
11       “rural health network” means a formal cooperative  
12       arrangement between participating hospitals, physi-  
13       cians, and other health care providers which—

14                   (A) furnishes health care services to medi-  
15       care beneficiaries and medicaid beneficiaries;

16                   (B) is located in a rural area; and

17                   (C) is governed by a board of directors se-  
18       lected by participating health care providers.

19           (2) MEDICAID BENEFICIARY.—The term “med-  
20       icaid beneficiary” means an individual receiving ben-  
21       efits under title XIX of the Social Security Act who  
22       resides in a rural area or who receives health care  
23       services from a health care provider located in a  
24       rural area.



1 the purpose of testing and evaluating mechanisms to  
2 increase the number and percentage of medical stu-  
3 dents entering primary care practice relative to those  
4 entering nonprimary care practice through the use  
5 of funds otherwise available for direct graduate med-  
6 ical education costs under section 1886(h) of the So-  
7 cial Security Act.

8 “(2) APPLICATIONS.—

9 “(A) IN GENERAL.—Each State desiring to  
10 conduct a demonstration project under this sub-  
11 section shall prepare and submit to the Sec-  
12 retary an application, at such time, in such  
13 manner, and containing such information as the  
14 Secretary may require, including—

15 “(i) information demonstrating that  
16 the State has consulted with interested  
17 parties with respect to conducting a dem-  
18 onstration project under this subsection,  
19 including State medical associations, State  
20 hospital associations, and medical schools  
21 located in the State;

22 “(ii) an assurance that in conducting  
23 a demonstration project under this sub-  
24 section no single teaching hospital located  
25 in the State will lose more than 10 percent

1 of such hospital's approved medical resi-  
2 dency positions in any year; and

3 “(iii) an explanation of a plan for  
4 evaluating the project.

5 “(B) APPROVAL OF APPLICATIONS.—A  
6 State that submits an application under sub-  
7 paragraph (A) may begin a demonstration  
8 project under this subsection—

9 “(i) upon approval of such application  
10 by the Secretary; or

11 “(ii) at the end of the 60-day period  
12 beginning on the date such application is  
13 submitted, unless the Secretary denies the  
14 application during such period.

15 “(C) NOTICE AND COMMENT.—A State  
16 shall issue a public notice on the date it sub-  
17 mits an application under subparagraph (A)  
18 which contains a general description of the pro-  
19 posed demonstration project. Any interested  
20 party may comment on the proposed dem-  
21 onstration project to the State or the Secretary  
22 during the 30-day period beginning on the date  
23 the public notice is issued.

24 “(3) FUNDING FOR DEMONSTRATION  
25 PROJECTS.—

1 “(A) ALLOCATION OF GME FUNDS.—

2 “(i) IN GENERAL.—For each year a  
3 State conducts a demonstration project  
4 under this subsection the Secretary shall  
5 pay to such State an amount equal to the  
6 total amount available to hospitals located  
7 in the State under section 1886(h) of the  
8 Social Security Act. In the case of a State  
9 which establishes any health care training  
10 consortium under clause (ii)(II), the State  
11 shall designate a teaching hospital for each  
12 resident assigned to such a consortium  
13 which the Secretary shall use to calculate  
14 the State’s payment amount under such  
15 section. Such teaching hospital shall be the  
16 hospital where the resident receives the  
17 majority of the resident’s hospital-based,  
18 nonambulatory training experience.

19 “(ii) USE OF FUNDS.—Each State  
20 that receives a payment under clause (i)  
21 shall use such funds to conduct activities  
22 which test and evaluate mechanisms to in-  
23 crease the number and percentage of medi-  
24 cal students entering primary care practice

1 relative to those entering nonprimary care  
2 practice as follows:

3 “(I) The State may apply  
4 weighting factors that are different  
5 than the weighting factors set forth in  
6 section 1886(h)(4)(C) of the Social  
7 Security Act for the purpose of mak-  
8 ing direct graduate medical education  
9 payments. In applying different  
10 weighting factors, the State may re-  
11 quire entities receiving payments to  
12 use a portion of such payments to in-  
13 crease stipends paid to primary care  
14 residents relative to nonprimary care  
15 residents.

16 “(II) The State may use funds to  
17 provide for the establishment and op-  
18 eration of any health care training  
19 consortium. The State shall make  
20 payments to any such consortium  
21 through an entity identified by the  
22 consortium as appropriate for receiv-  
23 ing payment on behalf of the consor-  
24 tium. The consortium shall have dis-  
25 cretion in determining the purposes

1 for which such payments may be used  
2 and may direct such payments to con-  
3 sortium medical schools for primary  
4 care medical student education pro-  
5 grams.

6 “(B) GRANTS FOR PLANNING AND EVAL-  
7 UATIONS.—

8 “(i) IN GENERAL.—The Secretary  
9 may award grants to States conducting  
10 demonstration projects under this sub-  
11 section for the purpose of developing and  
12 evaluating such projects. A State may con-  
13 duct such an evaluation or contract with a  
14 private entity to conduct the evaluation.  
15 Each State desiring to receive a grant  
16 under this subparagraph shall prepare and  
17 submit to the Secretary an application, at  
18 such time, in such manner, and containing  
19 such information as the Secretary may  
20 require.

21 “(ii) AUTHORIZATION OF APPROPRIA-  
22 TIONS.—There are authorized to be appro-  
23 priated such sums as may be necessary to  
24 carry out the purposes of this subpara-  
25 graph for fiscal years 1995 through 2003.

1           “(4) MAINTENANCE OF EFFORT.—Any funds  
2           available for the activities covered by a demonstra-  
3           tion project conducted under this subsection shall  
4           supplement, and shall not supplant, funds that are  
5           expended for similar purposes under any State, re-  
6           gional, or local program.

7           “(b) CONSORTIUM DEMONSTRATION PROGRAM.—

8           “(1) IN GENERAL.—The Secretary, acting  
9           through the Administrator of the Health Resources  
10          and Services Administration, shall provide for the  
11          establishment of demonstration projects for no more  
12          than 7 health care training consortia which are lo-  
13          cated in States that are not conducting a demonstra-  
14          tion project under subsection (a) for the purpose of  
15          testing and evaluating mechanisms to increase the  
16          number and percentage of medical students entering  
17          primary care practice relative to those entering  
18          nonprimary care practice through the use of funds  
19          otherwise available for direct graduate medical edu-  
20          cation costs under section 1886(h) of the Social  
21          Security Act.

22          “(2) APPLICATIONS.—

23                 “(A) IN GENERAL.—Each health care  
24                 training consortium desiring to conduct a dem-  
25                 onstration project under this subsection shall

1 prepare and submit to the Secretary an applica-  
2 tion, at such time, in such manner, and con-  
3 taining such information as the Secretary may  
4 require, including an explanation of a plan for  
5 evaluating the project.

