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103D CONGRESS
2D SESSION

H. R. 4469

To restrain health care costs and ensure adequate medical care for all Americans by providing for a State and market-based system of choice among qualified health plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 1994

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

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A BILL

To restrain health care costs and ensure adequate medical care for all Americans by providing for a State and market-based system of choice among qualified health plans, and for other purposes.

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

SECTION 1. SHORT TITLES; TABLE OF CONTENTS.

(a) SHORT TITLES.—This Act may be cited as the ''Multiple Choice Health Care Act of 1994'' or the ''Multicare Act of 1994''.

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

SEC. 2. GOALS AND STRATEGIES.

(a) GOALS.—The goals of this Act are—

(1) to restrain health care price inflation through market incentives and competition,

(2) to ensure adequate medical care for all Americans,

(3) to distribute Federal health subsidies more fairly across the population,

(4) to allow meaningful consumer choice among health care plans and providers,

(5) to allow States flexibility to tailor health programs to local needs, and

(6) to accomplish these goals at no added cost to taxpayers.

(b) STRATEGIES.—The strategies to be used in this Act to achieve these goals are—

(1) to increase the role and flexibility of State and local governments in providing health care information to consumers, in ensuring health care for the needy, and in promoting competition among health plans,

(2) to replace the current tax exemption for employer-paid insurance with a payment towards health care premiums for all Americans,

(3) to increase public-private partnership by allowing individuals in public programs to meet their health care needs through the purchase of private health insurance,

(4) to reduce the amount of direct regulation of health care providers, and

(5) to allow individuals to participate in open enrollment health plans.

SEC. 3. GENERAL DEFINITIONS.

In this Act:

(1) The term ''acute care services'' means such services, identified by the Secretary, of the type covered under multicare plans.

(2) The term ''eligible individual'' means, with respect to a State, an individual—

(A) who is a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien otherwise lawfully residing permanently in the United States under color of law, and

(B) who is a resident of the State (as defined by the Secretary).

(3) The term ''exempt individual'' means an individual who—

(A) is entitled to benefits under part A or part B of title XVIII of the Social Security Act);

(B) is entitled to medicare and dental care under section 1074(a) of title 10, United States Code; or

(C) is a member on active duty (as defined in section 101(22) of such title) of the armed forces of the United States.

(4) The term ''family income'' means the total value of income of the individual and the individual's family members (as defined by the Secretary), as defined by the State in which the individual resides and includes at least—

(A) cash income,

(B) aid under title IV of the Social Security Act (relating to the aid to families with dependent children program) and assistance received under title XVI of such Act,

(C) the value of State or Federal housing assistance (as determined by the State),

(D) the cash value of food stamps,

(E) general relief, and

(F) other State and local cash welfare payment.

(5) The term ''Federal official poverty level'' means the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(6) The term ''medicaid eligible individual'' means an individual who is entitled to medical assistance under a State medicaid plan, or would be so eligible but for the election of a State under section 101(c)(1)(A).

(7) The terms ''medicaid opt-out State'' and ''medicaid opt-in State'' mean a State that in its multicare program has elected the option described in section 101(c)(1)(A) or in section 101(c)(1)(B), respectively.

(8) The term ''multicare plan'' means a health benefits plan which is determined to meet the requirements of title II, and includes a health benefit plan in which an individual is enrolled under chapter 89 of title 5, United States Code, if the plan participates in a reinsurance system that meets the requirements of section 108.

(9) The term ''near poor individual'' means an individual whose family income is greater than 100 percent, but does not exceed 150 percent, of the

Federal official poverty level applicable to a family of the size involved.

(10) The term ''open enrollment multicare plan'' means a multicare plan offered in an area of a State that permits all eligible residents of the area to enroll under the plan.

(11) The term ''poor individual'' means an individual whose family income does not exceed the Federal official poverty level applicable to a family of the size involved.

(12) The term ''Secretary'' means the Secretary of Health and Human Services.

(13) The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term ''State medicaid plan'' means the plan of a State approved under title XIX of the Social Security Act, and includes a statewide medical assistance plan operating under section 1115 of such Act.

(15) The term ''State multicare program'' means such a program that the Secretary finds meets the requirements of title I.

TITLE I—ESTABLISHMENT OF STATE MULTICARE PROGRAMS; TAX CHANGES

Subtitle A—Establishment of State Multicare Programs

SEC. 101. GRANTS TO STATES FOR STATE MULTICARE PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide grants to each State to establish a State multicare program for the offering of competing multicare plans in the State.

(b) GRANT APPLICATION.—No grant may be made under this section to a State unless—

(1) the State has submitted an application in such form and manner as the Secretary shall specify, and

(2) the Secretary determines that the application provides for the operation of a State multicare program that meets the requirements of the succeeding sections of this title.

(c) AMOUNT OF GRANT.—

(1) BASE AMOUNT.—For any State, subject to the succeeding provisions of this subsection, the amount of a grant under this section, with respect to each eligible individual (other than an exempt in-

dividual) enrolled in a multicare plan, is equal to the Federal contribution amount (determined under section 121) for the class of enrollment involved.

(2) SUPPLEMENTAL PAYMENT TO STATES.—The amount of such a grant shall be increased, with respect to each eligible individual (other than an exempt individual) who is not enrolled in a multicare plan, by an amount equal to the amount that would have been paid under paragraph (1) if the individual were enrolled in a multicare plan.

(3) ADDITIONAL AMOUNTS.—The amount of such a grant shall be further increased by the sum of the following:

(A) MEDICAID SAVINGS.—

(i) IN GENERAL.—The amount described in clause (ii) for the State, increased (for each year after the last full year referred to in clause (ii)(I), up to the year involved) by the applicable inflator (specified in section 107(b)(2)(D)) for the year, and subject to any adjustment for changes in population under section 107(b)(4).

(ii) AMOUNT DESCRIBED.—The amount described in this clause for a State is—

(I) the total amount of Federal payments made to the State under section 1903(a) of the Social Security Act for acute care services during the last full year prior to the implementation of a State multicare program in the State, reduced by

(II) the product of $400 and the average number of individuals entitled to assistance for such services under the medicaid program in the State during that year.

(B) CASH ASSISTANCE SAVINGS.—The total amount of the reductions in Federal payments under title IV or XVI of the Social Security Act, the Food Stamp Act, and other Federal welfare programs for residents of a State resulting directly from the implementation of the financial assistance provided under section 107 as a substitute for medical assistance for acute care services under the State medicaid plan.

(d) USE OF FUNDS.—

(1) USE OF BASE AMOUNTS.—At least 97 percent of the funds provided to a State under subsection (c)(1) with respect to enrollment of an eligible individual shall be used only, in accordance with section 106, for payment of all or a portion of the premium for enrollment of such an eligible individual in a multicare plan under the multicare program.

(2) USE OF FEDERAL SUPPLEMENTAL AMOUNTS.—At least 97 percent of the funds provided to the State under subsection (c)(2) shall be used only towards—

(A) financing the State reinsurance mechanism under section 108, or

(B) providing additional subsidies for poor and near poor individuals under section 107.

(3) USE OF ADDITIONAL AMOUNTS FOR FINANCIAL ASSISTANCE.—At least 97 percent of the funds provided to the State under subsection (c)(3) shall be used only for additional financial assistance for poor and near poor individuals under section 107.

(4) APPLICATION TOWARD ADMINISTRATIVE COSTS.—

(A) IN GENERAL.—Except as provided in the previous paragraphs, Federal grant funds

may only be used to finance administrative costs.

(B) ADMINISTRATIVE COSTS.—In this paragraph, the term ''administrative costs'' includes costs associated with—

(i) soliciting bids and negotiating with multicare plans and certifying compliance of plans with the requirements of title II,

(ii) preparing and disseminating comparative value information on multicare plans,

(iii) planning, developing, and implementing the process for enrollment of eligible individuals in multicare plans, and

(iv) establishing and administering the reinsurance mechanism under section 108 (not including reinsurance payments made under such a mechanism).

(5) REQUIRED USE OF STATE SUPPLEMENTAL FUNDS.—

(A) IN GENERAL.—Each State multicare program shall assure that—

(i) at least 97 percent of the funds described in subparagraph (C) are used towards—

(I) financing the State reinsurance mechanism under section 108, or

(II) providing additional subsidies for poor and near poor individuals under section 107, and

(ii) at least 97 percent of the funds described in section 107(b)(5) (relating to State welfare savings) are used towards providing additional subsidies for poor and near poor individuals under section 107.

(B) STATE SUPPLEMENTAL FUNDS DESCRIBED.—The funds described in this subparagraph are the amount by which (i) the State aggregate contribution amount (described in section 106(b)(2)), exceeds (ii) the aggregate amounts of the contributions paid by the State under section 106(b)(1)(B) (determined as if the reference to ''97 percent'' in such section were a reference to ''100 percent'').

(e) SPECIAL RULES FOR TERRITORIES.—The Secretary may establish such special rules as may be appropriate to adapt the provisions of this title (and titles II and III) in the case of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 102. REQUIREMENT FOR CERTIFICATION OF MULTICARE PLANS.

