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103D CONGRESS
2D SESSION

H. R. 5300

To improve access to health insurance and contain health care costs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 29, 1994

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

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A BILL

To improve access to health insurance and contain health care costs, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Care Now Act of 1994''.

(b) TABLE OF CONTENTS OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families
Subtitle B—Reform of Health Insurance
Subtitle C—Preemption
Subtitle D—Health Deduction Fairness
Subtitle E—Improved Access to Community Health Services
Subtitle F—Improved Access to Rural Health Services
Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance
Subtitle H—Medicaid Reform
Subtitle I—Remedies and Enforcement with Respect to Group Health Plans
Subtitle J—Delivery of Health Care Services to Illegal Immigrants

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform
Subtitle B—Administrative Cost Savings and Fair Health Information Practices
Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts
Subtitle D—Anti-Fraud
Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Reforms
Subtitle F—Health Care Antitrust Improvements
Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities
Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests
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TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

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

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

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

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

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

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

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

(b) SPECIAL RULES.—

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

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

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

(C) there are no more than 2 full-time eligible employees who both are not covered under any group health plan and do not have health insurance coverage.

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

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

(c) REQUIRED COVERAGE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the required coverage specified in this subsection is standard coverage (consistent with section 1102(c)), including at least one option (either a fee-for-service option or a point-of-service option) that permits covered individuals an unlimited choice of the lawful providers for which covered benefits are made available.

(2) SPECIAL TREATMENT OF SMALL EMPLOYERS NOT CONTRIBUTING TO EMPLOYEE COVERAGE.—In the case of a small employer (as defined in section 1131(9)) that has not contributed during the previous plan year to the cost of coverage for any eligible employee under any group health plan, the required coverage specified in this subsection for the plan year (with respect to each eligible employee) is—

(A) MedAccess standard coverage, with a fee-for-service option and, if available, a point-of-service option and a managed care option (as defined in section 1033);

(B) MedAccess catastrophic coverage; and

(C) if available, MedAccess medisave coverage,

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

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

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

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

(A) the group health plan is in effect in the plan year in which July 1, 1994, occurs, and

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

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan until the expiration of a contract in effect on the date of the enactment of this Act or, if earlier, January 1, 2000.

PART 2—PORTABILITY AND NONDISCRIMINATION

SEC. 1011. NONDISCRIMINATION BASED ON HEALTH STATUS.

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

(1) in the case of any individual eligible for such coverage, such individual has such coverage at the time at which such individual first becomes eligible;

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

(3) the limitation or exclusion relates to pregnancy;

(4) the condition relates to a condition that was not diagnosed or treated within 3 months (or 6 months in the case of coverage not under a group health plan) before the date of such coverage; or

(5) the limitation or exclusion extends over more than 6 months (or 12 months in the case of coverage not under a group health plan) after the date of such coverage.

In the case of an individual who is eligible for coverage but for a waiting period imposed by the employer, in applying paragraphs (4) and (5), the individual shall be treated as having had such coverage as of the earliest date of the beginning of the waiting period.

(b) ONE-TIME AMNESTY PERIOD.—

(1) IN GENERAL.—In the case of an individual who, as of the first date of the amnesty period is—

(A) covered under a group health plan or has health insurance coverage, such coverage shall not be subject to pre-existing condition exclusions on and after such date; or

(B) not so covered, if the individual obtains coverage under a group health plan or health insurance coverage during the next avail-

able open enrollment period with respect to the individual, coverage so obtained shall not be subject to pre-existing condition exclusions on and after the effective date of such coverage.

(2) AMNESTY PERIOD.—The amnesty period described in this paragraph, with respect to an individual who is a resident of a State, is the 45-calendar-day period beginning on the effective date of this part (under section 1032(b)).

(3) ESTABLISHMENT OF SPECIAL ALLOCATION OF RISK POOL FOR AMNESTY.—Each State shall establish rules and requirements relating to the allocation of risk among insurers with respect to additional risks assumed as a result of the amnesty period under this subsection (including individuals previously covered for whom a preexisting condition exclusion will be no longer applicable).

(c) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provi-

sions of this part so long as such exclusion is applied consistent with the provisions of this part.

SEC. 1012. PORTABILITY.

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

(b) CONTINUOUS COVERAGE REQUIRED.—

(1) IN GENERAL.—Subsection (a) shall no longer apply if there is a continuous period of more than 60 days (or, in the case of an individual described in paragraph (2), 6 months) for which the individual did not have health insurance coverage for the condition or was not covered under a group health plan for the condition.

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

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

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

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

(c) TRANSITION FOR NON-CONFORMING POLICIES.—Notwithstanding State law or the provision of any agreement to the contrary, effective January 1, 1997, an insurer may cancel or refuse to renew health insurance coverage in a State prior to the application of this subtitle to health insurance coverage issued in the State if the coverage does not provide for either standard or catastrophic coverage, but only if the insurer offers the covered individual affected the opportunity to obtain health insurance coverage that meets the applicable requirements of this title.

(d) APPLICABILITY OF COVERAGE UNDER PUBLIC INSURANCE.—In this section, an individual shall be considered to have health insurance coverage for a condition

without regard to whether such coverage is under a private or public plan.

SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

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

(1) for nonpayment of contributions,

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

(3) for noncompliance with plan provisions, or

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

(b) INSURERS.—

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

(A) for nonpayment of premiums,

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

(C) for noncompliance with plan provisions, or

(D) subject to paragraph (2), because the insurer is ceasing to provide any health insurance coverage (or the same type of health insurance coverage in the same individual or small employer insurance market) in a State, or, in the case of a health maintenance organization or other network plan, in a geographic area.

(2) NOTICE REQUIREMENT FOR MARKET EXIT.—Paragraph (1)(D) shall not apply to an insurer ceasing to provide coverage unless the insurer provides notice of such termination to employers and individuals covered at least 180 days before the date of termination of coverage.

(3) LIMITATION ON REENTRY IN EMPLOYER AND INDIVIDUAL MARKETS.—If an insurer ceases to offer or provide health insurance coverage (or a type of insurance coverage) in an area with respect to the individual or small group market, the insurer may not offer such health insurance coverage (or type of coverage) in the area in such market until 5 years after the date of the termination.

(4) TYPE OF COVERAGE AND INSURANCE MARKET DEFINED.—In this subsection—

(A) MedAccess standard coverage, MedAccess catastrophic coverage, and

MedAccess medisave coverage shall each be considered to be separate types of health insurance coverage; and

(B) the term ''small group market'' means the insurance market offered to individuals seeking health care coverage on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to an employer or an association.

PART 3—STANDARDS FOR MANAGED CARE ARRANGEMENTS

SEC. 1021. STANDARDS FOR MANAGED CARE ARRANGEMENTS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each group health plan, and each insurer providing health insurance coverage, for health care through a managed care arrangement shall comply with the applicable requirements of this section.