6 “(B) APPROVAL OF APPLICATIONS.—A  
7 consortium that submits an application under  
8 subparagraph (A) may begin a demonstration  
9 project under this subsection—

10 “(i) upon approval of such application  
11 by the Secretary; or

12 “(ii) at the end of the 60-day period  
13 beginning on the date such application is  
14 submitted, unless the Secretary denies the  
15 application during such period.

16 “(3) FUNDING FOR DEMONSTRATION  
17 PROJECTS.—

18 “(A) ALLOCATION OF GME FUNDS.—

19 “(i) IN GENERAL.—For each year a  
20 consortium conducts a demonstration  
21 project under this subsection the Secretary  
22 shall pay to such consortium an amount  
23 equal to the total amount available to hos-  
24 pitals that are members of the consortium  
25 under section 1886(h) of the Social Secu-

1 rity Act. The consortium shall designate a  
2 teaching hospital for each resident as-  
3 signed to the consortium which the Sec-  
4 retary shall use to calculate the consor-  
5 tium's payment amount under such sec-  
6 tion. Such teaching hospital shall be the  
7 hospital where the resident receives the  
8 majority of the resident's hospital-based,  
9 nonambulatory training experience.

10 “(ii) USE OF FUNDS.—

11 “(I) TESTING AND EVALUA-  
12 TION.—Each consortium that receives  
13 a payment under clause (i) shall use  
14 such funds to conduct activities which  
15 test and evaluate mechanisms to in-  
16 crease the number and percentage of  
17 medical students entering primary  
18 care practice relative to those entering  
19 nonprimary care practice.

20 “(II) ESTABLISHMENT AND OP-  
21 ERATION.—Each consortium that re-  
22 ceives a payment under clause (i) may  
23 also use such funds for the establish-  
24 ment and operation of the consortium.  
25 The Secretary shall make payments to

1 the consortium through an entity  
2 identified by the consortium as appro-  
3 priate for receiving payment on behalf  
4 of the consortium. The consortium  
5 shall have discretion in determining  
6 the purposes for which such payments  
7 may be used and may direct such pay-  
8 ments to consortium medical schools  
9 for primary care medical student edu-  
10 cation programs.

11 “(B) GRANTS FOR PLANNING AND EVAL-  
12 UATIONS.—

13 “(i) IN GENERAL.—The Secretary  
14 may award grants to consortia conducting  
15 demonstration projects under this sub-  
16 section for the purpose of developing and  
17 evaluating such projects. Each consortium  
18 desiring to receive a grant under this sub-  
19 paragraph shall prepare and submit to the  
20 Secretary an application, at such time, in  
21 such manner, and containing such infor-  
22 mation as the Secretary may require.

23 “(ii) AUTHORIZATION OF APPROPRIA-  
24 TIONS.—There are authorized to be appro-  
25 priated such sums as may be necessary to

1 carry out the purposes of this subpara-  
2 graph for fiscal years 1995 through 2003.

3 “(4) MAINTENANCE OF EFFORT.—Any funds  
4 available for the activities covered by a demonstra-  
5 tion project conducted under this subsection shall  
6 supplement, and shall not supplant, funds that are  
7 expended for similar purposes under any State, re-  
8 gional, or local program.

9 “(c) DURATION.—A demonstration project under this  
10 section shall be conducted for a period not to exceed 8  
11 years. The Secretary may terminate a project if the Sec-  
12 retary determines that the State or consortium conducting  
13 the project is not in substantial compliance with the terms  
14 of the application approved by the Secretary under this  
15 section.

16 “(d) EVALUATIONS AND REPORTS.—

17 “(1) EVALUATIONS.—Each State or consortium  
18 that conducts a demonstration project under this  
19 section shall submit to the Secretary a final evalua-  
20 tion of such project within 360 days of the termi-  
21 nation of such project and such interim evaluations  
22 as the Secretary may require.

23 “(2) REPORTS TO CONGRESS.—Not later than  
24 360 days after the first demonstration project under  
25 this section begins, and annually thereafter for each

1 year in which a project is conducted under this sec-  
2 tion, the Secretary shall submit a report to the ap-  
3 propriate committees of the Congress which evalu-  
4 ates the effectiveness of the demonstration projects  
5 conducted under this section and includes any legis-  
6 lative recommendations determined appropriate by  
7 the Secretary.

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

9 “(1) AMBULATORY TRAINING SITES.—The term  
10 ‘ambulatory training sites’ includes, but is not lim-  
11 ited to, health maintenance organizations, federally  
12 qualified health centers, community health centers,  
13 migrant health centers, rural health clinics, nursing  
14 homes, hospice, and other community-based provid-  
15 ers, including private practices.

16 “(2) HEALTH CARE TRAINING CONSORTIUM.—  
17 The term ‘health care training consortium’ means a  
18 State, regional, or local entity which—

19 “(A) includes teaching hospitals, ambula-  
20 tory training sites, and one or more schools of  
21 medicine located in the same geographic region;  
22 and

23 “(B) is operated in a manner intended to  
24 ensure that by the end of the 8-year demonstra-  
25 tion project at least 50 percent of the graduates

1 of the schools included in the entity will become  
2 primary care providers during the 1-year period  
3 immediately following the date such graduates  
4 complete their residency training.

5 “(3) PRIMARY CARE.—The term ‘primary care’  
6 means family practice, general internal medicine,  
7 and general pediatrics, and may also include obstet-  
8 rics and gynecology if such care is person-centered,  
9 comprehensive care that is not organ or problem  
10 specific.”.

11 **SEC. 512. FUNDING UNDER MEDICARE FOR TRAINING IN**  
12 **NONHOSPITAL-OWNED FACILITIES.**

13 (a) RESIDENCY TRAINING TIME IN NONHOSPITAL-  
14 OWNED FACILITIES COUNTED IN DETERMINING FULL-  
15 TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE  
16 MEDICAL EDUCATION PAYMENTS.—Section  
17 1886(h)(4)(E) of the Social Security Act (42 U.S.C.  
18 1395ww(h)(4)(E)) is amended by striking “, if the hos-  
19 pital incurs all, or substantially all, of the costs for the  
20 training program in that setting”.

21 (b) RESIDENCY TRAINING TIME IN NONHOSPITAL-  
22 OWNED FACILITIES COUNTED IN DETERMINING FULL-  
23 TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL  
24 EDUCATION PAYMENTS.—

1           (1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of  
2 the Social Security Act (42 U.S.C.  
3 1395ww(d)(5)(B)(iv)) is amended to read as follows:

4                   “(iv) In determining such adjustment,  
5 the Secretary shall count interns and resi-  
6 dents—

7                           “(I) assigned to any patient serv-  
8 ice environment which is part of the  
9 hospital’s approved medical residency  
10 training program (as defined in sec-  
11 tion 1886(h)(5)(A)), or

12                           “(II) providing services at any  
13 entity receiving a grant under section  
14 330 of the Public Health Service Act  
15 that is under the ownership or control  
16 of the hospital (if the hospital incurs  
17 all, or substantially all, of the costs of  
18 the services furnished by such interns  
19 and residents),

20 as part of the calculation of the full-time-  
21 equivalent number of interns and resi-  
22 dents.”.