(a) PROCESS.—

(1) IN GENERAL.—Each State multicare program shall provide a mechanism for certifying at least 2 competing open enrollment multicare plans in all areas of the State.

(2) WAIVER AUTHORITY.—The Secretary may waive the requirement of paragraph (1) that a State multicare program offer more than 1 open enrollment multicare plan in all areas of a State if the Secretary finds that a single, coordinated open enrollment multicare plan would be more cost-effective.

(b) REQUIREMENTS FOR CERTIFICATION.—A program shall not certify a multicare plan for purposes of subsection (a) unless the program determines that the plan—

(1) is in compliance with the requirements of title II (including requirements relating to consumer education and assistance and consumer rights) and other Federal health care regulations, and

(2) meets such standards as the program or the Secretary may establish relating to financial solvency and quality of care.

(c) TREATMENT OF MULTI-STATE REGIONS.—The State multicare programs of one or more adjacent States

may establish agreements, consistent with the requirements of this Act, governing the certification and operation of multicare plans that enroll individuals residing in an area that includes portions of such States.

(d) GENERAL AUTHORITY OF STATES.—Nothing in this Act shall be construed as preventing a State—

(1) from sponsoring a multicare plan,

(2) from requiring individuals to select enrollment under the plan,

(3) from providing additional subsidies for individuals selecting such a plan, or

(4) from requiring employers to provide for payment of multicare premiums of employees through automatic payroll deductions.

(e) TREATMENT OF FEHBP PLANS.—Nothing in this title (other than section 108) shall be construed as authorizing a State to regulate health plans offered under the Federal Employees Health Benefits Program, under chapter 89, of title 5, United States Code.

SEC. 103. REQUIREMENT FOR ENROLLMENT PROCESS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each State multicare program—

(A) shall provide a mechanism for the enrollment, during open season periods, of eligible

individuals (other than exempt individuals) who are residents of the State in multicare plans, and

(B) may require each eligible individual (other than such an exempt individual or an individual described in paragraph (2)) residing in the State to be enrolled in a multicare plan and may require that such a plan be a multicare plan operated directly by the program.

(2) EXCEPTION.—A State may, at its option, except from the requirement described in paragraph (1)(B) any of the following:

(A) An individual who is within a class of individuals eligible for health care benefits from the Department of Veterans Affairs.

(B) An individual who is incarcerated.

(C) An individual who is within any other class of individuals with respect to whom the State determines that members of the class are likely to have health care coverage reasonably comparable to the coverage available through enrollment in a multicare plan.

(b) PERMITTING CLOSED ENROLLMENT PLANS.—

(1) IN GENERAL.—A State multicare program may not deny approval of a plan (such as an em-

ployer self-insured plan or a plan based on an association with or membership in a group) as a multicare plan because the plan is not an open enrollment multicare plan and limits enrollment to individuals associated with an employer or association.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as waiving the requirement under section 204 that a multicare plan participate in a reinsurance system (established under the State multicare program under section 108 or by the Secretary under section 301 or 331).

(c) DISTRIBUTION OF COMPARATIVE VALUE INFORMATION.—

(1) IN GENERAL.—Each State multicare program shall provide for the distribution to eligible individuals of comparative value information. Such program may require that the information conform to the national standards established under paragraph (3).

(2) CONTENTS.—The comparative value information shall include, with respect to each multicare plan offered, information on—

(A) benefits, premiums costs, and patient cost-sharing arrangements (including projected annual costs for medium-risk individuals), and

(B) indicators of the quality of health care offered under the plan.

(3) STANDARDS.—The Secretary shall establish national standards for the collection and distribution of comparative value information.

(d) USE OF EMPLOYERS.—A State multicare program may require employers to distribute the comparative value information concerning multicare plans to employees and to require automatic payroll deductions for payment of premiums for such plans by such employees.

SEC. 104. SUGGESTIVE LIST OF MULTICARE SERVICES; LIMITS ON COST-SHARING; TREATMENT PRACTICE GUIDELINES.

(a) MULTICARE SERVICES.—

(1) NATIONAL SUGGESTED LIST.—The Secretary shall develop a national list of services which may be covered by a multicare plan. Such list shall include those services identified as cost-effective by the Secretary.

(2) STATE SUGGESTED LIST.—

(A) ESTABLISHMENT.—Each State multicare program shall establish a State-specific list of covered health care services. Such list may, but need not, include the services in-

cluded in the national standard list developed under paragraph (1).

(B) LIMITATIONS.—A State multicare program may, with respect to a covered service, limit the amount, duration, or scope of the service to be included in the list of services.

(b) CATASTROPHIC PROTECTION.—A State multicare program may decrease, under section 203(e)(2)(C) or otherwise, the amount of the cost-sharing limit otherwise permitted under multicare plans.

(c) SUGGESTED TREATMENT PRACTICE GUIDELINES.—The Secretary shall publish and distribute treatment practice guidelines for use by multicare plans under State multicare programs.

SEC. 105. CONTINUITY OF COVERAGE.

(a) PROCESS.—Each State multicare program shall establish procedures, including procedures for administering changes in enrollment in cases of changes in area of residence, employment, and family status, to ensure for eligible individuals residing in each State continuity of coverage under a multicare plan.

(b) GUARANTEED ISSUANCE AND PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.—In addition, each State multicare program shall establish procedures to ensure—

(1) the multicare plans do not deny coverage to any eligible individual, and

(2) multicare plans do not exclude coverage on the basis of preexisting conditions.

SEC. 106. CONTRIBUTION TOWARD PREMIUM COSTS FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Each State multicare program shall provide, for each eligible individual (other than an exempt individual) enrolled in a multicare plan under the program for a contribution toward the premium cost of such enrollment.

(b) AMOUNT OF CONTRIBUTION.—

(1) IN GENERAL.—The amount of the contribution under subsection (a) with respect to an eligible individual is equal to the sum of—

(A) not less than 97 percent of the funds provided to a State under section 101(d)(1) with respect to enrollment of the eligible individual, and

(B) not less than 97 percent of the amount specified under paragraph (2) with respect to the enrollment of the individual.

Except as the Secretary may otherwise permit, such contribution shall be provided on a monthly basis.

(2) STATE CONTRIBUTION AMOUNT.—

(A) INITIAL AMOUNT.—

(i) IN GENERAL.—Subject to subparagraph (C), the State aggregate contribution amount for a year is equal to—

(I) the total amount of available funds (determined under clause (ii)) for the year, divided by

(II) the average number of individuals described in clause (iii) for the year.

(ii) FUNDS AVAILABLE.—The total amount of available funds for a year is equal to the increase in all State revenues (including employment-related excise taxes) effected as a result of section 111 and the amendment made by section 123.

(iii) INDIVIDUALS DESCRIBED.—The number of individuals described in this clause for a year is the estimated total average population of the State in the year, less the sum of the average number of exempt individuals (as defined in section 121(d)) in the State in the year.

(B) APPLICATION BY ENROLLMENT CLASS.—The State shall adjust the State aggre-

gate contribution amount determined under this section among enrollment classes established under section 121(c)(1) in the same manner as the Secretary provides for adjustment of the Federal contribution amount among such classes under section 121(c)(2).

SEC. 107. ADDITIONAL SUBSIDIES FOR POOR AND NEAR POOR INDIVIDUALS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each State multicare program shall include a mechanism for providing additional financial assistance, consistent with this section, to poor individuals and near poor individuals (as defined in section 3) to assist them in purchasing coverage under multicare plans.

(2) INCOME DETERMINATIONS.—Each such program is responsible for making income determinations necessary to determine if individuals are poor or near poor individuals.

(b) MAINTENANCE OF EFFORT REQUIRED.—

(1) IN GENERAL.—The financial assistance provided under this section shall not be less than the maintenance-of-effort level described in paragraph (2).

(2) MAINTENANCE-OF-EFFORT LEVEL.—Subject to paragraphs (4) and (5), for a State for a year, the ''maintenance-of-effort level'' described in this subparagraph is equal to—

(A) the total amount of expenditures made under the State medicaid plan (net of any Federal payments under section 1903(a) of the Social Security Act) during the last full year prior to the implementation of a State multicare program in the State for acute care services, increased

(B) for each subsequent year (up to the year involved) by the applicable inflator (specified in paragraph (3)) for the year.

Expenditures under paragraph (A) shall include payments to disproportionate share hospitals under section 1923 of the Social Security Act.

(3) APPLICABLE INFLATOR.—For purposes of paragraph (1)(B), the applicable inflator for a year is the lesser of—

(A) the rate of health care inflation for the year, as determined by the Secretary, or

(B) the percentage increase in the consumer price index for all urban consumers

(all items; U.S. city average) for the year (as specified by the Secretary), plus—

(i) for the first year in which the State multicare program is implemented, 3 percentage points,

(ii) for the second such year, 2.5 percentage points,

(iii) for the third such year, 2.0 percentage points,

(iv) for the fourth such year, 1.5 percentage points,

(v) for the fifth such year, 1.0 percentage points,

(vi) for the sixth such year 0.5 percentage points, and

(vii) for any subsequent year, 0 percentage points.