(2) DEFINITIONS.—In this section:

(A) MANAGED CARE ARRANGEMENT DEFINED.—The term ''managed care arrangement'' means, with respect to an arrangement under a group health plan or under health insurance coverage, providers who have entered

into an agreement under the arrangement under which such providers are obligated to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A) under a managed care arrangement.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall enter into such agreements with health care providers (including primary and specialty providers for children) or have such other arrangements as may be necessary to assure that covered individuals have reasonably prompt access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided (including access to emergency services on a 24-hour basis where medically necessary), in a man-

ner that assures the continuity of the provision of such items and services.

(2) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise of designated centers of excellence. Such entity shall demonstrate such access according to standards developed by the Secretary, including requirements relating to arrangements with such centers and referral of patients to such centers.

(B) DESIGNATION OF CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities, including children's hospitals and other pediatric facilities, as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

(3) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—An entity providing for a managed care arrangement may not require an individual to obtain a referral from a physician in order to obtain covered items and services within the network of the arrangement from a physician who specializes in obstetrics and gynecology.

(c) PROVISION OF EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage must cover medically necessary emergency and urgent care services provided to covered individuals (including trauma services provided by designated trauma

centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the entity to provide items or services to covered individuals and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term ''designated trauma center''—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) DUE PROCESS STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(A) ESTABLISHMENT.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall establish standards to be used by the entity for contracting with health care providers with respect the entity's provider network. Such standards shall be established in consultation with providers who are members of the network.

(B) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards shall be made available upon request to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers.

(2) NOTICE REQUIREMENT.—

(A) IN GENERAL.—The entity may not terminate or refuse to renew an agreement with a provider to participate in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or to refuse to renew the agreement. The notification shall include a statement

of the reasons for the entity's decision, consistent with the standards established under paragraph (1).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(3) REVIEW PROCESS.—

(A) IN GENERAL.—The entity shall provide a process under which the provider may request a review of the entity's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the entity's provider network or employees of the entity, and who are members of the same profession as the provider who requests the review.

(B) COUNSEL.—If the provider requests in advance, the entity shall permit an attorney

representing the provider to be present at the provider's review.

(C) REVIEW ADVISORY.—The findings and conclusions of a review under this paragraph shall be advisory and non-binding.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

SEC. 1022. UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—A group health plan or insurer providing health insurance coverage may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs, consistent with subsection (c), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties, including representatives of health care providers, specialists, insurers, plan administrators, and other experts.

(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (a)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence; and

(5) providers shall participate in the development of the utilization review program.

(d) PREEMPTION.—For provision preempting State laws relating to utilization review, see section 1203(a)(3).

PART 4—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 1031. ENFORCEMENT.

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

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

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY PENALTY FOR INSURERS.—

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

"SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

''(a) IMPOSITION OF PENALTY.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under parts 2 and 3 of subtitle A of title I and subtitle B of the Affordable Health Care Now Act of 1994.

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

''(b) AMOUNT OF PENALTY.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to health insurance coverage shall not exceed 25 percent of the amounts received for such coverage during the period such failure persists.

''(c) LIABILITY FOR PENALTY.—The penalty imposed by this section shall be paid by the insurer.

''(d) EXCEPTIONS.—

''(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

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

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

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

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'insurer' have the respective meanings given such terms in section 1033 of the Affordable Health Care Now Act of 1994.''.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

''Sec. 4980C. Failure of insurer to comply with health insurance standards.''

SEC. 1032. EFFECTIVE DATES.

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

(b) PARTS 2 AND 3.—The requirements of parts 2 and 3 shall apply with respect to—

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

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

SEC. 1033. DEFINITIONS AND SPECIAL RULES.

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

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

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

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

(i) under 19 years of age, or

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

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis at least 10 hours of service per week for that employer. Such term shall not include any employee who is not reasonably expected as of the 1st day of a month to be employed by the employer for a period

of 120 consecutive days during any 365-day period that includes such 1st day.

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

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

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

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

the definition of a health insurance coverage under section 1131(4)(B).

(B) The term ''plan'' means a group health plan (including any such plan which is a multiemployer plan) and an exempted multiple employer health plan.

(7) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' shall have the meaning applicable under section 1131(4).

(8) FULLY INSURED.—The term ''fully insured'' shall have the meaning applicable under section 701(9) of Employee Retirement Income Security Act of 1974 (as added by section 1211 of this title).

(9) INSURER.—The term ''insurer'' has the meaning given such term in section 1131(6).

(10) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term ''multiple employer welfare arrangement'' shall have the meaning applicable under section 3(40) of the Employee Retirement Income Security Act of 1974.

(11) OPTIONS.—

(A) FEE-FOR-SERVICE OPTION.—Standard coverage is considered to provide a ''fee-for-service option'' if benefits with respect to the

covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services.

(B) MANAGED CARE OPTION.—Standard coverage is considered to provide a ''managed care option'' if benefits with respect to the covered items and services in the coverage are made available exclusively through a managed care arrangement (as defined in section 1021(a)(2)), except in the case of emergency and urgent services and as otherwise required under law.

(C) POINT-OF-SERVICE OPTION.—Standard coverage is considered to provide a ''point-of-service option'' if the benefits with respect to covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the enrollee to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are

provided through such an arrangement or outside such an arrangement.

(b) APPLICATION OF ERISA DEFINITIONS.—Except as otherwise provided in this subtitle, terms used in this subtitle shall have the meanings applicable to such terms under section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

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

Subtitle B—Reform of Health Insurance

PART 1—MARKETPLACE FOR SMALL BUSINESS

SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER MEDACCESS COVERAGE.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each insurer (as defined in section 1131(6)) that makes available any health insurance coverage (as defined in section 1131(4)) to a small employer (as defined in section 1131(9)) in a State—

(A) shall make available to each small employer in the State MedAccess standard coverage (as defined in section 1102(a)(2)), with a

fee-for-service option and, if available, a point-of-service option and a managed care option (as defined in section 1033),

(B) shall make available to each small employer in the State MedAccess catastrophic coverage (as defined in section 1102(a)(2)), and

(C) may make available to each small employer in the State MedAccess medisave coverage (as defined in section 1102(a)(2)).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraph (1)(A) (with regard to requiring a fee-for-service option), and paragraphs (1)(B) and (1)(C) shall not apply with respect to a health insurance coverage that—

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

(B) is not provided by such an organization but is provided by an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

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

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

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

(b) GUARANTEED ISSUE OF MEDACCESS COVERAGE.—Subject to subsection (c)—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), each insurer that offers MedAccess coverage to a small employer in a State—

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

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (5)) who applies for enrollment on a timely basis (consistent with paragraph (4)) and may not place any restriction on the eligibility of an individual to enroll so long as such individual is an eligible individual.