23           (2) ADJUSTMENT OF INDIRECT TEACHING AD-  
24 JUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRAL-  
25 ITY.—Section 1886(d)(5)(B)(ii) of the Social Secu-

1 rity Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amend-  
2 ed to read as follows:

3 “(ii)(I) For purposes of clause (i)(II),  
4 the indirect teaching adjustment factor is  
5 equal to  $1.89 \times (((1+r \times t)$  to the nth  
6 power) – 1).

7 “(II) For purposes of subclause (i)—

8 “(aa) ‘r’ is the ratio of the hos-  
9 pital’s full-time-equivalent interns and  
10 residents to beds;

11 “(bb) ‘t’ is the ratio of the num-  
12 ber of full-time-equivalent interns and  
13 residents of all hospitals paid under  
14 this paragraph and used in the cal-  
15 culation of ‘r’ on June 1, 1993, to the  
16 number of full-time-equivalent interns  
17 and residents of all hospitals paid  
18 under this paragraph and used in the  
19 calculation of ‘r’ on June 1, 1994;  
20 and

21 “(cc) ‘n’ equals .405.’”.

1 **SEC. 513. INCREASE IN NATIONAL HEALTH SERVICE CORPS**  
2 **FUNDING.**

3 (a) GENERAL AUTHORIZATION.—Section 338H(b)(1)  
4 of the Public Health Service Act (42 U.S.C. 254q(b)(1))  
5 is amended—

6 (1) by striking “1991, and” and inserting  
7 “1991,”; and

8 (2) by striking “through 2000” and inserting “,  
9 1993, and 1994, \$120,000,000 for fiscal year 1995,  
10 and such sums as may be necessary for each of the  
11 fiscal years 1996 through 1998”.

12 (b) GRANTS FOR STATE LOAN REPAYMENT PRO-  
13 GRAMS.—Section 338I(i)(1) of such Act (42 U.S.C. 254q-  
14 1(i)(1)) is amended to read as follows:

15 “(1) IN GENERAL.—The Secretary shall ensure  
16 that not less than one-third of the amounts appro-  
17 priated under section 338H(b)(1) for each fiscal  
18 year shall be made available for grants under this  
19 section.”.

20 **SEC. 514. INCREASE IN HEALTH PROFESSIONS FUNDING**  
21 **FOR PRIMARY CARE PHYSICIANS.**

22 (a) FAMILY MEDICINE.—Section 747(d)(1) of the  
23 Public Health Service Act (42 U.S.C. 293k(d)(1)) is  
24 amended by striking “for each of” and all that follows  
25 through “1995” and inserting “for each of the fiscal years  
26 1993 and 1994, \$67,500,000 for fiscal year 1995, and

1 such sums as may be necessary for each of the fiscal years  
2 1996 and 1997”.

3 (b) GENERAL INTERNAL MEDICINE AND PEDIAT-  
4 RICS.—Section 748(c) of the Public Health Service Act  
5 (42 U.S.C. 293l(c)) is amended by striking “for each of”  
6 and all that follows through “1995” and inserting “for  
7 each of the fiscal years 1993 and 1994, \$31,250,000 for  
8 fiscal year 1995, and such sums as may be necessary for  
9 each of the fiscal years 1996 and 1997”.

10 **SEC. 515. HEALTH PROFESSIONS FUNDING FOR NURSE**  
11 **PRACTITIONERS AND PHYSICIAN ASSISTANTS**  
12 **PROGRAMS.**

13 (a) PHYSICIAN ASSISTANTS.—Section 750(d)(1) of  
14 the Public Health Service Act (42 U.S.C. 293n(d)(1)) is  
15 amended by striking “for each of the fiscal years 1993  
16 through 1995” and inserting “for each of the fiscal years  
17 1993 and 1994, \$11,250,000 for fiscal year 1995, and  
18 such sums as may be necessary for each of the fiscal years  
19 1996 and 1997.”.

20 (b) NURSE PRACTITIONERS.—Section 822(d) of such  
21 Act (42 U.S.C. 296m(d)) is amended by striking “1994.”  
22 and inserting “1994, \$25,000,000 for fiscal year 1995,  
23 and such sums as may be necessary for each of the fiscal  
24 years 1996 and 1997”.

1 (c) ADVANCED EDUCATION OR PROFESSIONAL  
2 NURSES.—Section 830(f)(1) of the Public Health Service  
3 Act (42 U.S.C. 297(f)(1)) is amended by striking “for  
4 each of” and all that follows through “1995” and insert-  
5 ing “for each of the fiscal years 1993 and 1994,  
6 \$25,000,000 for fiscal year 1995, and such sums as may  
7 be necessary for each of the fiscal years 1996 and 1997”.

8 (d) SCHOLARSHIP PROGRAM FOR PHYSICIAN ASSIST-  
9 ANTS.—Part C of title VII of the Public Health Service  
10 Act (42 U.S.C. 293j et seq.), as amended by section 511,  
11 is further amended by adding at the end thereof the fol-  
12 lowing new section:

13 **“SEC. 754. PHYSICIAN ASSISTANT SCHOLARSHIP PROGRAM.**

14 “(a) IN GENERAL.—The Secretary may award grants  
15 to public and nonprofit private entities to enable such enti-  
16 ties to meet the cost of providing traineeships for individ-  
17 uals in baccalaureate and advanced-degree programs in  
18 order to educate such individuals to serve in and prepare  
19 for practice as physician assistants.

20 “(b) SPECIAL CONSIDERATION IN MAKING  
21 GRANTS.—In awarding grants for traineeships under sub-  
22 section (a), the Secretary shall give special consideration  
23 to entities submitting applications for the conduct of  
24 traineeship programs that conform to the guidelines estab-  
25 lished by the Secretary under section 750(b)(2).

1       “(c) PREFERENCES IN AWARDING GRANTS.—The  
2 Secretary may award a grant under subsection (a) only  
3 if the grant applicant involved agrees that, in providing  
4 traineeships under such grant, the applicant will give pref-  
5 erence to individuals who are residents of health profes-  
6 sional shortage areas designated under section 332.

7       “(d) USE OF GRANT.—The Secretary may award a  
8 grant under subsection (a) only if the grant applicant in-  
9 volved agrees that traineeships provided with amounts re-  
10 ceived under the grant will pay all or part of the costs  
11 of—

12               “(1) the tuition, books, and fees of the physi-  
13 cian assistants’ program with respect to which the  
14 traineeship is provided; and

15               “(2) amounts necessary to pay the reasonable  
16 living expenses of the individual involved during the  
17 period for which the traineeship is provided.