(4) ADJUSTMENT TO REFLECT CHANGES IN POPULATION.—The Secretary may adjust the maintenance-of-effort level of a State to reflect changes in the population of poor and near poor individuals in the State between the year described in paragraph (2)(A) and the year involved.

(5) STATE SAVINGS FROM WELFARE PROGRAMS.—The maintenance-of-effort level for a State

shall be increased by the total amount of the reductions in State payments under title IV or XVI of the Social Security Act, the Food Stamp Act, and other Federal welfare programs (net of any Federal payments) for residents of a State resulting directly from the implementation of the financial assistance provided under this section as a substitute for medical assistance for acute care services under the State medicaid plan.

(c) MEDICAID REVISIONS.—Notwithstanding any other provision of law—

(1) a State may deny medical assistance for acute care services under its State medicaid plan to any poor or near poor individual who is eligible to enroll under a multicare plan and for whom additional financial assistance is made available under this section; and

(2) no Federal financial participation is allowable under section 1903(a) of the Social Security Act for expenditures relating to acute care services to any poor or near poor individual who is eligible to enroll under a multicare plan and for whom additional financial assistance is made available under this section.

Expenditures under paragraph (2) shall include payments to disproportionate share hospitals under section 1923 of the Social Security Act.

(d) SPECIFIC LIMITATIONS ON COST-SHARING.—

(1) SLIDING SCALE.—The premiums and cost-sharing imposed under the lowest cost multicare plans for poor and near poor individuals shall be determined on a sliding scale based on the family income of an individual.

(2) MAXIMUM LEVEL.—Such premiums and cost-sharing may not exceed—

(A) in the case of a poor individual, 5 percent of the individual's family income, and

(B) in the case of a near-poor individual, 5 percent of the Federal official poverty level (applicable to a family of the size involved) plus 10 percent of the amount by which the individual's family income exceeds such poverty level.

SEC. 108. ESTABLISHMENT OF REINSURANCE MECHANISM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Each State multicare program shall include a reinsurance mechanism for high risk individuals enrolled (or enrolling) in multicare plans offered in the State.

(2) GOVERNANCE.—The mechanism shall be governed by a commission appointed by the chief executive officer of the State. The membership of the commission shall include such officer (or the officer's designee) and representatives of plan sponsors, major providers, labor, consumers, State governments, and the business community.

(b) REQUIREMENTS.—The mechanism under this section shall require all multicare plans—

(1) to pay into a common fund for each below-average-risk individual an amount related to the degree to which the individual's risk is below the average risk, and

(2) to receive from the common fund for each above-average-risk individual an amount related to the degree to which the individual's risk is above the average risk.

The mechanism may not use the fact that a plan is a below-average-cost plan as an indicator that the plan serves below-average-risk individuals.

(c) OPTIONS.—

(1) STOP-LOSS.—The mechanism also may provide for additional payments from the common fund to multicare plans for individuals whose costs exceed a particular threshold, and may require all plans (in-

cluding plans participating in the Federal Employees Health Benefits program under chapter 89 of title 5, United States Code) to make contributions to the fund to offset such additional payments.

(2) CONTINUOUS COVERAGE INCENTIVES.—The mechanism may provide for appropriate incentives to encourage continuous coverage of individuals and groups.

(3) COST-SHARING LIMIT.—The mechanism may provide for limits on the non-premium cost-sharing of enrollees.

(4) MULTI-STATE OPTION.—State multicare programs may cooperate and establish multistate reinsurance mechanisms to carry out this section.

(d) TREATMENT OF SELF-INSURED PLANS.—

(1) IN GENERAL.—In the case of a multicare plan that is a self-insured plan (as defined by the Secretary), except as provided in paragraph (2), the plan is subject to the requirements of this section, notwithstanding any provision of the Employee Retirement Income Security Act of 1974 to the contrary.

(2) EXCEPTION.—Paragraph (1) and the provisions of subsections (a) through (c) shall not apply to a self-insured plan that operates in at least 3

States and that has elected, under section 331(c), to participate in the national reinsurance mechanism (under section 331) rather than in State reinsurance mechanisms under this section.

SEC. 109. CONSUMER EDUCATION AND ASSISTANCE.

(a) IN GENERAL.—Each State multicare program shall establish procedures—

(1) for collecting, publishing, and distributing comparative value information (described in section 103(c)) on multicare plans to consumers, and

(2) for educating individuals eligible for State health care subsidies regarding their health care options and the requirements under section 107 to qualify for reduced cost-sharing.

(b) DISTRIBUTION OF PLAN INFORMATION THROUGH EMPLOYERS.—A State multicare program may require employers to supply basic information on multicare plans in the State (whether prepared by the program or the plans) to their employees.

SEC. 110. CONSUMER RIGHTS ENFORCEMENT.

Each State multicare program shall assure compliance of multicare plans with the consumer rights under section 203.

SEC. 111. COMPLIANCE OF STATE INCOME TAX LAWS.

Each State multicare program shall provide for assurances that any income tax laws of the State, insofar as they provide for the determination of tax based upon income as determined under the Federal income tax laws, treat employer payments for health care premiums and expenses of employees or dependents as payment of wages to such employees and dependents.

SEC. 112. DISTRIBUTION OF INFORMATION ON AVERAGE PRICES OF COMMON HEALTH CARE SERVICES.

Each State multicare program shall provide for the distribution, on both a State and local level, of information on the average prices of common health care services, including such services as the Secretary may specify.

Subtitle B—Federal Contribution Toward Multicare Plan Premiums; Tax Law Changes

SEC. 121. COMPUTATION OF AMOUNT OF FEDERAL CONTRIBUTION.

(a) DETERMINATION OF AMOUNT.—The Secretary shall determine for each year (beginning with 1996) an annual Federal contribution amount in accordance with this section.

(b) AMOUNT.—Subject to subsection (c):

(1) AMOUNT FOR YEARS BEFORE 2002.—

(A) IN GENERAL.—The Federal contribution amount for a year before 2002 is equal to—

(i) the total amount of available funds (determined under subparagraph (B)) for the year, divided by

(ii) the average number of individuals described in subparagraph (C) for the year.

(B) FUNDS AVAILABLE.—The total amount of available funds for a year is equal to the sum of the following:

(i) ADDITIONAL NET FEDERAL REVENUES.—The amount described in this subparagraph is the amount by which—

(I) the increase in all Federal revenues (including employment-related excise taxes) resulting from the amendments made by sections 122 and 123, exceeds

(II) the increase in appropriations resulting from the increase in authorization of appropriations provided under section 441(a) (relating

to facilitating development and use of medical practice guidelines).

(ii) ADDITIONAL MEDICAID-RELATED AMOUNT.—The product described in section 101(c)(3)(A)(ii)(II) for the State, increased (for each year after the last full year referred to in section 101(c)(3)(A)(ii)(I), up to the year involved) by the applicable inflator (specified in section 107(b)(2)(D)) for the year, and subject to any adjustment for changes in population under section 107(b)(4).

(C) INDIVIDUALS DESCRIBED.—

(i) IN GENERAL.—The number of individuals described in this subparagraph for a year is—

(I) the estimated total average population of the United States in the year, less

(II) the sum of the average number of exempt individuals in the year.

(2) YEARS BEGINNING WITH 2002.—The Federal contribution amount for a year after 2001 is equal to the Federal contribution amount determined under this subsection for the previous year in-

creased by the applicable inflator for the year involved (as specified under section 107(b)(3)).

(c) APPLICATION BY ENROLLMENT CLASS.—

(1) ESTABLISHMENT OF ENROLLMENT CLASSES.—

(A) IN GENERAL.—The Secretary shall establish one or more sets of enrollment classes based on both—

(i) family composition, and

(ii) ages of family members.

(B) USE OF COMMON CLASSIFICATIONS FOR FAMILY ENROLLMENT.—The family classifications under subparagraph (A)(i) shall be based on common family enrollment categories, such as individual only, individual with children, married couple without children, and a married couple with children.

(2) ADJUSTMENT OF FEDERAL CONTRIBUTION BASED ON ENROLLMENT CLASS.—The Secretary shall adjust the Federal contribution amount determined under this section for each of the enrollment classes so that, without changing the total amount of the Federal contribution, the ratio of the Federal contribution amount for enrollees in the different classes is equal to the ratio of average costs under

multicare plans for enrollees in the respective classes.

SEC. 122. TERMINATION OF EXCLUSION FOR EMPLOYER-PROVIDED HEALTH CARE COVERAGE AND OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED.