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

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

(B) limit the individuals who may be enrolled under such coverage to those who reside in the service area for such organization; and

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

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

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

(iii) it will not offer coverage to such employers within such service area for a

period of at least 180 days after such coverage is denied.

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

(3) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In the case of coverage offered by an insurer other than a health maintenance organization or network plan, the insurer may deny such coverage to small employers if the organization demonstrates that—

(A) it does not have the financial reserves necessary to underwrite additional coverage,

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

(C) it shall not offer coverage to such employers within such service area for a period of at least 180 days after such coverage is denied.

(4) CLARIFICATION OF TIMELY ENROLLMENT.—

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

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—Enrollment under MedAccess coverage is considered to be timely in the case of an eligible individual who—

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

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

(iii) lost coverage under a group health plan or other health insurance coverage (as a result of the termination of the

coverage, termination or reduction of employment, or other reason), and

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

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each insurer and each group health plan providing MedAccess coverage shall provide for at least one period (of not less than 30 days) each year during which enrollment under such coverage shall be considered to be timely.

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

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

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

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse)

and any dependent child of an eligible employee shall be considered to be timely if a request for enrollment is made either—

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

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

(ii) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date of the marriage or the date of birth or adoption of the child (as the case may be).

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

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

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

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

SEC. 1102. MEDACCESS COVERAGE DEFINED.

(a) MEDACCESS COVERAGE DEFINED.—In this subtitle:

(1) IN GENERAL.—The term ''MedAccess coverage'' means a health insurance coverage (whether under a managed-care plan, indemnity plan, or other plan) that meets the following requirements:

(A) The coverage—

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

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

(iii) is designed to provide medisave coverage (consistent with subsection (e)).

(B) The coverage includes only services, including (but not limited to) medical, surgical, hospital, and preventive services, which are essential and medically necessary; except that no specific procedure or treatment, or classes thereof, is required to be included in such coverage, by this Act or through regulations.

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

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

(2) MEDACCESS STANDARD, CATASTROPHIC, AND MEDISAVE COVERAGE.—The terms ''MedAccess standard coverage'', ''MedAccess catastrophic coverage'', ''MedAccess medisave coverage'' mean MedAccess coverage that provides for at least standard coverage (referred to in paragraph (1)(A)(i)), for only catastrophic coverage (referred to in para-

graph (1)(A)(ii)), or medisave coverage (referred to in paragraph (1)(A)(iii)), respectively.

(b) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules, including an appropriate set of safe-harbors, which the NAIC determines is sufficient for determining, in the case of any health insurance coverage and for purposes of this section, the actuarial value of the coverage offered.

(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this part. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

(c) STANDARD COVERAGE.—

(1) IN GENERAL.—For purposes of this Act, health insurance coverage is considered to provide standard coverage consistent with this subsection if the benefits are specified in a written instrument

providing for such coverage as essential and medically necessary services described in subsection (a)(1)(B) and determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the applicable target actuarial value for standard coverage established under paragraph (2).

(2) INITIAL DETERMINATION OF APPLICABLE TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a procedure for determining the applicable target actuarial value for standard coverage (which may vary by geographic area). Such value shall be equal to the average actuarial value of a representative range of the different types of health benefits provisions (which include cost-sharing) typically offered as standard coverage in the small employer health coverage market. In determining the actuarial value, the benefits considered should be sufficient to cover only services, including (but not

limited to) medical, surgical, hospital, and preventive services, which are essential and medically necessary; except that no specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors (which may vary by geographic area).

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

(d) CATASTROPHIC COVERAGE.—

(1) IN GENERAL.—For purposes of subsection (a)(1)(B), health insurance coverage is considered to

provide catastrophic coverage consistent with this subsection if—

(A) benefits are available under such coverage for a year only to the extent that expenses for covered services in a year exceed a deductible amount that is consistent with the dollar amounts specified in section 220(c)(2)(A) of the Internal Revenue Code of 1986, as added by section 2202, and

(B) the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the target actuarial value for catastrophic coverage established under paragraph (2).

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

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for catastrophic coverage equal to the actuarial value that would have been computed under subsection (c)(2)(A) if a deductible that represents the midpoint of the range of deductibles per-

mitted consistent with subsections (b)(2) and (c)(2)(A) of section 220 of the Internal Revenue Code of 1986 were used in place of any deductible that otherwise would be applicable.

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

(e) MEDISAVE COVERAGE.—

(1) IN GENERAL.—For purposes of subsection (a)(1)(C), health insurance coverage is considered to provide medisave coverage consistent with this subsection if such coverage consists of—

(A) coverage under a catastrophic health plan (within the meaning of section 220(c)(2) of the Internal Revenue Code of 1986, as inserted by section 2202 of this Act), and

(B) a medical savings account described in section 220(d)(1)(B) of such Code.

(f) SUBSEQUENT REVISIONS.—

(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence previously established or determined under this section if the NAIC determines such revision necessary to take into account changes in the relevant types of health benefits provisions, in deductible levels for catastrophic coverage, or in demographic conditions which form the basis for such set of rules. The provisions of subsection (b)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

(2) SECRETARY.—The Secretary may by regulation revise such set or rules and values from time to time if the Secretary determines such revision necessary to take into account changes described in paragraph (1).

SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STANDARDS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regula-

tions that specify standards with respect to each of the following:

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

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

(B) The requirements of section 1104 (relating to use of modified community rating, uniform marketing materials, and miscellaneous consumer protections).

If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements de-

scribed in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

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

(4) PREEMPTION OF STATE LAW.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a State may not establish or enforce standards for health insurance coverage made available to small employers and individuals that are different from the standards established under this part.

(B) GRANDFATHER.—In the case of a State that, as of August 1, 1994, required that premiums in the individual and small group market sectors be community-rated and not vary based on age, the State continue such standards (and reasonable modifications thereof) in force.

(5) DEFINITIONS.—In this section:

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

(B) MEDACCESS STANDARDS.—The term ''MedAccess standards'' means the standards established under paragraph (1)(A) (relating to the requirements of section 1101), and includes the consumer protection standards insofar as they relate to MedAccess coverage.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF MEDACCESS STANDARDS.—

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

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year

after the date the MedAccess standards are established under subsection (a).

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

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

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

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

deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the MedAccess standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and plans providing MedAccess coverage offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected. In exercising authority under this subparagraph, the Secretary shall determine whether the use of a risk-allocation mechanism, described in section

1101(c), would be more consistent with the small employer group health coverage market in the State than the guaranteed availability provisions of section 1101(b).