18       “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
19 purpose of carrying out this section, there are authorized  
20 to be appropriated \$25,000,000 for fiscal year 1995, and  
21 such sums as may be necessary for each of the fiscal years  
22 1996 and 1997.”.

1 **SEC. 516. STATE GRANTS TO INCREASE THE NUMBER OF**  
2 **PRIMARY CARE PROVIDERS.**

3 Part B of title III of the Public Health Service Act  
4 (42 U.S.C. 243 et seq.) is amended by adding at the end  
5 thereof the following new section:

6 **“SEC. 320A. PRIMARY CARE DEMONSTRATION GRANTS.**

7 “(a) AUTHORIZATION.—The Secretary, acting  
8 through the Health Resources and Services Administra-  
9 tion, shall award grants to States or nonprofit entities to  
10 fund not less than 10 demonstration projects to enable  
11 such States or entities to evaluate one or more of the  
12 following:

13 “(1) State mechanisms, including changes in  
14 the scope of practice laws, to enhance the delivery of  
15 primary care by nurse practitioners or physician  
16 assistants.

17 “(2) The feasibility of, and the most effective  
18 means to train subspecialists to deliver primary care  
19 as primary care providers.

20 “(3) State mechanisms to increase the supply  
21 or improve the distribution of primary care provid-  
22 ers.

23 “(b) APPLICATION.—To be eligible to receive a grant  
24 under this section a State or nonprofit entity shall prepare  
25 and submit to the Secretary an application at such time,  
26 in such manner, and containing such information as the

1 Secretary may require. In reviewing such applications, the  
2 Secretary may not consider whether or not a State permits  
3 persons other than licensed physicians to perform legal  
4 abortions, and nothing in this Act or any other Act may  
5 be construed to conflict with any State law or regulation  
6 or program guideline pertaining to the professional quali-  
7 fications required to perform or assist in abortions.

8 “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
9 are authorized to be appropriated to carry out this section,  
10 \$9,000,000 for fiscal year 1995, and such sums as may  
11 be necessary for each of the fiscal years 1996 through  
12 1998.”.

13 **Subtitle C—Programs Relating to**  
14 **Primary and Preventive Care**  
15 **Services**

16 **SEC. 521. MATERNAL AND INFANT CARE COORDINATION.**

17 (a) PURPOSE.—It is the purpose of this section to  
18 assist States in the development and implementation of  
19 coordinated, multidisciplinary, and comprehensive primary  
20 health care and social services, and health and nutrition  
21 education programs, designed to improve maternal and  
22 child health.

23 (b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

24 (1) AUTHORITY.—The Secretary of Health and  
25 Human Services (hereafter referred to in this section

1 as the “Secretary”) is authorized to award grants to  
2 States to enable such States to plan and implement  
3 coordinated, multidisciplinary, and comprehensive  
4 primary health care and social service programs tar-  
5 geted to pregnant women and infants.

6 (2) ELIGIBILITY.—To be eligible to receive a  
7 grant under this section, a State shall—

8 (A) prepare and submit to the Secretary  
9 an application at such time, in such manner,  
10 and containing such information as the Sec-  
11 retary may require;

12 (B) as part of the State application, pro-  
13 vide assurances that under the program estab-  
14 lished with amounts received under a grant, in-  
15 dividuals will have access to a broad range of  
16 primary health care services, social services,  
17 and health and nutrition programs designed to  
18 improve maternal and child health and a de-  
19 scription of how coordination of such services  
20 will improve maternal and child health based  
21 upon the goals of “Healthy People 2000: Na-  
22 tional Health Promotion and Disease Preven-  
23 tion Objectives”;

24 (C) as part of the State application, sub-  
25 mit a plan for the coordination of existing and

1 proposed Federal and State resources, as ap-  
2 propriate, including amounts provided under  
3 the medicaid program under title XIX of the  
4 Social Security Act, the special supplemental  
5 food program under section 17 of the Child Nu-  
6 trition Act of 1966, family planning programs,  
7 substance abuse programs, State maternal and  
8 child health programs funded under title V of  
9 the Social Security Act, community and mi-  
10 grant health center programs under the Public  
11 Health Service Act, and other publicly, or where  
12 practicable, privately supported programs;

13 (D) demonstrate that the major service  
14 providers to be involved, including private non-  
15 profit entities committed to improving maternal  
16 and infant health, are committed to and in-  
17 volved in the program to be funded with  
18 amounts received under the grant;

19 (E) with respect to States with high infant  
20 mortality rates among minority populations,  
21 demonstrate the involvement of major health,  
22 multiservice, professional, or civic group rep-  
23 resentatives of such minority groups in the  
24 planning and implementation of the State pro-  
25 gram; and

1 (F) demonstrate that activities under the  
2 State program are targeted to women of child-  
3 bearing age, particularly those at risk for hav-  
4 ing low birth weight babies.

5 (3) TERM OF GRANT.—A grant awarded under  
6 this subsection shall be for a period of 5 years.

7 (4) USE OF AMOUNTS.—Amounts received by a  
8 State under a grant awarded under this subsection  
9 shall be used to establish a State program to provide  
10 coordinated, multidisciplinary, and comprehensive  
11 primary health care and social services, and health  
12 and nutrition education program services, that are  
13 designed to improve maternal and child health. Such  
14 amounts shall not be used for the construction of  
15 buildings or the purchase of medical equipment.

16 (5) MAINTENANCE OF EFFORT.—Any funds re-  
17 ceived by a State under this subsection shall supple-  
18 ment, and shall not supplant, funds that are ex-  
19 pended for similar purposes by the State.

20 (6) AUTHORIZATION OF APPROPRIATIONS.—  
21 There are authorized to be appropriated such sums  
22 as may be necessary to carry out the purposes of  
23 this subsection for fiscal years 1995 through 1998.

1 **SEC. 522. FRONTIER STATES.**

2 (a) IN GENERAL.—Frontier States (including Alaska,  
3 Wyoming and Montana) may implement proposals to offer  
4 preventive services, including mobile preventive health cen-  
5 ters which may include centers equipped with various pre-  
6 ventive health services, such as mammography, eye care,  
7 X-ray, and other advanced equipment, and which may be  
8 located on aircraft, watercraft, or other forms of transpor-  
9 tation.

10 (b) DEMONSTRATION PROJECTS.—Frontier States  
11 may participate in demonstration projects under this or  
12 any other Act to improve recruitment, retention, and  
13 training of rural providers, including nurse practitioners  
14 and physician assistants. Such demonstration projects  
15 shall give special consideration to the diverse needs of  
16 Frontier States, and shall involve cooperative agreements  
17 with a range of service delivery systems and teaching  
18 hospitals.