(a) TERMINATION OF EXCLUSION FOR EMPLOYER-PROVIDED HEALTH CARE COVERAGE.—

(1) IN GENERAL.—The text of section 106 of the Internal Revenue Code of 1986 is amended to read as follows:

''(a) IN GENERAL.—Gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) TERMINATION.—

''(1) IN GENERAL.—This section shall not apply to any taxable year beginning on or after the first day of the second calendar year beginning after the date of the enactment of this subsection.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a medical or dental care plan provided under section 1074(a) of title 10, United States Code.

''(c) SPECIAL RULES FOR DETERMINING AMOUNT OF INCLUSION.—

''(1) IN GENERAL.—For purposes of this section, the value of any coverage shall be determined on the basis of the average cost of providing such coverage to the beneficiaries receiving such coverage.

''(2) SPECIAL RULE.—To the extent provided by the Secretary, cost determinations under paragraph (1) may be made on the basis of reasonable estimates but shall not vary based on the age of employees or their dependents.''

(2) REPORTING ON W-2 FORM.—Subsection (a) of section 6051 of such Code (relating to receipts for employees) is amended by striking ''and'' at the end of paragraph (8), by striking the period at the end of paragraph (9) and inserting '', and'', and by inserting after paragraph (9) the following new paragraph:

''(10) the value of the employer-provided coverage under any accident or health plan (determined in accordance with section 106(c)) which is not excludable from gross income under section 106 by reason of section 106(b) and the number of months during such calendar year that such coverage was provided.''

(b) TERMINATION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED.—Subsection (l) of

section 162 of such Code is amended by adding at the end thereof the following new paragraph:

''(7) TERMINATION ON IMPLEMENTATION OF MULTICARE.—In no event shall this subsection apply to any taxable year beginning on or after the first day of the second calendar year beginning after the date of the enactment of this paragraph.''

(c) APPLICATION OF FICA TAXES AND INCOME TAX WITHHOLDING.—

(1) FICA TAXES.—Subsection (a) of section 3121 of such Code is amended by adding at the end thereof the following new flush sentence:

''Paragraphs (2) and (4) shall not apply to any amount paid for coverage of an employee or any of his dependents under an accident or health plan.''

(2) WAGE WITHHOLDING.—Subsection (a) of section 3401 of such Code is amended by adding at the end thereof the following new flush sentence:

''The term 'wages' shall include amounts paid for coverage of an employee or any of his dependents under an accident or health plan.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning on or after the first day of the second calendar

year beginning after the date of the enactment of this Act.

SEC. 123. TERMINATION OF DEDUCTION FOR MEDICAL CARE.

Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) TERMINATION ON IMPLEMENTATION OF MULTICARE.—In no event shall this section apply to any taxable year beginning on or after the first day of the second calendar year beginning after the date of the enactment of this subsection.''

TITLE II—REQUIREMENTS FOR MULTICARE PLANS

Subtitle A—General Requirements

SEC. 201. ENROLLMENT AND CONTINUITY OF COVERAGE.

(a) IN GENERAL.—Each multicare plan shall—

(1) accept for enrollment (except to the extent the Secretary may provide) all individuals eligible for enrollment, except as provided in section 103(b); and

(2) not condition or limit the provision or payment for services based on any pre-existing condition.

(b) CERTIFICATION OF ENROLLMENT FOR PURPOSES OF RECEIPT OF FEDERAL CONTRIBUTION.—Each

multicare plan shall provide for notice to the Secretary or the State multicare program of such information as the Secretary may require in order to establish the entitlement of the plan to payment from a State multicare program under section 106.

SEC. 202. COVERED SERVICES.

A multicare plan must—

(1) clearly disclose to each enrollee (in a manner specified by the State multicare program) the differences between the services covered under the plan and the list of services established under section 104(a)(2)(A), and

(2) include, for purposes of applying the catastrophic protection under section 203(e), hospital, professional, and other services specified by the Secretary.

SEC. 203. PREMIUMS AND COST-SHARING; CATASTROPHIC PROTECTION.

(a) IN GENERAL.—Except as a State multicare program otherwise provides under title I and except as provided in this section, a multicare plan—

(1) may impose cost-sharing in the form of premiums, deductibles, coinsurance, and copayments, and

(2) shall disclose the portion of such a premium which is met through the contribution provided under section 106.

(b) LIMITS ON PREMIUM VARIATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the premiums with respect to multicare plans offered in an area of a State shall be established, and shall vary, based only on the enrollment classes provided under section 121(c)(1). Each plan shall fairly allocate the costs of such premiums among such classes.

(2) USE OF BEHAVIORAL FACTORS.—Premiums under a multicare plan may vary based on factors (such as smoking, substance abuse, and excessive weight) which are defined by the Secretary and for which personal behavior is clearly related to receipt of health care services.

(c) LIMITATION ON ADJUSTMENT OF COINSURANCE AND COPAYMENTS.—A multicare plan—

(1) may adjust coinsurance or copayment rates to encourage enrollees to use (A) preferred providers, (B) providers that charge lower amounts, or (C) different procedures, but

(2) may not adjust coinsurance based on individual patient characteristics, including the age, sex, wellness, or medical history of the individual.

(d) USE OF MEDICAL SAVINGS ACCOUNTS.—A multicare plan may establish for its enrollees medical savings accounts—

(1) from which payments for services (below a catastrophic limit) are made by the enrollees, and

(2) for which balances may be carried forward from year to year and may be applied against future expenses, be rebated to the enrollee, or used for retirement purposes.

(e) CATASTROPHIC PROTECTION.—

(1) IN GENERAL.—A multicare plan shall include a maximum limit on the annual amount of patient cost-sharing for premiums and out-of-pocket expenses for covered services.

(2) LIMIT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, such annual maximum limit shall not exceed—

(i) $5,000 for any individual, and

(ii) $10,000, in the aggregate, for all members of a family.

(B) INDEXING.—For any year, after the year in which this Act is enacted, the dollar amounts specified under subparagraph (A) shall be the dollar amounts specified under this paragraph for the previous year (taking into account any previous application of this subparagraph) increased by the applicable inflator for the year (as specified under section 107(b)(3)).

(C) ADDITIONAL LIMITS.—A State multicare program may—

(i) impose dollar limits that are less than the limits otherwise specified under this paragraph; and

(ii) provide for the application of limits for expenses over a multi-year period.

(D) STATE AUTHORITY.—If a State multicare program provides for a subsidy of stop-loss limits for catastrophic coverage for lower income residents (under its reinsurance mechanism under section 108), the program may establish regulations designed to prevent manipulation of household size and membership so as to qualify for catastrophic protection benefits.

(f) APPLICATION OF EXCESS CONTRIBUTION AMOUNT TOWARDS COST SHARING.—If the amount of the State contribution under section 106(b) toward the premium of an individual exceeds the individual's premium for a multicare plan, the excess amount shall be counted by the plan towards the cost sharing for the individual under the plan.

SEC. 204. PARTICIPATION IN REINSURANCE SYSTEM.

Each multicare plan shall participate in the applicable reinsurance system (established by the State multicare program under section 108 or by the Secretary pursuant to section 301 or 331).

SEC. 205. DATA REQUIREMENT.

(a) IN GENERAL.—Each multicare plan (and health care providers participating in the plan) shall collect and provide to the State multicare program data on costs of health care, prices for services, and patient outcomes, in accordance with standards established by the Secretary by regulation.

(b) PRICING INFORMATION.—A multicare plan shall condition the payment under the plan for services of a provider upon the provider disclosing to the public, in a form, manner, and at a time specified by the Secretary, such information on the provider's charges as the State

multicare program specifies, in accordance with guidelines of the Secretary.

SEC. 206. MEDICAL MALPRACTICE REFORM AND ADMINISTRATIVE COST SAVINGS.

Each multicare plan (and health care providers participating in the plan) shall comply with the applicable requirements of—

(1) title IV (relating to medical malpractice liability reform),

(2) subtitle A of title V (relating to standardization of claims processing), and

(3) subtitle B of title V (relating to electronic medical data standards).

SEC. 207. CONSUMER RIGHTS.

(a) NOTICE OF RIGHTS; ENFORCEMENT.—

(1) NOTICE.—Each multicare plan shall notify enrollees of their consumer rights under this section and of the procedures established by the plan to ensure these rights.

(2) DEVELOPMENT OF REGULATIONS.—The Secretary shall develop regulation to implement the consumer rights established under this section.

(3) STATE ENFORCEMENT.—States are responsible, under their multicare programs, for assuring

compliance of multicare plans with the requirements of this section.

(b) PROVISION OF PATIENT COST-SHARING INFORMATION.—

(1) IN GENERAL.—Each multicare plan which provides for cost-sharing (other than premiums) shall ensure that enrollees are provided, in advance of the receipt of treatment (except as provided in paragraph (3)), with information on the expected total costs of treatment and their expected share of the costs. Such information may be based on the estimates for the average cost for such treatment.

(2) TOTAL COST.—For purposes of paragraph (1), the total cost of treatment—

(A) in the case of a patient's initial visit, shall consist of the initial visit only, and

(B) in the case of subsequent treatment, shall include all expenses resulting from the treatment procedure prescribed by the provider.