(3) APPLICATION OF CONSUMER PROTECTION STANDARDS.—

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

(B) DEADLINE FOR REPORT.—

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

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

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

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

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

(4) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided

adequate enforcement of the consumer protection standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and health insurance coverage (other than MedAccess coverage) offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

SEC. 1104. USE OF MODIFIED COMMUNITY RATING, UNIFORM MARKETING MATERIALS, AND MISCELLANEOUS CONSUMER PROTECTIONS.

(a) USE OF MODIFIED COMMUNITY RATING.—

(1) IN GENERAL.—As a standard under section 1103(a)(1)(B), subject to paragraph (2), the premium rate established by an insurer for coverage

may not vary within a type of product except by the following:

(A) AGE.—By age, based on classes of age established by a State.

(B) GEOGRAPHIC AREA.—By geographic area, based on 3-digit zip code or counties, as identified by a State.

(C) FAMILY SIZE.—Family size, based on a classification of individual, individual with one or more children, married couple without children, and married couple with children.

(2) DISCOUNT FOR EMPLOYER WELLNESS PROGRAM.—An insurer may provide for a group discount with respect to an employer that provides for a wellness program for employees.

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

(c) ACTUARIAL CERTIFICATION.—Each insurer that offers health insurance coverage to a small employer in a State shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable

to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health insurance coverage—

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

(2) the rating methods are actuarially sound.

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

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

(e) MARKETING MATERIAL.—Each insurer that issues any health insurance coverage to a small employer in a State shall file with the State those marketing materials relating to the offer and sale of health insurance coverage to be used for distribution before the materials are used. Such materials shall be in a uniform format specified under the standards established under section 1101. Such materials (including information on plan designs offered by different insurers) shall be distributed to employ-

ers that do not contribute to health insurance coverage for their employees, in order to distribute such information to their employees as part of the offer of coverage under section 1001(a).

SEC. 1105. MONITORING AND RESPONSE TO ADVERSE SELECTION; RISK ADJUSTMENT PROGRAMS.

(a) MONITORING.—The Secretary of Labor shall monitor the prevalence and impact of adverse risk selection in the fully insured plans made available to small employers resulting from the decision of small employers to self insure. State insurance commissioners may submit to the Secretary such information on such adverse risk selection as they determine to be appropriate.

(b) RESPONSE.—If the Secretary of Labor determines, on the basis of such information or otherwise, that, due to decisions of small employers to self-insure, there has been substantial or significant favorable selection with respect to self-insured plans or unfavorable selection with respect to fully insured plans in a State, the Secretary shall develop a risk adjustment program under subsection (c) that responds to such a pattern in the State. The Secretary shall request the NAIC to submit to the Secretary recommendations regarding the structure and operation of such a program.

(c) ESTABLISHMENT OF RISK ADJUSTMENT PROGRAM.—The risk adjustment program applied in a State under this subsection—

(1) shall be designed to be operated on a nongovernmental basis,

(2) shall require participation of each small employer in the State that is self-insured,

(3) shall require the imposition of such assessments on self-insured plans offered by such employers as may be appropriate to prevent further adverse or favorable selection, and

(4) shall provide for the distribution of such assessments to the State involved for purposes of making payments to insurers to stabilize the small group insurance market.

The amounts of the assessments under paragraph (3) for individual employers may take into account the number of lives covered under the plans of such employers and the area of residence of the lives covered.

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

(a) ESTABLISHMENT OF STANDARDS.—

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

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

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

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

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

(2) FEDERAL ROLE.—

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

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

each State an appropriate reinsurance mechanism.

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

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

PART 2—MARKETPLACE FOR INDIVIDUALS

SEC. 1111. APPLICATION OF SIMILAR REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c)—

(1) the provisions of part 1 of this subtitle shall apply to insurers offering health insurance coverage to individuals in the individual market (as defined in subsection (b)) in the same manner as such provisions apply to insurers offering health insurance coverage to employers, and

(2) the standards established under section 1103 shall apply under this part in the same manner as they apply under part 1.

For purposes of this subsection, any reference to an employee or eligible employee is deemed a reference to such an individual.

(b) INDIVIDUAL MARKET DEFINED.—In subsection (a), the term ''individual market'' means the insurance market offered to individuals seeking health care coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment, membership in a organization, or through another group purchasing arrangement.

(c) EXCEPTION AND SPECIAL RULE.—

(1) WELLNESS DISCOUNTS.—Section 1104(a)(2) (relating to discounts for employer wellness programs) shall not apply under this part.

(2) SEPARATE APPLICATION OF RISK ADJUSTMENT TO INDIVIDUAL MARKET SECTOR.—Section 1105 (relating to monitoring and response to adverse selection; risk adjustment programs) shall be applied under this part in a manner that is separate from its application under part A.

(3) SEPARATE AGE RATING FACTOR FOR THE INDIVIDUAL MARKET.—The provisions regarding age under section 1104(a)(1)(A) shall be determined separately for each year of age and not by the classes of age referred to in such section.

(4) CONVERSION OF PERMANENT HEALTH INSURANCE POLICIES.—The provisions of section 1104 shall not apply in connection with a permanent policy of health insurance existing on the effective date, if each individual covered under the policy is given the option to convert the policy to a policy of health insurance subject to this part.

(d) APPLICATION OF REQUIREMENTS.—Coverage offered by an insurer shall not be treated as MedAccess coverage under this part unless the insurer complies with the requirements of part 3 of subtitle A (relating to standards

for managed care arrangements and essential community providers) in the same manner as such requirements apply to a group health plan.

PART 3—VOLUNTARY HEALTH PURCHASING ARRANGEMENTS

SEC. 1121. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Voluntary health purchasing arrangements (in this part referred to as ''purchasing arrangements'') may be established in accordance with this part. Each purchasing arrangement shall be chartered under State law and operated as a not-for-profit corporation. An insurer may not form, underwrite, or possess a majority vote of a purchasing arrangement, but may administer such an arrangement.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each purchasing arrangement shall be governed by a Board of Directors. Such Board shall initially be appointed under procedures established by the State in which it operates. Subsequently, the Board shall be elected by the members of the arrangement in accordance with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees),

and eligible individuals in the area in which the arrangement operates.

(2) MEMBERSHIP.—A purchasing arrangement shall accept all small employers, eligible employees, and eligible individuals residing within the area served by the arrangement as members if such employers, employees or individuals request such membership.

(3) VOTING.—Members of a purchasing arrangement shall have voting rights consistent with the rules established under the bylaws governing the arrangement.

(c) DUTIES OF PURCHASING ARRANGEMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), each purchasing arrangement shall—

(A) market MedAccess coverage to members throughout the entire area served by the arrangement;

(B) enter into agreements with insurers offering MedAccess coverage under section 1122;

(C) enter into agreements with small employers under section 1123;

(D) enroll individuals in MedAccess coverage, only in accordance with section 1124; and

(E) carry out other functions provided for under this part.