19 **Subtitle D—Limitation on Funding**  
20 **for Abortions**

21 **SEC. 531. LIMITATION ON FUNDING FOR ABORTIONS.**

22 (a) IN GENERAL.—Nothing in this title shall be con-  
23 strued to authorize funding for any abortion, except to  
24 prevent the death of the mother.

25 (b) NO REQUIREMENT ON STATE AS A CONDITION  
26 OF FUNDING.—The provision of abortion services by a

1 State or any other entity shall not be regarded as a condi-  
2 tion for participation in any grant or benefit authorized  
3 in this title.

4 **TITLE VI—ADMINISTRATIVE**  
5 **COST SAVINGS**  
6 **Subtitle A—Standardization of**  
7 **Claims Processing**

8 **SEC. 601. ADOPTION OF DATA ELEMENTS, UNIFORM**  
9 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**  
10 **MISSION STANDARDS.**

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

13 (1) Data elements for use in paper and elec-  
14 tronic claims processing under health insurance  
15 plans, as well as for use in utilization review and  
16 management of care (including data fields, formats,  
17 and medical nomenclature, and including plan bene-  
18 fit and insurance information).

19 (2) Uniform claims forms (including uniform  
20 procedure and billing codes for uses with such forms  
21 and including information on other health insurance  
22 plans that may be liable for benefits).

23 (3) Uniform electronic transmission of the data  
24 elements (for purposes of billing and utilization  
25 review).

1 Standards under paragraph (3) relating to electronic  
2 transmission of data elements for claims for services shall  
3 supersede (to the extent specified in such standards) the  
4 standards adopted under paragraph (2) relating to the  
5 submission of paper claims for such services. Standards  
6 under paragraph (3) shall include protections to assure  
7 the confidentiality of patient-specific information and to  
8 protect against the unauthorized use and disclosure of in-  
9 formation.

10 (b) USE OF TASK FORCES.—In adopting standards  
11 under this section—

12 (1) the Secretary shall take into account the  
13 recommendations of current task forces, including at  
14 least the Workgroup on Electronic Data Inter-  
15 change, National Uniform Billing Committee, the  
16 Uniform Claim Task Force, and the Computer-based  
17 Patient Record Institute;

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

22 (3) the Secretary shall, to the maximum extent  
23 practicable, seek to make the standards consistent  
24 with any uniform clinical data sets which have been  
25 adopted and are widely recognized.

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

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

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

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

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

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

22 **SEC. 602. APPLICATION OF STANDARDS.**

23 (a) IN GENERAL.—If the Secretary determines, at  
24 the end of the 2-year period beginning on the date that  
25 standards are adopted under section 601 with respect to

1 classes of services, that a significant number of claims for  
2 benefits for such services under health insurance plans are  
3 not being submitted in accordance with such standards,  
4 the Secretary may require, after notice in the Federal  
5 Register of not less than 6 months, that all providers of  
6 such services must submit claims to health insurance plans  
7 in accordance with such standards. The Secretary may  
8 waive the application of such a requirement in such cases  
9 as the Secretary finds that the imposition of the require-  
10 ment would not be economically practicable.

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

18 (c) APPLICATION OF REQUIREMENT.—

19 (1) IN GENERAL.—If the Secretary imposes the  
20 requirement under subsection (a)—

21 (A) in the case of a requirement that im-  
22 poses the standards relating to electronic trans-  
23 mission of claims for a class of services, each  
24 health care provider that furnishes such services  
25 for which benefits are payable under a health

1 insurance plan shall transmit electronically and  
2 directly to the plan on behalf of the beneficiary  
3 involved a claim for such services in accordance  
4 with such standards;

5 (B) any health insurance plan may reject  
6 any claim subject to the standards adopted  
7 under section 601 but which is not submitted in  
8 accordance with such standards;

9 (C) it is unlawful for a health insurance  
10 plan (i) to reject any such claim on the basis  
11 of the form in which it is submitted if it is sub-  
12 mitted in accordance with such standards or (ii)  
13 to require, for the purpose of utilization review  
14 or as a condition of providing benefits under  
15 the plan, a provider to transmit medical data  
16 elements that are inconsistent with the stand-  
17 ards established under section 601(a)(1); and

18 (D) the Secretary may impose a civil  
19 money penalty on any provider that knowingly  
20 and repeatedly submits claims in violation of  
21 such standards or on any health insurance plan  
22 (other than a health insurance plan described in  
23 paragraph (2)) that knowingly and repeatedly  
24 rejects claims in violation of subparagraph (B),

1           in an amount not to exceed \$100 for each such  
2           claim.

3           The provisions of section 1128A of the Social Secu-  
4           rity Act (other than the first sentence of subsection  
5           (a) and other than subsection (b)) shall apply to a  
6           civil money penalty under subparagraph (D) in the  
7           same manner as such provisions apply to a penalty  
8           or proceeding under section 1128A(a) of such Act.

9           (2) PLANS SUBJECT TO EFFECTIVE STATE REG-  
10          ULATION.—A plan described in this paragraph is a  
11          health insurance plan—

12                 (A) that is subject to regulation by a  
13                 State, and

14                 (B) with respect to which the Secretary  
15                 finds that—

16                         (i) the State provides for application  
17                         of the standards established under section  
18                         601, and

19                         (ii) the State regulatory program pro-  
20                         vides for the appropriate and effective en-  
21                         forcement of such standards.

22          (d) TREATMENT OF REJECTIONS.—If a plan rejects  
23          a claim pursuant to subsection (c)(1), the plan shall per-  
24          mit the person submitting the claim a reasonable oppor-  
25          tunity to resubmit the claim on a form or in an electronic

1 manner that meets the requirements for acceptance of the  
2 claim under such subsection.

3 **SEC. 603. PERIODIC REVIEW AND REVISION OF STAND-**  
4 **ARDS.**

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

6 (1) provide for the ongoing receipt and review  
7 of comments and suggestions for changes in the  
8 standards adopted and promulgated under section  
9 601;

10 (2) establish a schedule for the periodic review  
11 of such standards; and

12 (3) based upon such comments, suggestions,  
13 and review, revise such standards and promulgate  
14 such revisions.

15 (b) APPLICATION OF REVISED STANDARDS.—If the  
16 Secretary under subsection (a) revises the standards de-  
17 scribed in 601, then, in the case of any claim for benefits  
18 submitted under a health insurance plan more than the  
19 minimum period (of not less than 6 months specified by  
20 the Secretary) after the date the revision is promulgated  
21 under subsection (a)(3), such standards shall apply under  
22 section 602 instead of the standards previously promul-  
23 gated.