(3) EXCEPTION FOR EMERGENCIES.—In the case of emergency treatment, the information under this subsection shall be provided at the earliest reasonable time after such treatment is initiated.

(c) PROVISION OF PRICE INFORMATION BY HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—Each health care provider is required to make available information on the provider's prices for health care services. Such information shall be made available to the public and to individuals and organizations upon request.

(2) STANDARDS.—Such information shall be made available in accordance with standards and a common format established by the Secretary.

(d) PATIENT ACCESS TO MEDICAL INFORMATION.—Each individual has a right to obtain, through the multicare plan in which the individual is enrolled, information contained in the medical record of a provider that has provided health care services for which payment may be made under the plan.

Subtitle B—Multiple Employer Health Benefits Protections

SEC. 211. LIMITED EXEMPTION UNDER PREEMPTION RULES FOR MULTIPLE EMPLOYER PLANS PROVIDING HEALTH BENEFITS SUBJECT TO CERTAIN FEDERAL STANDARDS.

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

''Part 7—Multiple Employer Health Plans

"SEC. 701. DEFINITIONS.

''For purposes of this part:

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

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

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

''(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets

such reasonable standards and qualifications as the Secretary may provide by regulation.

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

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

''(A) IN GENERAL.—A multiple employer welfare arrangement shall be treated as covering individuals located in a State only if the minimum required number of individuals who are covered under the arrangement are located in such State, except that if the minimum required number of individuals are not located in any State, such arrangement shall be treated as covering individuals in any State in which any covered individual is located.

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

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

''(ii) 50.

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

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

''(8) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this part, most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

''(9) FULLY INSURED ARRANGEMENT.—A multiple employer welfare arrangement shall be treated as fully insured only if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any com-

bination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective of any recourse they may have against other parties).

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

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

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

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

such arrangement is an employee welfare benefit plan, and

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

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

''(c) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care described in section 607(1) which has not commenced operations as of January 1, 1994, may commence operations only if an exemption granted to the arrangement under this part is in effect (or there is pending with respect to the arrangement a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate).

''SEC. 703. EXEMPTION PROCEDURE.

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

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

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

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

''(A) administratively feasible,

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

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

''(b) NOTICE AND HEARING.—Before granting an exemption under this section, the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this section unless the Secretary affords an opportunity for a

hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

''(a) APPLICATION FOR EXEMPTION.—

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

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

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

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

''(i) the sponsor, and

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

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

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

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

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

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

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

''(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the ex-

pected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

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

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

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

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

''(1) SPONSOR.—The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce or other business group, for substantial purposes other than that of obtaining or providing medical care described in section 607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

''(2) OPERATING COMMITTEE.—The arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications

for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the committee serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

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

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

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

''(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at

least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

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

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

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

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

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

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

''(1) IN GENERAL.—In the case of any application for an exemption under this part with respect to a multiple employer welfare arrangement, if the Secretary determines that the sponsor of the arrangement or any other person associated with the arrangement is subject to disqualification under paragraph (2), the Secretary may deny the exemption with respect to such arrangement.

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

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

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

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

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

''(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order lawfully issued by the Secretary compelling such response,

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

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

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

section (b)(1) with respect to a sponsor are met with respect to the network.

''(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this section in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but for the failure to meet any requirement of section 3(40)(C)—

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

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

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

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

''(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is

among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

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

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

''(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan

year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

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

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

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

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

''(d) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted to a multiple employer welfare arrangement under this part shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this paragraph, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

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

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

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

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

''(3) a statement indicating—

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

''(B) whether or not there is in effect with respect to the arrangement an exemption granted under this part and, if there is in effect such an exemption, that the arrangement is (or is treated as) an employee welfare benefit plan under this title, and

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

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

"**SEC. 707. MAINTENANCE OF RESERVES.**

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

''(1) a reserve for unearned contributions,

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

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

''(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2) shall not be less than an amount equal to 25 percent of expected incurred claims and expenses for the plan year.

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

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

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

erage provided with respect to such arrangement or arrangements.

"SEC. 708. CORRECTIVE ACTIONS.

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

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

''(b) TERMINATION.—

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

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

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

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

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

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

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

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

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

''(2) if the Secretary finds that—

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

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

injurious to participating employers, or covered individuals,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''PART 7—MULTIPLE EMPLOYER HEALTH PLANS

''Sec. 701. Definitions.
''Sec. 702. Exempted multiple employer welfare arrangements treated as employee welfare benefit plans and exempt from certain restrictions on preemption.
''Sec. 703. Exemption procedure.
''Sec. 704. Eligibility requirements.
''Sec. 705. Additional requirements applicable to exempted arrangements.
''Sec. 706. Disclosure to participating employers by arrangements providing medical care.
''Sec. 707. Maintenance of reserves.
''Sec. 708. Corrective actions.
''Sec. 709. Expiration, suspension, or revocation of exemption.
''Sec. 710. Review of actions of the Secretary.''.

SEC. 212. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

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

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

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

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

SEC. 213. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

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

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

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

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

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

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

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

SEC. 214. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 215. EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

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

''(43) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) CREATION OF EMPLOYMENT RELATIONSHIP.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 216. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

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

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

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

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

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

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

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

(3) by adding at the end the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 217. FILING REQUIREMENTS FOR HEALTH BENEFIT MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

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

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

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

''(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1994) and no later than February 15 of each year (in the case of an arrangement

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

''(2) Each registration statement—

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

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

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

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

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

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

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

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

SEC. 218. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

''(1) STATE ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

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

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

SEC. 219. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect January 1, 1994, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1994, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

Subtitle C—Repeal of COBRA Continuation Requirements

SEC. 221. REPEAL OF REQUIREMENTS OF THE INTERNAL REVENUE CODE OF 1954.

(a) IN GENERAL.—Section 4980B of the Internal Revenue Code of 1986 is repealed.

(b) CONFORMING AMENDMENTS.—Section 414 of such Code is amended—

(1) in subsection (n)(3)(C), by striking ''505, and 4980B'' and inserting ''and 505'', and

(2) in subsection (t)(2), by striking ''505, or 4980B'' and inserting ''or 505''.

(c) EFFECTIVE DATE.—The repeal effected by subsection (a) shall apply to health plans offered in a State by an employer as of the first date that a State multicare program is in effect in the State.

SEC. 222. REPEAL OF REQUIREMENTS OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is repealed.

(b) CONFORMING AMENDMENT.—Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606 or''.

(c) EFFECTIVE DATE.—The repeal effected by subsection (a) shall apply to health plans offered in a State by an employer as of the first date that a State multicare program is in effect in the State.

SEC. 223. REPEAL OF REQUIREMENTS OF PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Title XXII of the Public Health Service Act is repealed.

(b) EFFECTIVE DATE.—The repeal effected by subsection (a) shall apply to health plans offered in a State by an employer as of the first date that a State multicare program is in effect in the State.

TITLE III—STATES WITHOUT STATE MULTICARE PROGRAMS; FEDERAL HEALTH CARE PROGRAMS; NATIONAL REINSURANCE POOL

Subtitle A—Multicare Plans in States without State Multicare Programs

SEC. 301. GENERAL PROVISIONS.

(a) IN GENERAL.—In the case of a State without a State multicare program approved under title I, the Secretary may provide for—

(1) the operation (through the Department of Health and Human Services) of such a program in the State, and

(2) the approval and offering of multistate plans in the State,

in the same manner as such a program and plans would have been offered if a State multicare program were in operation in the State.

(b) APPLICATION OF ALL REQUIREMENTS.—In the case of multicare plans offered pursuant to subsection (a), such plans shall meet all the same requirements of title II (including requirements relating to consumer rights) that would have applied if the plans were offered under a State multicare program.

(c) CONSUMER EDUCATION AND ASSISTANCE.—In the case of a State without a State multicare program approved under title I:

(1) DISTRIBUTION OF PLAN INFORMATION.—The Secretary shall provide, through local Social Security Administration offices and State welfare offices, for assistance to medicare, medicaid, and low-income beneficiaries in the selection of multicare plans pursuant to this section. Such offices shall provide eligible individuals with the information nec-

essary to qualify them for reduced cost-sharing and to explain their available options.

(2) DISTRIBUTION OF PLAN INFORMATION.—The Secretary shall provide for distribution of information on approved multicare plans.

Subtitle B—Federal Health Care Programs

SEC. 321. MEDICARE PROGRAM.

(a) NEGOTIATION AUTHORITY.—The Secretary of Health and Human Services is authorized to negotiate an agreement with a State multicare program to provide medicare-eligible individuals with access to multicare plans.

(b) TERMS OF AGREEMENTS.—

(1) IN GENERAL.—Under an agreement under this section, medicare-eligible individuals—

(A) are permitted to choose to enroll in multicare plans, and

(B) are provided payment of an amount towards the cost of enrolling in the plan.

(2) OTHER TERMS.—An agreement under this section—

(A) may not increase the total Federal cost of care, and

(B) shall ensure that medicare-eligible individuals can easily compare the benefits of en-

rollment under a multicare plan to the benefits provided under the medicare program.