(2) LIMITATION ON ACTIVITIES.—A purchasing arrangement shall not—

(A) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(B) perform any activity (including certification or enforcement) relating to compliance of insurers or coverage with the requirements of parts 1 or 2;

(C) assume financial risk in relation to any such coverage; or

(D) perform other activities identified by the State as being inconsistent with the performance of its duties under paragraph (1).

(3) CHARACTERISTICS OF SERVICE AREA.—A purchasing arrangement need not serve areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established for geographic areas used in establishing premium rates in the individual and small group marketplace. If a purchasing arrangement serves a part of a metropolitan statistical area the arrangement shall serve the entire area.

(d) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(1) that a purchasing arrangement be established in each area of a State in which it operates; and

(2) that there be only one purchasing arrangement established with respect to any area.

SEC. 1122. AGREEMENTS WITH INSURERS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing arrangement for an area shall enter into an agreement under this section with each insurer that desires to make MedAccess coverage available through the purchasing arrangement (consistent with any procedures established by the State).

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing arrangement may terminate an agreement under paragraph (1) if the insurer's license or certification under State law is terminated or for other good cause shown.

(3) LIMITATION ON RENEWAL OF AGREEMENTS.—Subsequent to the 12-month period de-

scribed in paragraph (2), a purchasing arrangement may—

(A) refuse to enter into a subsequent agreement with an insurer if the arrangement determines that the enrollment or premium is too low, and

(B) if a previous agreement with an insurer was terminated for good cause and the arrangement determines appropriate actions have not been taken to correct the problems, refuse to enter into a subsequent agreement with the insurer.

(4) NO PROHIBITION ON OFFERING OF COVERAGE.—Nothing in this subsection shall be construed as prohibiting an insurer that does not enter into an agreement under paragraph (1) from offering health insurance coverage to small employers and eligible individuals within any area, so long as the premium rates charged outside such arrangement are the same as those charged within the arrangement (subject to reasonable differences in premiums that only reflect savings in administrative costs under such an arrangement).

(b) RECEIPT OF PREMIUMS ON BEHALF OF PLANS.—

(1) IN GENERAL.—Under an agreement under this section between a purchasing arrangement and an insurer—

(A) premiums shall be payable, and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the purchasing arrangement for the benefit of the insurer.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on a quarterly basis). The purchasing arrangement may provide for reasonable penalties and grace periods for late payment.

(3) QUALIFIED HEALTH PLANS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing arrangement any risk associated with the failure of individuals and employers to make prompt payment of premiums to the purchasing arrangement (other than the portion of the premium representing the purchasing arrangement administrative fee under section 1125). Each small employer and eligible individual who enrolls with an insurer through the purchas-

ing arrangement is liable to the insurer for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments for an insurer are made to the purchasing arrangement, the purchasing arrangement shall forward to the insurer the amount of the premiums and the purchasing arrangement (and not the employer or individual) shall be liable for the premium payment collected under such arrangement.

(2) PAYMENTS.—Payments shall be made by the purchasing arrangement under this subsection within a period of days (specified by the Secretary and not to exceed 7 days) after receipt of the premium from the small employer of the eligible employee or the eligible individual, as the case may be.

SEC. 1123. PROVISION OF INFORMATION.

(a) IN GENERAL.—Each purchasing arrangement for an area shall provide, upon request, to each small employer that employs individuals in the area and to each eligible individual who resides in the area—

(1) information provided to the purchasing arrangement by the State or insurers in accordance

with rules by the State in which such arrangement is located, and

(2) the opportunity to enter into an agreement with the arrangement for the purchase of coverage through the insurer.

(b) FORWARDING INFORMATION AND PAYROLL DEDUCTIONS.—As part of an agreement entered into under this section, a small employer shall forward the information and make the payroll deductions required under section 1001.

SEC. 1124. ENROLLING ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS THROUGH A PURCHASING ARRANGEMENT.

A purchasing arrangement shall offer, on behalf of each insurer with which an agreement was entered into under section 1122 and in accordance with the enrollment procedures of such insurers, enrollment in health insurance coverage only to—

(1) all eligible employees employed by small employers in the area served by the purchasing arrangement; and

(2) all eligible individuals residing in such area.

SEC. 1125. RESTRICTION ON CHARGES.

(a) IN GENERAL.—A purchasing arrangement may impose an administrative fee with respect to an eligible

employee or eligible individual obtaining coverage through the purchasing arrangement.

(b) FEE.—A purchasing arrangement that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for such coverage and is imposed uniformly with respect to all coverage provided through the arrangement.

PART 4—DEFINITIONS AND MISCELLANEOUS PROVISIONS

SEC. 1131. DEFINITIONS.

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

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

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who—

(A) normally performs on a monthly basis at least 10 hours of service per week for that employer; or

(B) is reasonably expected as of the 1st day of such month to be employed by the employer for a period of 120 consecutive days dur-

ing any 365-day period that includes such 1st day.

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

(4) HEALTH INSURANCE COVERAGE.—

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

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

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

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(5) NETWORK PLAN.—The term ''network plan'' includes, as defined in standards established under section 1103, an organization that provides health insurance coverage which meets specified standards and under which health services are offered to be provided on an at-risk basis primarily through a defined set of providers.

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

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

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

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

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

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

SEC. 1132. ENFORCEMENT.

For enforcement of requirements of this subtitle, see section 1031.

SEC. 1133. PROHIBITION OF IMPROPER INCENTIVES.

(a) LIMITATION ON FINANCIAL INCENTIVES.—No insurer that offers health insurance coverage may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) PROHIBITION OF TIE-IN ARRANGEMENTS.—No insurer that offers health insurance coverage may require the purchase of any other insurance or product as a condition for the purchase of such coverage.

SEC. 1134. ANNUAL REPORTS.

(a) IN GENERAL.—The Secretary shall submit to Congress an annual report on the implementation of this subtitle and the need for additional reforms to assure and expand coverage.

(b) INFORMATION REGARDING IMPACT OF REFORMS.—Each annual report shall include information concerning at least the following:

(1) Implementation and enforcement of the applicable MedAccess standards and consumer protection standards under this subtitle by the States and by the Secretary.

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

(A) guaranteed availability of health coverage,

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

(C) requirement for continuity of coverage,

(D) risk-management mechanisms for health coverage,

(E) limits on premium variations, and

(F) preemption of State benefit mandates.

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

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

(c) INFORMATION REGARDING COVERAGE OF THE UNINSURED.—The report submitted under this section 5 years after the date of the enactment of this Act also shall include findings and recommendations regarding each of the following:

(1) Characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution.

(2) Steps which should be taken to improve access to health care and increase health insurance coverage of the chronically uninsured.