1 **SEC. 604. HEALTH INSURANCE PLAN DEFINED.**

2 In this title, the term “health insurance plan” has  
3 the meaning given such term in section 101(b)(1) and in-  
4 cludes—

5 (1) the medicare program (under title XVIII of  
6 the Social Security Act) and medicare supplemental  
7 health insurance, and

8 (2) a State medicaid plan (approved under title  
9 XIX of such Act).

10 **Subtitle B—Electronic Medical**  
11 **Data Standards**

12 **SEC. 611. MEDICAL DATA STANDARDS FOR HOSPITALS AND**  
13 **OTHER PROVIDERS.**

14 (a) PROMULGATION OF HOSPITAL DATA STAND-  
15 ARDS.—

16 (1) IN GENERAL.—Between July 1, 1995, and  
17 January 1, 1996, the Secretary shall promulgate  
18 standards described in subsection (b) for hospitals  
19 concerning electronic medical data.

20 (2) REVISION.—The Secretary may from time  
21 to time revise the standards promulgated under this  
22 subsection.

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

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

4           (2) A definition of the set of comprehensive  
5           data elements, which set shall include for hospitals  
6           the standard set of data elements defined under  
7           paragraph (1).

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

12          (4) A specification of, and manner of presen-  
13          tation of, the individual data elements of the sets  
14          and system under this subsection.

15          (5) Standards concerning the transmission of  
16          electronic medical data.

17          (6) Standards relating to confidentiality of pa-  
18          tient-specific information.

19 The standards under this section shall be consistent with  
20 standards for data elements established under section 601.

21          (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-  
22          VIDERS.—

23           (1) IN GENERAL.—The Secretary may promul-  
24           gate standards described in paragraph (2) concern-  
25           ing electronic medical data for providers that are not

1 hospitals. The Secretary may from time to time re-  
2 vise the standards promulgated under this sub-  
3 section.

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

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

11 (1) consult with the American National Stand-  
12 ards Institute, hospitals, with the advisory commis-  
13 sion established under section 615, and with other  
14 affected providers, health insurance plans, and other  
15 interested parties, and

16 (2) take into consideration, in developing stand-  
17 ards under subsection (b)(1), the data set used by  
18 the utilization and quality control peer review pro-  
19 gram under part B of title XI of the Social Security  
20 Act.

21 **SEC. 612. APPLICATION OF ELECTRONIC DATA STANDARDS**  
22 **TO CERTAIN HOSPITALS.**

23 (a) MEDICARE REQUIREMENT FOR SHARING OF  
24 HOSPITAL INFORMATION.—As of January 1, 1996, sub-  
25 ject to paragraph (2), each hospital, as a requirement of

1 each participation agreement under section 1866 of the  
2 Social Security Act, shall—

3 (1) maintain clinical data included in the set of  
4 comprehensive data elements under section  
5 611(b)(2) in electronic form on all inpatients,

6 (2) upon request of the Secretary or of a utili-  
7 zation and quality control peer review organization  
8 (with which the Secretary has entered into a con-  
9 tract under part B of title XI of such Act), transmit  
10 electronically the data set, and

11 (3) upon request of the Secretary, or of a fiscal  
12 intermediary or carrier, transmit electronically any  
13 data (with respect to a claim) from such data set,  
14 in accordance with the standards promulgated under sec-  
15 tion 611(a).

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

17 (1) The Secretary may waive the application of  
18 the requirements of subsection (a) for a hospital  
19 that is a small rural hospital, for such period as the  
20 hospital demonstrates compliance with such require-  
21 ments would constitute an undue financial hardship.

22 (2) The Secretary may waive the application of  
23 the requirements of subsection (a) for a hospital  
24 that is in the process of developing a system to pro-  
25 vide the required data set and executes agreements

1 with its fiscal intermediary and its utilization and  
2 quality control peer review organization that the hos-  
3 pital will meet the requirements of subsection (a) by  
4 a specified date (not later than January 1, 2000).

5 (3) The Secretary may waive the application of  
6 the requirement of subsection (a)(1) for a hospital  
7 that agrees to obtain from its records the data ele-  
8 ments that are needed to meet the requirements of  
9 paragraphs (2) and (3) of subsection (a) and agrees  
10 to subject its data transfer process to a quality as-  
11 surance program specified by the Secretary.

12 (c) APPLICATION TO HOSPITALS OF THE DEPART-  
13 MENT OF VETERANS AFFAIRS.—

14 (1) IN GENERAL.—The Secretary of Veterans  
15 Affairs shall provide that each hospital of the De-  
16 partment of Veterans Affairs shall comply with the  
17 requirements of subsection (a) in the same manner  
18 as such requirements would apply to the hospital if  
19 it were participating in the Medicare program.

20 (2) WAIVER.—The Secretary of Veterans Af-  
21 fairs may waive the application of such requirements  
22 to a hospital in the same manner as the Secretary  
23 of Health and Human Services may waive under  
24 subsection (b) the application of the requirements of  
25 subsection (a).

1 **SEC. 613. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**  
2 **CIES.**

3 (a) IN GENERAL.—Effective January 1, 2000, if a  
4 provider is required under a Federal program to transmit  
5 a data element that is subject to a presentation or trans-  
6 mission standard (as defined in subsection (b)), the head  
7 of the Federal agency responsible for such program (if not  
8 otherwise authorized) is authorized to require the provider  
9 to present and transmit the data element electronically in  
10 accordance with such a standard.

11 (b) PRESENTATION OR TRANSMISSION STANDARD  
12 DEFINED.—In subsection (a), the term “presentation or  
13 transmission standard” means a standard, promulgated  
14 under subsection (b) or (c) of section 611, described in  
15 paragraph (4) or (5) of section 611(b).

16 **SEC. 614. LIMITATION ON DATA REQUIREMENTS WHERE**  
17 **STANDARDS IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data  
19 elements are promulgated under section 611 with respect  
20 to a class of provider, a health insurance plan may not  
21 require, for the purpose of utilization review or as a condi-  
22 tion of providing benefits under the plan, that a provider  
23 in the class—

24 (1) provide any data element not in the set of  
25 comprehensive data elements specified under such  
26 standards, or

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

4           (b) COMPLIANCE.—

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

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

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

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

1 **SEC. 615. ADVISORY COMMISSION.**

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

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

14 (1) the standards established under this sub-  
15 title, and

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

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

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
23 are authorized to be appropriated \$2,000,000 for each of  
24 fiscal years 1995 through 2000 to carry out this section.

1 **Subtitle C—Development and Dis-**  
2 **tribution of Comparative Value**  
3 **Information**

4 **SEC. 621. STATE COMPARATIVE VALUE INFORMATION PRO-**  
5 **GRAMS FOR HEALTH CARE PURCHASING.**

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

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

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

23 (2) The information contained in such systems  
24 covers at least the average prices of common health  
25 care services (as defined in subsection (d)) and

1 health insurance plans, and, where available, meas-  
2 ures of the variability of these prices within a State  
3 or other market areas.