(c) SPECIAL RULES.—

(1) NO FEDERAL CONTRIBUTION.—No Federal contribution is available to a State under section 101(c)(1) with respect to enrollment of an individual with a multicare plan under an agreement under this section.

(2) CONSTRUCTION.—Nothing in this section shall be construed as—

(A) requiring a State multicare program to enter into an agreement under this section as a condition of approval of the program under this Act or otherwise, or

(B) as authorizing the Secretary or a State to require a medicare-eligible individual to enroll with a multicare plan under the agreement.

SEC. 322. FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM.

(a) USE OF FEDERAL CONTRIBUTION TOWARD PURCHASE OF MULTICARE PLAN.—In the case of an individual who is a Federal employee or annuitant eligible to enroll in a health benefit plan under chapter 89 of title 5, United States Code and is residing in a State—

(1) with a State multicare program, instead of enrolling under such a plan the individual is entitled to elect (in a form and manner specified by the Director of the Office of Personnel Management in consultation with the Secretary) to have the amount of the Federal Government contribution toward such plan under such chapter applied toward enrollment of the individual (and qualified family members) under a multicare plan; and

(2) without a State multicare program, instead of enrolling under such a plan the individual is entitled to elect (in a form and manner specified by the Director of the Office of Personnel Management in consultation with the Secretary) to have the amount of the Federal Government contribution toward such plan under such chapter applied toward enrollment of the individual (and qualified family members) under a Federally approved multicare plan.

(b) APPROVAL OF FEHBP PLANS.—The Secretary may approve a health benefit plan offered under chapter 89 of title 5, United States Code, as a multicare plan under this Act if the plan—

(1) participates in a reinsurance mechanism that meets the requirements of section 107, and

(2) otherwise complies with the requirements for a multicare plan under title II.

(c) TREATMENT OF FEHBP PLANS AS MULTICARE PLANS FOR PURPOSES OF FEDERAL CONTRIBUTION.—For purposes of section 121, a health benefit plan in which an individual is enrolled under chapter 89 of title 5, United States Code is treated as a multicare plan in which the individual is enrolled.

(d) CONSTRUCTION.—Nothing in this section shall be construed as authorizing the Office of Personnel Management to require any individual to enroll with a multicare plan under this section.

SEC. 323. REPORT RECOMMENDING INTEGRATION OF CHAMPUS, VETERANS HEALTH, AND INDIAN HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the Secretary of Veterans Affairs, the Secretary of Defense, and the Secretary of the Interior, shall submit to Congress a report that includes recommendations on how (and the extent to which) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health care programs of the Department of Veterans Affairs, and the Indian Health Service may be integrated with the multicare program established under this Act.

(b) DEADLINE.—The report under subsection (a) shall be submitted not later than 2 years after the date of the enactment of this Act to the Committees on Armed Services, Energy and Commerce, Interior, Veterans' Affairs, and Ways and Means of the House of Representatives and to the Committees on Armed Services, Finance, Labor and Human Resources, and Veterans' Affairs of the Senate.

SEC. 324. CONSUMER RIGHTS FOR INDIVIDUALS IN FEDERAL PROGRAMS.

(a) NOTICE OF RIGHTS; ENFORCEMENT.—

(1) NOTICE.—The Secretary shall notify individuals provided health care services under a Federal health care program of their consumer rights under this section and of the procedures established by the Secretary to ensure these rights.

(2) DEVELOPMENT OF REGULATIONS.—The Secretary shall develop regulation to implement the consumer rights established under this section.

(3) STATE ENFORCEMENT.—The Secretary is responsible, through modification of requirements of Federal health care programs, for assuring compliance of physicians with the requirements of this section.

(b) PROVISION OF PATIENT COST-SHARING INFORMATION.—

(1) IN GENERAL.—Each physician who furnishes professional services for which payment may be made under a Federal health care program shall provide, as a condition for the payment of funds for such services under such program, that a patient is provided, in advance of the receipt of the services (except as provided by the Secretary in the case of emergency services), with information on the expected total costs of the services and an estimate of the patient's share of the costs. Such information may be based on the estimates for the average cost for such services.

(2) TOTAL COST.—For purposes of paragraph (1), the total cost of treatment—

(A) in the case of a patient's initial visit, shall consist of the initial visit only, and

(B) in the case of subsequent treatment, shall include all expenses resulting from the treatment procedure prescribed by the physician.

(3) EXCEPTION FOR EMERGENCIES.—In the case of emergency services, the information under

this subsection shall be provided at the earliest reasonable time after such services are provided.

(c) PATIENT ACCESS TO MEDICAL INFORMATION.—In the case of an individual who receives professional services from a physician for which payment may be made under a Federal health care program, the individual has a right to obtain information contained in the individual's medical record maintained by the physician.

(d) FEDERAL HEALTH CARE PROGRAM.—In this section, the term ''Federal health care program'' includes the medicare program, the medicaid program, and the Federal employees health benefits program.

Subtitle C—National Reinsurance Mechanism

SEC. 331. NATIONAL REINSURANCE MECHANISM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a national reinsurance mechanism for use by self-insured closed multicare plans described in subsection (b) which have not made an election described in subsection (c). Such a mechanism shall be designed to meet the requirements described in section 107(b).

(2) GOVERNANCE.—The mechanism shall be governed by a commission appointed by the Sec-

retary. The membership of the commission shall include the Secretary (or the Secretary's designee) and representatives of plan sponsors, major providers, labor, State reinsurance mechanisms, consumers, State governments, and the business community.

(b) PLANS COVERED.—The plans described in this subsection are self-insured plans that operate in 3 or more States.

(c) ELECTION.—A plan described in subsection (b) shall be permitted to make a one-time election as to whether to participate in the national reinsurance mechanism under this section or to participate in State reinsurance mechanisms established under section 107 (or by the Secretary under section 301).

TITLE IV—MEDICAL MALPRACTICE LIABILITY REFORM

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 401. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) CONGRESSIONAL FINDINGS.—

(1) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance

industries are industries affecting interstate commerce and the medical malpractice litigation systems existing throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for malpractice insurance purchased by health care providers.

(2) EFFECT ON FEDERAL SPENDING.—Congress finds that the medical malpractice litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

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

(C) the large number of health care providers and health care professionals who provide items or services for which the Federal Government makes payments; and

(D) the large number of such providers and professionals who have received direct or indirect financial assistance from the Federal

Government because of their status as such professionals or providers.

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

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

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

(c) PREEMPTION OF STATE LAW.—Subject to section 421, this subtitle supersedes State law only to the extent that State law differs from any provision of law established by or under this subtitle. Any issue that is not governed by any provision of law established by or under this subtitle shall be governed by otherwise applicable State or Federal law.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical

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

SEC. 402. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established by a State that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability claim, or, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such a claim is alleged.

(3) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or

certified by the State to provide such services in the State.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or claim.

(7) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a civil action (other than an action in which the plaintiff's sole allegation is an allegation of an intentional tort) brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the action is based) in which the plaintiff alleges a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term ''medical malpractice liability claim'' means a claim in which the claimant alleges

that injury was caused by the provision of (or the failure to provide) health care services.

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

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

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

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

SEC. 403. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and sections 419 and 442, this subtitle shall apply with respect to claims accruing or actions brought on or after

the expiration of the 3-year period that begins on the date of the enactment of this Act.

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

(1) APPLICATION.—A State may submit an application to the Secretary requesting the early implementation of this subtitle with respect to claims or actions brought in the State.

(2) DECISION BY SECRETARY.—The Secretary shall issue a response to a State's application under paragraph (1) not later than 90 days after receiving the application. If the Secretary determines that the State meets the requirements of this subtitle at the time of submitting its application, the Secretary shall approve the State's application, and this subtitle shall apply with respect to actions brought in the State on or after the expiration of the 90-day period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—UNIFORM STANDARDS FOR MEDICAL MALPRACTICE LIABILITY ACTIONS

SEC. 411. STATUTE OF LIMITATIONS.

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

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

SEC. 412. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—No medical malpractice liability action may be brought in any State court unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dis-

pute resolution system certified by the Secretary under section 432(b).

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

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

(2) if the ADR determines that the defendant is liable, the ADR determines the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) DEADLINE.—No medical malpractice liability action may be brought unless the action is filed in a court of competent jurisdiction not later than 90 days after an opinion resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(2) COURT OF COMPETENT JURISDICTION.—For purposes of paragraph (1), the term ''court of competent jurisdiction'' means—

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

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

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

(e) TREATMENT OF ADR DECISION.—

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

(A) show that—

(i) the decision was procured by corruption, fraud, or undue means,

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

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

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

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

(2) BURDEN OF PROOF.—In any medical malpractice liability action, the trier of fact shall uphold the decision made under the previous alternative dispute resolution system with respect to the claim that is the subject of the action unless the party contesting the decision proves by a preponderance of the evidence that the decision was incorrect.