(3) Effectiveness of efforts to measure and improve health care outcomes in the public and private sectors.

(4) Effectiveness of initiatives targeted to improving access of underserved urban and rural populations to health care services.

(5) Effectiveness of new Federal subsidy programs, including recommendations to restrain future growth of such programs.

SEC. 1135. RESEARCH AND DEMONSTRATION PROJECTS; DEVELOPMENT OF A HEALTH RISK POOLING MODEL.

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

(1) to conduct research on the impact of this subtitle on the availability of affordable health coverage for employees and dependents in the small employers group and individual health care coverage market and other topics described in section 1134(b), and

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

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

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

(2) METHODOLOGY.—The methods—

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

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

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

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

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

(2) REDISTRIBUTION OF RISK.—Under such model, insurers and group health plans with below average health risks would be required to contribute to a common fund for payment to insurers and group health plans with above average health risks, each in relation to the degree of their favorable or adverse risk selection.

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

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

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

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 in each of fiscal years 1995 through 1999.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

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

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

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

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under a multiple employer welfare arrangement under which all coverage consists of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 and is fully insured.

SEC. 1203. PREEMPTION OF STATE ANTI-MANAGED CARE LAWS.

(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 re-

stricts the ability of a group health plan or insurer to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan or insurer 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,

(E) imposes liability for delays in performing such review, or

(F) requires standards in addition to or inconsistent with standards established under section 1022(b).

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

(b) GAO STUDY.—

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

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

whether the provisions of subsection (a) should be extended) as may be appropriate.

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

SEC. 1204. DEFINITIONS.

For purposes of this part, the terms ''dependent'', ''employee'', ''employer'', ''fully insured'', ''group health plan'', ''health insurance plan'', ''multiple employer welfare arrangement'', and ''State'' have the meanings given such terms in section 1023(a).

PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

SEC. 1211. LIMITED EXEMPTION FROM CERTAIN RESTRICTIONS ON ERISA PREEMPTION OF STATE LAW FOR HEALTH PLANS MAINTAINED BY MULTIPLE EMPLOYERS SUBJECT TO CERTAIN FEDERAL STANDARDS.

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

''Part 7—Multiple Employer Health Plans

''SEC. 701. DEFINITIONS.

''For purposes of this part—

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

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

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

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

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

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

''(7) 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.

''(8) FULLY INSURED.—Coverage under a multiple employer welfare arrangement is 'fully insured' if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective

of any recourse they may have against other parties).

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

''(10) COMMUNITY HEALTH NETWORK.—The term 'community health network' has the meaning given such term in section 1421 of the Affordable Health Care Now Act of 1994.

"SEC. 702. EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS 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 under which coverage is not fully insured and with respect to which there is in effect an exemption granted by the Secretary under this part (or with respect to which there is pending a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate)—

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

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

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

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

"SEC. 703. EXEMPTION PROCEDURE.

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

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

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

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

''(A) administratively feasible,

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

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

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

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

"SEC. 704. ELIGIBILITY REQUIREMENTS.

''(a) APPLICATION FOR EXEMPTION.—

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

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

sole purpose of administering the exemption procedures under this part.

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

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

''(i) the sponsor, and

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

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

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

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

provided to individuals covered under the arrangement.

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

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

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

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

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

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

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

other expenses associated with the operation of the arrangement.

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

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

''(1) SPONSOR.—

''(A) IN GENERAL.—Except in a case to which subparagraph (B) or (C) applies, 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 similar business group), for substantial purposes other than that of obtaining or providing medical care

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

''(B) SPECIAL RULE FOR COMMUNITY HEALTH NETWORKS.—In the case of an arrangement that is a community health network (as defined in section 701(11)), the sponsor is the operating committee of the network.

''(C) SPECIAL RULE FOR EMPLOYERS IN THE SAME TRADE OR BUSINESS.—In the case of an arrangement under which all participating employers are engaged in a common type of trade or business, the sponsor is the operating committee of the arrangement.

''(2) OPERATING COMMITTEE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year

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

''(B) SPECIAL RULE FOR COMMUNITY HEALTH NETWORKS.—In the case of an arrangement that is a community health network (as defined in section 701(11)), the operating committee is the board of the entity that is the network.

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

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

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

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

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

''(i) all participating employers must be members or affiliated members of the

sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an 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 subsection (b)(1) with respect to a sponsor are met with respect to the network.

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

ployers 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 MULTIPLE EMPLOYER HEALTH PLANS.

''(a) NOTICE OF MATERIAL CHANGES.—In the case of any exempted multiple employer health plan, descriptions of material changes in any information which was required to be submitted with the application for the exemption granted under this part 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 which is or has been an exempted multiple employer health plan 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 which is or has been an exempted multiple employer health plan 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) that the arrangement is not a licensed insurer under the laws of any State,

''(B) whether coverage under the arrangement is fully insured, and

''(C) if coverage under the arrangement if not fully insured, (i) whether the arrangement is (or has ceased to be) an exempted multiple employer health plan, and (ii) if such an arrangement is an exempted multiple employer health plan, that such arrangement is treated as an employee welfare benefit plan under this title.

''(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 which is or has been an exempted multiple employer health plan and under which coverage is not fully insured shall establish and maintain reserves, consisting of—

''(1) a reserve for unearned contributions,

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

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

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

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

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

''(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to

the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

''(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement (including a community health network) to substitute, for all or part of the reserves required under subsection (a), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall continue to meet the requirements of section 707, irrespective of whether such exemption continues in effect. The operating committee of such arrangement shall determine semiannually whether the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination

and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

''(b) TERMINATION.—

''(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple employer welfare arrangement which is or has been an exempted multiple employer health plan 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 which is or has been an exempted multiple employer health plan 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 expi-

rations 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 which is or has been an exempted multiple employer health plan (as defined in section 701(10)).''.

(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 health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
''Sec. 703. Exemption procedure.
''Sec. 704. Eligibility requirements.
''Sec. 705. Additional requirements applicable to exempted multiple employer health plans.
''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. 1212. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting '', but only, in the case of an arrangement which provides medical care described in section 607(1) and with respect to which an exemption under part 7 is not in effect,'' before ''to the extent not inconsistent with the preceding sections of this title''.

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

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

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

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

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

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

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

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

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is

made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.''.

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

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

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

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

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

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

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

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

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

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

employment in such a bargaining unit), or

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

''(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause (ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan statistical area, this clause shall be applied by reference to the

State in which the sponsoring organization represents employees,

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

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

''(II) if, for any year, 10 percent or more of the covered individuals under the plan are individuals not described 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 Board determines to have been negotiated or otherwise

agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

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

''(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I) or cases given priority under section 10 of the National Labor Relations Act (29 U.S.C. 160).