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

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

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

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

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

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

5 (2) OFFSET AUTHORITY.—If, at any time with-  
6 in the 3-year period following the receipt by a State  
7 of a grant under this subsection, the Secretary is re-  
8 quired by section 622 to implement a health care in-  
9 formation program in the State, the Secretary may  
10 recover the amount of the grant under this sub-  
11 section by offset against any other amount payable  
12 to the State under the Social Security Act. The  
13 amount of the offset shall be made available (from  
14 the appropriation account with respect to which the  
15 offset was taken) to the Secretary to carry out such  
16 section.

17 (3) AUTHORIZATION OF APPROPRIATIONS.—  
18 There are authorized to be appropriated such sums  
19 as are necessary to make grants under this sub-  
20 section, to remain available until expended.

21 (d) COMMON HEALTH CARE SERVICES DEFINED.—  
22 In this section, the term “common health care services”  
23 includes such procedures as the Secretary may specify and  
24 any additional health care services which a State may wish  
25 to include in its comparative value information program.

1 (e) STATE DEFINED.—In this title, the term “State”  
2 includes the District of Columbia, Puerto Rico, the Virgin  
3 Islands, Guam, and American Samoa.

4 **SEC. 622. FEDERAL IMPLEMENTATION.**

5 (a) IN GENERAL.—If the Secretary finds, at any  
6 time, that a State has failed to develop or to continue to  
7 implement a health care value information program in ac-  
8 cordance with the criteria and schedule in section 621(b),  
9 the Secretary shall take the actions necessary, directly or  
10 through grants or contract, to implement a comparable  
11 program in the State.

12 (b) FEES.—Fees may be charged by the Secretary  
13 for the information materials provided pursuant to a pro-  
14 gram under this section. Any amounts so collected shall  
15 be deposited in the appropriation account from which the  
16 Secretary’s costs of providing such materials were met,  
17 and shall remain available for such purposes until  
18 expended.

19 **SEC. 623. COMPARATIVE VALUE INFORMATION CONCERN-**  
20 **ING FEDERAL PROGRAMS.**

21 (a) DEVELOPMENT.—The head of each Federal agen-  
22 cy with responsibility for the provision of health insurance  
23 or of health care services to individuals shall promptly de-  
24 velop health care value information relating to each pro-  
25 gram that such head administers and covering the same

1 types of data that a State program meeting the criteria  
2 of section 621(b) would provide.

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

6 **Subtitle D—Preemption of State**  
7 **Quill Pen Laws**

8 **SEC. 631. PREEMPTION OF STATE QUILL PEN LAWS.**

9 (a) IN GENERAL.—Effective January 1, 1996, no ef-  
10 fect shall be given to any provision of State law that re-  
11 quires medical or health insurance records (including bill-  
12 ing information) to be maintained in written, rather than  
13 electronic form.

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

1       **TITLE VIII—ANTI-FRAUD AND**  
2                   **ANTI-RATIONING**  
3       **Subtitle A—Criminal Prosecution**  
4                   **of Health Care Fraud**

5       **SEC. 701. PENALTIES FOR HEALTH CARE FRAUD.**

6           (a) IN GENERAL.—Chapter 63 of title 18, United  
7 States Code, is amended by adding at the end the  
8 following:

9       **“§ 1347. Health care fraud**

10           “(a) OFFENSE.—Whoever, being a health care pro-  
11 vider, knowingly engages in any scheme or artifice to de-  
12 fraud any person in connection with the provision of  
13 health care shall be fined under this title or imprisoned  
14 not more than 5 years, or both.

15           “(b) DEFINITION.—In this section, the term ‘health  
16 care provider’ means—

17                   “(1) a physician, nurse, dentist, therapist, phar-  
18 macist, or other professional provider of health care;  
19 and

20                   “(2) a hospital, health maintenance organiza-  
21 tion, pharmacy, laboratory, clinic, or other health  
22 care facility or a provider of medical services, medi-  
23 cal devices, medical equipment, or other medical  
24 supplies.

1 (b) CLERICAL AMENDMENT.—The table of sections  
2 at the beginning of chapter 63 of title 18, United States  
3 Code, is amended by adding at the end the following new  
4 item:

“1347. Health care fraud.”.

5 **SEC. 702. REWARDS FOR INFORMATION LEADING TO PROS-**  
6 **ECUTION AND CONVICTION.**

7 Section 3059 of title 18, United States Code, is  
8 amended by adding at the end the following new sub-  
9 section:

10 “(c)(1) In special circumstances and in the Attorney  
11 General’s sole discretion, the Attorney General may make  
12 a payment of up to \$10,000 to a person who furnishes  
13 information unknown to the Government relating to a pos-  
14 sible prosecution under section 1101.

15 “(2) A person is not eligible for a payment under  
16 paragraph (1) if—

17 “(A) the person is a current or former officer  
18 or employee of a Federal or State government agen-  
19 cy or instrumentality who furnishes information dis-  
20 covered or gathered in the course of government em-  
21 ployment;

22 “(B) the person knowingly participated in the  
23 offense;

1           “(C) the information furnished by the person  
2 consists of allegations or transactions that have been  
3 disclosed to the public—

4           “(i) in a criminal, civil, or administrative  
5 proceeding;

6           “(ii) in a congressional, administrative or  
7 General Accounting Office report, hearing,  
8 audit, or investigation; or

9           “(iii) by the news media, unless the person  
10 is the original source of the information; or

11          “(D) when, in the judgment of the Attorney  
12 General, it appears that a person whose illegal ac-  
13 tivities are being prosecuted or investigated could  
14 benefit from the award.

15          “(3) For the purposes of paragraph (2)(C)(iii), the  
16 term ‘original source’ means a person who has direct and  
17 independent knowledge of the information that is fur-  
18 nished and has voluntarily provided the information to the  
19 Government prior to disclosure by the news media.

20          “(4) Neither the failure of the Attorney General to  
21 authorize a payment under paragraph (1) nor the amount  
22 authorized shall be subject to judicial review.”.

1 **Subtitle B—Coordination of Health**  
2 **Care Anti-Fraud and Abuse Ac-**  
3 **tivities**

4 **SEC. 711. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**  
5 **AND ABUSE SANCTIONS TO ALL FRAUD AND**  
6 **ABUSE AGAINST ANY HEALTH INSURANCE**  
7 **PLAN.**

8 (a) CIVIL MONETARY PENALTIES.—Section 1128A  
9 of the Social Security Act (42 U.S.C. 1320a–7a) is amend-  
10 ed as follows:

11 (1) In subsection (a)(1), in the matter before  
12 subparagraph (A), by inserting “or of any health in-  
13 surance plan,” after “subsection (i)(1),”.

14 (2) In subsection (b)(1)(A), by inserting “or  
15 under a health insurance plan” after “title XIX”.