SEC. 413. RELATION TO ALTERNATIVE DISPUTE RESOLUTION OF FEDERAL AGENCIES.

(a) MANDATORY APPLICATION OF FEDERAL ADR IN MALPRACTICE CLAIMS AGAINST UNITED STATES.—Section 2672 of title 28, United States Code, is amended by striking the period at the end of the first paragraph and inserting the following: ‘‘, except that each Federal agency shall use arbitration or such alternative means of dispute resolution to settle any tort claim against the United States consisting of a medical malpractice liability claim (as defined in section 402(8) of the Multicare Act of 1994).’’.

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

''(k) Each agency shall transmit on a regular basis to the Administrator for Health Care Policy and Research information on issues in controversy consisting of medical malpractice liability claims (as defined in section 402(8) of Multicare Act of 1994) that are resolved under the agency's dispute resolution proceeding under this subchapter, in a manner that assures that the identity of the parties to such proceedings shall not be revealed.''.

SEC. 414. MANDATORY PRE-TRIAL SETTLEMENT CONFERENCE.

(a) IN GENERAL.—Before the beginning of the trial phase of any medical malpractice liability action, the parties shall attend a conference called by the court for purposes of determining whether grounds exist upon which the parties may negotiate a settlement for the action.

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

SEC. 415. CALCULATION AND PAYMENT OF DAMAGES.

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

(b) TREATMENT OF PUNITIVE DAMAGES.—

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

(2) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(A) IN GENERAL.—Any punitive damages imposed under a medical malpractice liability action shall be paid to the State in which the action is brought.

(B) ACTIVITIES DESCRIBED.—A State shall use amount paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services pro-

vided in the State, including (but not limited to)—

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

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(C) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subparagraph (A) to supplement and not to replace amounts spent by the State for the activities described in subparagraph (B).

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If more than $100,000 in damages for expenses to be incurred in the future is awarded to the plaintiff in a medical malpractice liability action, the defendant shall provide

for payment for such damages on a periodic basis determined appropriate by the court (based upon projections of when such expenses are likely to be incurred), unless the court determines that it is not in the plaintiff's best interests to receive payments for such damages on such a periodic basis.

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

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

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

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

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to a plaintiff shall be reduced under paragraph (1) shall be—

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

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

SEC. 416. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON ATTORNEY'S FEES.—If the plaintiff in a medical malpractice liability action has entered into an agreement with the plaintiff's attorney to pay the attorney's fees on a contingency basis, the attorney's fees for the action may not exceed—

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

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

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

(1) IN GENERAL.—If the court in a medical malpractice liability action upholds a ruling of the alternative dispute resolution system with respect to whether or not a health care professional or health care provider committed malpractice or with respect to the amount of damages awarded, the court shall require the party that contested the ruling to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim that is the subject of the action under the alternative dispute resolution system).

(2) PERMITTING COURT TO WAIVE OR MODIFY IMPOSITION OF COSTS.—A court may issue a written order waiving or modifying the application of paragraph (1) to a party if the court finds that the application of such paragraph to the party would constitute an undue hardship, or if the medical malpractice liability action raised a novel issue of law. The order shall specify the grounds for the court's decision to waive or modify the application of such paragraph.

SEC. 417. JOINT AND SEVERAL LIABILITY.

The liability of each defendant in a medical malpractice liability action shall be several only and shall not be joint, and each defendant shall be liable only for the amount of damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

SEC. 418. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

Except as provided in subsection (b), a defendant in a medical malpractice liability action may not be found to have acted negligently unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

SEC. 419. APPLICATION OF MEDICAL PRACTICE GUIDELINES IN MALPRACTICE LIABILITY ACTIONS.

(a) USE OF GUIDELINES AS AFFIRMATIVE DEFENSE.—In any medical malpractice liability action, it shall be a complete defense to any allegation that the defendant was negligent that, in the provision of (or the failure to provide) the services that are the subject of the action, the defendant followed the appropriate practice guideline.

(b) RESTRICTION ON GUIDELINES CONSIDERED APPROPRIATE.—

(1) GUIDELINES SANCTIONED BY SECRETARY.—For purposes of subsection (a), a practice guideline may not be considered appropriate with respect to actions brought during a year unless the Secretary has sanctioned the use of the guideline for purposes of an affirmative defense to medical malpractice liability actions brought during the year in accordance with paragraph (2) or (3).

(2) PROCESS FOR SANCTIONING GUIDELINES.—Not less frequently than October 1 of each year (beginning with 1995), the Secretary, shall review the practice guidelines and standards developed by the Administrator for Health Care Policy and Research pursuant to section 1142 of the Social Security Act, and shall sanction those guidelines which the Secretary considers appropriate for purposes of an affirmative defense to medical malpractice liability actions brought during the next calendar year as appropriate practice guidelines for purposes of subsection (a).

(3) USE OF STATE GUIDELINES.—Upon the application of a State, the Secretary may sanction practice guidelines selected by the State for purposes of an affirmative defense to medical malpractice liability actions brought in the State as appropriate

practice guidelines for purposes of subsection (a) if the guidelines meet such requirements as the Secretary may impose.

(c) PROHIBITING APPLICATION OF FAILURE TO FOLLOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEGLIGENCE.—No plaintiff in a medical malpractice liability action may be deemed to have presented prima facie evidence that a defendant was negligent solely by showing that the defendant failed to follow the appropriate practice guideline.

SEC. 420. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

(1) IN GENERAL.—In the case of a medical malpractice liability action relating to services provided during labor or the delivery of a baby, if the defendant health care professional did not previously treat the plaintiff for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the defendant unless the malpractice is proven by clear and convincing evidence.

(2) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of paragraph (1), a health care professional shall be

considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

(b) CLEAR AND CONVINCING EVIDENCE DEFINED.—In subsection (a), the term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

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

SEC. 421. PREEMPTION.

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

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

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

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

(4) establishes a stricter standard for determining whether a defendant was negligent or for determining the liability of defendants described in section 420(a) in actions described in such section.

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

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

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

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

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

of a foreign nation on the ground of inconvenient forum.

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

SEC. 431. BASIC REQUIREMENTS FOR ADR.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

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

(2) requires that a written opinion resolving the dispute be issued that contains findings of fact relating to the dispute;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

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

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings a medical malpractice liability action contesting the decision made under the system; and

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

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

respect to medical malpractice liability actions brought in the State.

SEC. 432. CERTIFICATION OF STATE SYSTEMS.

(a) IN GENERAL.—Not later than October 1 of each year (beginning with 1995), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(b) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection if the Secretary determines under subsection (a) that the system meets the requirements of section 431.

SEC. 433. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part.

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

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

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within such State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

Subtitle B—Other Requirements and Programs

SEC. 441. FACILITATING DEVELOPMENT AND USE OF MEDICAL PRACTICE GUIDELINES.

(a) INCREASE IN AUTHORIZATION OF APPROPRIATIONS.—Section 1142(i)(1) of the Social Security Act (42 U.S.C. 1320b–12(i)(1)) is amended by striking subparagraphs (D) and (E) and inserting the following:

''(D) $158,000,000 for fiscal year 1995 (of which $10,000,000 shall be used for sanction-

ing practice guidelines for purposes of an affirmative defense in medical malpractice liability actions);

''(E) $200,000,000 for fiscal year 1996 (of which $20,000,000 shall be used for sanctioning practice guidelines for purposes of an affirmative defense in medical malpractice liability actions); and

''(F) $20,000,000 for fiscal year 1997, to be used for sanctioning practice guidelines for purposes of an affirmative defense in medical malpractice liability actions.''.

(b) CONSIDERATION OF MALPRACTICE LIABILITY DATA IN DEVELOPING AND UPDATING GUIDELINES.—Section 1142(c)(5) of such Act (42 U.S.C. 1320b–12(c)(5)) is amended by striking ''claims data'' and all that follows through ''patients'' and inserting the following: ''claims data, data on clinical and functional status of patients, and data on medical malpractice liability actions''.

(c) DEVELOPMENT OF REPORTING FORMS FOR STATE ADR SYSTEMS.—The Secretary, in consultation with the Administrator for Health Care Policy and Research, shall develop a standard reporting form to be used by State alternative dispute resolution systems in trans-

mitting information to the Administrator pursuant to section 431(a)(6) on disputes resolved under such systems.

(d) STUDY OF EFFECT OF GUIDELINES ON MEDICAL MALPRACTICE.—

(1) STUDY.—The Secretary shall conduct a study of the effect of the use of the medical practice guidelines developed by the Administrator for Health Care Policy and Research on the incidence of and the costs associated with medical malpractice.

(2) REPORTS.—(A) Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit an interim report to Congress describing the availability and use of medical practice guidelines and the aggregate costs associated with medical malpractice.

(B) Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), together with recommendations regarding expanding the use of medical practice guidelines for determining the liability of health care professionals and health care providers for medical malpractice.

SEC. 442. PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.

(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care practitioner may enter into agreements with State or county professional societies of such type of health care practitioner to permit such societies to participate in the licensing of such health care practitioner, and to review any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner. Any such agreement shall comply with subsection (b).