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

in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

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

SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

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

''(43) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT.—

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

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

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

''(B) EXCEPTION.—Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the in-

dividuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.''.

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

''(E) The term 'multiple employer welfare arrangement' includes any employee leasing healthcare arrangement.''.

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

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

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

''(a) IN GENERAL.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrange-

ment 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, and

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

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

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

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

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

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by the

preceding provisions of this title) is further amended by inserting after the item relating to section 710 the following new item:

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

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

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

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

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

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

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

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

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

(3) by adding at the end the following:

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

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

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

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

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an exempted multiple employer welfare arrangement (as defined in section 701(10)),

''(2) being an employee leasing healthcare arrangement under an exemption granted under part 7, or

''(3) 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—

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

''(B) it 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 multiple employer welfare arrangements under which all coverage is fully insured, and

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

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

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

that the requirements of this section are met in connection with claims filed under the arrangement.''.

SEC. 1217. SOLVENCY REQUIREMENTS FOR CERTAIN SELF-INSURED GROUP HEALTH PLANS.

(a) IN GENERAL.—The Secretary of Labor shall prescribe by regulation provisions described in subsection (b) applicable to group health plans which are not multiple employer health plans, which offer coverage with respect to employees of small employers (as defined in section 1131), and under which some or all coverage is not fully insured (within the meaning of section 701(9) of the Employee Retirement Income Security Act of 1974)), for the purpose of promoting adequate funding of such plans.

(b) REQUIREMENTS.—

(1) GENERAL RULE.—Except as provided in paragraph (2), the provisions described in subsection (a) shall require the group health plan to establish and maintain reserves, consisting of—

(A) a reserve for unearned contributions, and

(B) 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.

(2) EXCEPTION.—The Secretary may in such regulations permit a group health plan to substitute, for all or part of the reserves required under paragraph (1), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis.

(c) CRITERIA FOR COMPLIANCE.—The criteria that the Secretary shall take into account in determining compliance with the requirements described in subsection (b) shall include—

(1) the size of the employer involved;

(2) the benefit package provided under the plan;

(3) whether the coverage provided under the plan is in the form of a fee-for-service arrangement, a health maintenance organization, or any other type of coverage;

(4) the extent to which excess/stop loss coverage is maintained for the plan; and

(5) the nature of any security, guarantee, or other financial arrangement described in subsection (b)(2) obtained for the plan.

SEC. 1218. FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING HEALTH BENEFITS.

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

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

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

''(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1995) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care described in section 607(1).

''(2) Each registration statement—

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

regulations which shall be prescribed by the Secretary, and

''(B) if coverage under 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 which is an exempted multiple employer health plan (as defined in section 701(10)), the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not an exempted multiple employer health plan, 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. 1219. 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 which are or have been exempted multiple employer health plans (as defined in section 701(10)). 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. 1220. EFFECTIVE DATE; TRANSITIONAL RULES.

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

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1995, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A)

of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

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

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

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

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

(2) by adding at the end the following:

''(B) Any determination of whether a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of

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

''(i) such plan provides at least standard coverage (consistent with section 102(c) of the Affordable Health Care Now Act of 1994), and

''(ii) in the case of an insured multiple employer health plan, it meets the requirements enforceable under section 514(b)(6)(B)(i) of the Employee Retirement Income Security Act of 1974 to the extent not preempted by section 1202 of the Affordable Health Care Now Act of 1994.''.

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

SEC. 1222. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

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

''(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1)) and is fully insured (as defined in section 701(9)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(d) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

SEC. 1223. COMPLIANCE WITH COVERAGE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

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

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

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

(1) IN GENERAL.—In any case in which an employer is, for any plan year, a participating employer (as defined in paragraph (3)) in an exempted multiple employer health plan or in a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1) of the Employee Retirement Income Security Act of 1974) and is fully insured (as defined in section 701(9) of such Act), the requirements of section 1001(a) shall be deemed to be met (and the ERISA requirements of paragraph (2) shall be deemed to be met by the employer) with respect to an eligible employee of the employer if—

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

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

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

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

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

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

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

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

(3) PARTICIPATING EMPLOYER.—In this subsection, the term ''participating employer'' means, in connection with an exempted multiple employer health plan or a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1) of the Employee Retirement Income Security Act of 1974) and is fully insured (as defined in section 701(9) of such Act), any employer if any of its employees, or any of the dependents of its employees, are or were cov-

ered under such plan or arrangement in connection with the employment of the employees.

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

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

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

(3) the employer facilitates collection of any employee contributions under the plan or arrangement and permits the employee to elect to have employee contributions under the plan or arrangement collected through payroll deduction, and

(4) in the case of a plan or arrangement to which part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of such Act in the form and manner

and at such times as are required under such part 1 with respect to employee welfare benefit plans.

Subtitle D—Health Deduction Fairness

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

(a) PERMANENT EXTENSION OF DEDUCTION.—

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

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1993.

(b) INCREASE IN AMOUNT OF DEDUCTION; INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(1) INCREASE IN AMOUNT OF DEDUCTION.—Paragraph (1) of section 162(l) of such Code is amended by striking ''25 percent of'' and inserting ''100 percent (25 percent in the case of taxable years beginning in 1994 or 1995 and 50 percent in the case of taxable years beginning in 1996 or 1997) of''.

(2) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) of such Code is amended by adding at the end thereof the following new subparagraph:

''(C) TREATMENT OF GROUP HEALTH PLANS.—For purposes of this subsection, an amount paid into a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) shall be deemed to be an amount paid for insurance which constitutes medical care.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

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

''(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

''(1) IN GENERAL.—Subsection (a) shall be applied without regard to the limitation based on adjusted gross income in the case of the applicable percentage of the amounts paid for insurance referred to in section 162(l)(2)(C) (and including payments referred to in section 162(l)(2)(D)).

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

''(A) 25 percent for taxable years beginning in 1994 or 1995,

''(B) 50 percent for taxable years beginning in 1996 or 1997, and

''(C) 100 percent for taxable years beginning after 1997.

''(3) DEDUCTION NOT ALLOWED TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any individual—

''(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

''(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer of such individual or spouse.

''(B) SUBSIDIZED CLASS.—For purposes of subparagraph (A), an individual is a member of a subsidized class of employees of an employer if, at any time during the 3 calendar years ending with or within the taxable year, any member of such class was eligible to participate in any subsidized health plan maintained by such employer.

''(C) SPECIAL RULES.—

''(i) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of subparagraph (B).

''(ii) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

''(4) COORDINATION WITH DEDUCTION FOR OTHER AMOUNTS.—Amounts allowable as a deduction under subsection (a) by reason of this subsection shall not be taken into account in determining the deduction under subsection (a) for other amounts.