16 (3) In subsection (f)—

17 (A) by redesignating paragraph (3) as  
18 paragraph (4); and

19 (B) by inserting after paragraph (2) the  
20 following new paragraph:

21 “(3) With respect to amounts recovered arising  
22 out of a claim under a health insurance plan, the  
23 portion of such amounts as is determined to have  
24 been paid by the plan shall be repaid to the plan.”.

25 (4) In subsection (i)—

1 (A) in paragraph (2), by inserting “or  
2 under a health insurance plan” before the pe-  
3 riod at the end, and

4 (B) in paragraph (5), by inserting “or  
5 under a health insurance plan” after “or XX”.

6 (b) CRIMES.—

7 (1) SOCIAL SECURITY ACT.—Section 1128B of  
8 such Act (42 U.S.C. 1320a-7b) is amended as  
9 follows:

10 (A) In the heading, by adding at the end  
11 the following: “OR HEALTH INSURANCE PLANS”.

12 (B) In subsection (a)(1)—

13 (i) by striking “title XVIII or” and  
14 inserting “title XVIII,”, and

15 (ii) by adding at the end the follow-  
16 ing: “or a health insurance plan (as de-  
17 fined in section 1128(i)),”.

18 (C) In subsection (a)(5), by striking “title  
19 XVIII or a State health care program” and in-  
20 serting “title XVIII, a State health care pro-  
21 gram, or a health insurance plan”.

22 (D) In the second sentence of subsection  
23 (a)—

1 (i) by inserting after “title XIX” the  
2 following: “or a health insurance plan”,  
3 and

4 (ii) by inserting after “the State” the  
5 following: “or the plan”.

6 (E) In subsection (b)(1), by striking “title  
7 XVIII or a State health care program” each  
8 place it appears and inserting “title XVIII, a  
9 State health care program, or a health insur-  
10 ance plan”.

11 (F) In subsection (b)(2), by striking “title  
12 XVIII or a State health care program” each  
13 place it appears and inserting “title XVIII, a  
14 State health care program, or a health insur-  
15 ance plan”.

16 (G) In subsection (b)(3), by striking “title  
17 XVIII or a State health care program” each  
18 place it appears in subparagraphs (A) and (C)  
19 and inserting “title XVIII, a State health care  
20 program, or a health insurance plan”.

21 (H) In subsection (d)(2)—

22 (i) by striking “title XIX,” and insert-  
23 ing “title XIX or under a health insurance  
24 plan,” and

1                   (ii) by striking “State plan,” and in-  
2                   serting “State plan or the health insurance  
3                   plan,”.

4                   (2) TREBLE DAMAGES FOR CRIMINAL SANC-  
5                   TIONS.—Section 1128B of such Act (42 U.S.C.  
6                   1320a–7b) is amended by adding at the end the fol-  
7                   lowing new subsection:

8                   “(f) In addition to the fines that may be imposed  
9                   under subsection (a), (b), or (c), any individual found to  
10                  have violated the provisions of any of such subsections  
11                  may be subject to treble damages.”.

12                  (3) IDENTIFICATION OF COMMUNITY SERVICE  
13                  OPPORTUNITIES.—Section 1128B of such Act (42  
14                  U.S.C. 1320a–7b) is further amended by adding at  
15                  the end the following new subsection:

16                  “(g) The Secretary shall—

17                         “(1) in consultation with State and local health  
18                         care officials, identify opportunities for the satisfac-  
19                         tion of community service obligations that a court  
20                         may impose upon the conviction of an offense under  
21                         this section, and

22                         “(2) make information concerning such oppor-  
23                         tunities available to Federal and State law enforce-  
24                         ment officers and State and local health care offi-  
25                         cials.”.

1 (c) HEALTH INSURANCE PLAN DEFINED.—Section  
2 1128 of such Act (42 U.S.C. 1320a-7) is amended by re-  
3 designating subsection (i) as subsection (j) and by insert-  
4 ing after subsection (h) the following new subsection:

5 “(i) HEALTH INSURANCE PLAN DEFINED.—For pur-  
6 poses of sections 1128A and 1128B, the term ‘health in-  
7 surance plan’ means a health insurance program other  
8 than the medicare program, the medicaid program, or a  
9 State health care program.”.

10 (d) CONFORMING AMENDMENT.—Section  
11 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a-  
12 7(b)(8)(B)(ii)) is amended by striking “1128A” and in-  
13 serting “1128A (other than a penalty arising from a  
14 health insurance plan, as defined in subsection (i))”.

15 (e) EFFECTIVE DATE.—The amendments made by  
16 this section shall take effect January 1, 1995.

17 **Subtitle C—Protection Against**  
18 **Rationing of Treatment**

19 **SEC. 721. PROHIBITION ON DENIAL OR TREATMENT BASED**  
20 **ON AGE, DISABILITY, DEGREE OF MEDICAL**  
21 **NEED, OR QUALITY OF LIFE.**

22 No health care provider or health insurance plan may  
23 deny medical treatment, or insurance coverage of medical  
24 treatment, that a patient is otherwise qualified to receive,  
25 against the wishes of a patient, or if the patient is incom-

1 petent, against the wishes of the patient's guardian, on  
 2 the basis of the patient's present or predicted age, disabil-  
 3 ity, degree of medical need, or quality of life.

4 **SEC. 722. ENFORCEMENT.**

5       The remedies and procedures set forth in subsections  
 6 (a) and (b) of Civil Rights Act of 1964 (42 U.S.C. 2000a-  
 7 3) are the remedies and procedures available under this  
 8 subtitle to nay person who is being subjected to denial of  
 9 medical treatment or denial of insurance coverage for  
 10 medical treatment, or who has reasonable grounds for be-  
 11 lieving that such person is about to be subjected to such  
 12 denial, in violation of this subtitle. A person who has been  
 13 subjected to such denial in violation of this subtitle, or  
 14 if that person has died, a person who would be entitled  
 15 to bring a cause of action for the dead person's wrongful  
 16 death under the laws of the State in which the denial of  
 17 treatment occurred, may also obtain damages, including  
 18 reasonable and appropriate punitive damages.

○

HR 4202 IH—2

HR 4202 IH—3

HR 4202 IH—4

HR 4202 IH—5

HR 4202 IH—6

HR 4202 IH—7

HR 4202 IH—8  
HR 4202 IH—9  
HR 4202 IH—10  
HR 4202 IH—11  
HR 4202 IH—12  
HR 4202 IH—13  
HR 4202 IH—14  
HR 4202 IH—15  
HR 4202 IH—16  
HR 4202 IH—17  
HR 4202 IH—18  
HR 4202 IH—19  
HR 4202 IH—20  
HR 4202 IH—21  
HR 4202 IH—22  
HR 4202 IH—23  
HR 4202 IH—24