(b) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under subsection (a) for licensing activities or the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall provide that—

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

(2) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

(3) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

(4) no individual affiliated with such society is liable for any damages or injury directly caused by the individual's actions in conducting such activities or review.

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

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

TITLE V—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

SEC. 501. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this title referred to as the ''Sec-

retary'') shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

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

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services.

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

(1) the Secretary shall take into account the recommendations of current taskforces, including at least the Workgroup on Electronic Data Inter-

change, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

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

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

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

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

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

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

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

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 502. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 501 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection

(a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

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

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 501 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to re-

quire, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 501(a)(1); and

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

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

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

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

(i) the State provides for application of the standards established under section 501, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 503. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 501;

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

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

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 501, then, in the case of any claim for benefits submitted under a health benefit plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 502 instead of the standards previously promulgated.

SEC. 504. HEALTH BENEFIT PLAN DEFINED.

In this title, the term ''health benefit plan'' has the meaning given such term in section 111(6) and includes—

(1) the medicare program (under title XVIII of the Social Security Act), and

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

Subtitle B—Electronic Medical Data Standards

SEC. 511. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1996, and January 1, 1997, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

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

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

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

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

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

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 501.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

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

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

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 515, and with other

affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 512. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1998, subject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 511(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set,

in accordance with the standards promulgated under section 511(a).

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

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

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the medicare program.

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

SEC. 513. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

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

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated

under subsection (b) or (c) of section 511, described in paragraph (4) or (5) of section 511(b).

SEC. 514. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 511 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

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

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a

civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

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

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

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

SEC. 515. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans' Affairs, and the Director of the Centers for Disease Control.

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

(1) the standards established under this subtitle, and

(2) operational concerns about the implementation of such standards under this subtitle.

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

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1995 through 1999 to carry out this section.

TITLE VI—REMOVING RESTRICTIONS ON MANAGED CARE

SEC. 601. REMOVING RESTRICTIONS ON MANAGED CARE.

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

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

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a

beneficiary to pay when a non-plan provider is used on a non-emergency basis.

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

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

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

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

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

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

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring that utilization review be conducted by a licensed health care profes-

sional or (ii) requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed.

(b) GAO STUDY.—

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

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

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

TITLE VII—MODIFICATION OF THE OPERATION OF THE ANTITRUST LAWS TO HOSPITALS

SEC. 701. PURPOSE.

The purpose of this title is to encourage cooperation among hospitals in order to contain costs and achieve a more efficient health care delivery system through the elimination of unnecessary duplication and proliferation of expensive medical services or expensive high technology equipment.

SEC. 702. EXEMPTIONS FROM THE OPERATION OF THE ANTITRUST LAWS.

(a) GENERAL EXEMPTION.—It shall not be unlawful under the antitrust laws for 2 or more hospitals to engage in conduct solely for the purpose of negotiating a proposed agreement, to be submitted under subsection (b), to share expensive medical services or expensive high technology equipment.

(b) SPECIFIC EXEMPTIONS.—

(1) AUTHORITY TO GRANT WAIVER.—The Secretary of Health and Human Services shall issue waivers in accordance with paragraph (4) to exempt from the operation of the antitrust laws conduct en-

gaged in by hospitals to carry out agreements contained in applications approved under paragraph (3).

(2) ELIGIBILITY.—To be eligible to receive a waiver under paragraph (1), 2 or more hospitals shall submit to the Secretary an application that contains (in accordance with guidelines established by the Secretary)—

(A) a proposed agreement that only—

(i) provides that such hospitals shall share the expensive medical services or expensive high technology equipment identified in such agreement,

(ii) specifies the period of time during which such agreement shall be in effect,

(iii) describes the particular medical services or high technology equipment to be shared under such agreement, and

(iv) contains such other terms and conditions as the Secretary may reasonably require, and

(B) such information and assurances as the Secretary may reasonably require.

(3) APPROVAL.—For purposes of determining whether to approve an application submitted under

paragraph (2), the Secretary shall consider whether—

(A) the proposed agreement contained in such application satisfies the guidelines issued under paragraph (6), and

(B) implementation of such agreement will result in—

(i) enhancement of the quality of hospital care or hospital-related care,

(ii) the preservation of hospital services in geographical proximity to the communities traditionally served by the applicants,

(iii) improvement in the cost-effectiveness of high-technology services provided by the applicants,

(iv) improvement in the efficient utilization of hospital resources and capital equipment,

(v) the provision of services that would not otherwise be available, or

(vi) the avoidance of duplication of hospital resources.

(4) ISSUANCE AND EFFECT OF WAIVER.—If—

(A) the Secretary approves under paragraph (3) an application submitted under paragraph (2), and

(B) the applicants enter into the proposed agreement contained in such application, modified as the Secretary may require as a condition for approval,

then the Secretary shall issue a waiver with respect to the agreement entered into. Except as provided in paragraph (5), such waiver shall exempt the applicants from the operation of the antitrust laws for conduct the applicants engage in during the period specified in such waiver and solely to carry out the agreement with respect to which such waiver is issued.

(5) REVOCATION OF WAIVER.—(A) If the Secretary determines that a hospital with respect to which a waiver is in effect under paragraph (4) is not carrying out, or has not carried out, fully the terms of the agreement with respect to which a waiver is issued under paragraph (4), the Secretary may revoke such waiver.

(B) If the Secretary revokes such waiver—

(i) the Secretary shall specify the period during which such hospital did not carry out fully the terms of such agreement, and

(ii) such waiver shall have no legal effect with respect to such period.

(6) ISSUANCE OF GUIDELINES.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall establish the guidelines for applications under paragraph (2).

(c) DELEGATION OF AUTHORITY.—The Secretary is authorized to delegate the authority under this section with respect to a hospital in a State to the State multicare program established under title I. To the extent the Secretary delegates authority to a State under the previous sentence with respect to hospitals in a State, any subsequent in this title to the ''Secretary'' is deemed a reference to the State multicare program.

SEC. 703. REPORTS.

(a) REPORTS TO THE SECRETARY.—Each hospital with respect to which a waiver is issued under section 702(b)(4) shall submit to the Secretary—

(1) during the period such waiver is in effect, an annual report at such time, in such form, and containing such information as the Secretary may require, including a detailed description of the imple-

mentation of the agreement to which such waiver applies, and

(2) such other information as the Secretary may require for purposes of determining compliance with section 702.

(b) REPORT TO COMMITTEES OF THE CONGRESS.—

(1) CHAIRMEN OF COMMITTEES.—Not later than 7 years after the date of the enactment of this Act, the Secretary shall submit the report described in paragraph (2) to—

(A) the chairman of the Committee on the Judiciary of the House of Representatives,

(B) the chairman of the Committee on Ways and Means of the House of Representatives,

(C) the chairman of the Committee on Energy and Commerce of the House of Representatives,

(D) the chairman of the Committee on the Judiciary of the Senate,

(E) the chairman of the Committee on Finance of the Senate, and

(F) the chairman of the Committee on Labor and Human Resources of the Senate.

(2) CONTENTS OF REPORT.—The report required by paragraph (1) shall contain a description of the nature of the agreements with respect to which the Secretary issued waivers under section 702(b)(4) and of the results of implementing such agreements, including an assessment of whether such agreements caused—

(A) a reduction in health care costs,

(B) an increase in access to medical services, and

(C) improvement in the quality of health care.

Such report shall also contain the recommendations of the Secretary with respect to other arrangements to facilitate cooperative activities to achieve the results specified in subparagraphs (A), (B), and (C).

SEC. 704. DEFINITIONS.

For purposes of this title:

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

(A) section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such

section applies to unfair methods of competition, and

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

(2) The term ''high technology equipment'' includes drugs, devices, equipment, and medical and surgical procedures utilized in medical care, and the organizational and support systems within which such care is provided, that—

(A) have high capital costs or extremely high annual operating costs, and

(B) use technologies with respect to which there is a reasonable expectation that shared ownership will avoid a significant degree of the potential excess capacity of service in the geographical area to be served.

(3) The term ''medical services'' includes services that—

(A) either have high capital costs or extremely high annual operating costs, and

(B) with respect to which there is a reasonable expectation that shared ownership will avoid a significant degree of the potential excess capacity of such services in the geographical area to be served,

and may include mobile services.

(4) The term ''hospital'' means a hospital that—

(A) has entered into, and has in effect, a participation agreement under section 1866(a) of the Social Security Act, or

(B) which has in effect a participation agreement under title XIX of such Act with the State in which the hospital is located.

(5) The term ''Secretary'' means the Secretary of Health and Human Services.

○

HR 4469 IH——2

HR 4469 IH——3

HR 4469 IH——4

HR 4469 IH——5

HR 4469 IH——6

HR 4469 IH——7

HR 4469 IH——8

HR 4469 IH——9

HR 4469 IH——10

HR 4469 IH——11

HR 4469 IH——12