''(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection shall not apply to amount paid for insurance covering an individual who is eligible for benefits under title XVIII of the Social Security Act.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

''(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the extent allowable by reason of section 213(f).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

Subtitle E—Improved Access to Community Health Services

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS

SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY HEALTH CARE SERVICES FOR UNDERSERVED POPULATIONS.

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall provide for a program of grants to migrant and community health centers (receiving grants or contracts under section 329, 330, or 340 of the Public Health Service Act) in order to promote the provision of primary health care services for underserved individuals. Such grants may be used—

(1) to promote the provision of off-site services (through means such as mobile medical clinics);

(2) to improve birth outcomes in areas with high infant mortality and morbidity;

(3) to establish primary care clinics in areas identified as in need of such clinics; and

(4) for recruitment and training costs of necessary providers and operating costs for unreimbursed services.

(b) CONDITIONS.—(1) Grants under this subsection shall only be made upon application, approved by the Secretary.

(2) The amount of grants made under this section shall be determined by the Secretary.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) in fiscal year 1995, $100,000,000,

(2) in fiscal year 1996, $200,000,000,

(3) in fiscal year 1997, $300,000,000,

(4) in fiscal year 1998, $400,000,000, and

(5) in fiscal year 1999, $500,000,000,

to carry out this section. Of the amounts appropriated each fiscal year under this section, at least 10 percent shall be used for grants described in subsection (a)(1) and at least 10 percent shall be used for grants described in subsection (a)(2). The Secretary may use not to exceed 50 percent of the amounts appropriated to carry out this section for the purpose of making new grants or contracts under sections 329, 330, and 340 of the Public Health Service Act.

(d) STUDY AND REPORT.—The Secretary shall conduct a study of the impact of the grants made under this section to migrant and community health centers on access to health care, birth outcomes, and the use of emer-

gency room services. Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and on recommendations for changes in the programs under this section in order to promote the appropriate use of cost-effective outpatient services.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF OUTPATIENT PRIMARY HEALTH SERVICES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

''Subpart VII—Delivery of Services

''PROJECTS FOR COORDINATING DELIVERY OF SERVICES

''SEC. 340E. (a) AUTHORITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities to carry out demonstration projects for the purpose of increasing access to outpatient primary health services in geographic areas described in subsection (b) through coordinating the delivery of such services under Federal, State, local, and private programs.

''(2) REQUIREMENT REGARDING PLAN.—The Secretary may make a grant under paragraph (1) only if—

''(A) the applicant involved has received a grant under subsection (l) and the Secretary has approved the plan developed with such grant; and

''(B) the applicant agrees to carry out the project under paragraph (1) in accordance with the plan.

''(b) QUALIFIED HEALTH SERVICE AREAS.—

''(1) IN GENERAL.—A geographic area described in this subsection is a geographic area that—

''(A) is a rational area for the delivery of health services;

''(B) has a population of not more than 500,000 individuals; and

''(C)(i) has been designated by the Secretary as an area with a shortage of personal health services; or

''(ii) has a significant number of individuals who have low incomes or who have insufficient insurance regarding health care.

''(2) AUTHORITY REGARDING MULTIPLE POLITICAL SUBDIVISIONS.—The Secretary shall make a determination of whether a geographic area is a geographic area described in paragraph (1) without regard to whether the area is a political subdivision, without regard to whether the area is located in 2 or more political subdivisions or States, and without regard to whether the area encompasses 2 or more political subdivisions.

''(c) PREFERENCES IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to applicants demonstrating that, with respect to the outpatient primary health services that will be the subject of the project conducted by the applicant under such subsection—

''(1)(A) the project will result in the reduction of administrative expenses associated with such services by increasing the efficiency of the administrative processes of the providers participating in the project, and

''(B) the resulting savings will be expended for the direct provision of such services for the designated population; or

''(2) the services that will be the subject of the project will be provided in facilities that are underutilized.

''(d) ACTIVITIES OF PROJECT MUST SERVE DESIGNATED POPULATION.—The Secretary may make a grant under subsection (a) to an applicant only if the applicant demonstrates that carrying out the project under such subsection will increase access to outpatient primary health services for a significant segment of the designated population.

''(e) MATCHING FUNDS.—

''(1) IN GENERAL.—With respect to the costs of the project to be carried out under subsection (a) by an applicant, the Secretary may make a grant under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant ex-

tent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

''(1) PROVISION OF HEALTH SERVICES; CONSTRUCTION OF FACILITIES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the grant will not be expended for the direct provision of any health service or for the construction or renovation of facilities.

''(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made for a project under subsection (a) may not exceed 4 years, and the aggregate amount of such payments for the period may not exceed $200,000. The provision of such payments shall be subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments.

''(3) FINANCIAL CAPACITY FOR CONTINUATION OF PROJECT AFTER TERMINATION OF GRANT.—The Secretary may make a grant under subsection (a) only if the Secretary determines that there is a reasonable basis for believing that, after termination of payments under such subsection pursuant to para-

graph (2), the project under such subsection will have the financial capacity to continue operating.

''(g) AGREEMENTS AMONG PARTICIPANTS IN PROJECTS.—

''(1) REQUIRED PARTICIPANTS.—The Secretary may make a grant under subsection (a) only if the applicant for the grant has, for purposes of carrying out a project under such subsection, entered into agreements with—

''(A) the chief public health officers, and the chief health officers for the elementary and secondary schools, of each of the political subdivisions of the qualified health service area in which the project under such subsection is to be carried out (or, in the case of a political subdivision that does not have such an official, with another appropriate official of such subdivision);

''(B) each hospital in the qualified health service area;

''(C) representatives of entities in such area that provide outpatient primary health services under Federal, State, local, or private programs;

''(D) representatives of businesses in such area, including small businesses; and

''(E) representatives of nonprofit private entities in such area.

''(2) OPTIONAL PARTICIPANTS.—With respect to compliance with this section, a grantee under subsection (a) may, for purposes of carrying out a project under such subsection, enter into such agreements with public and private entities in the qualified health service area involved (in addition to the entities specified in paragraph (1)) as the grantee may elect.

''(h) EXPENDITURES OF GRANT.—With respect to a project under subsection (a), the purposes for which a grant under such subsection may be expended include (but are not limited to) expenditures to increase the efficiency of the administrative processes of providers participating in the project, paying the costs of hiring and compensating staff, obtaining computers and other equipment (including vehicles to transport individuals to programs providing outpatient primary health services), and developing and operating provider networks.

''(i) MAINTENANCE OF EFFORT.—In the case of services and populations that are the subject of a project under subsection (a), the Secretary may make such a

grant for a fiscal year only if the applicant involved agrees that the applicant, and each entity making an agreement under subsection (g), will maintain expenditures of non-Federal amounts for such services and populations at a level that is not less than the level of such expenditures maintained by the applicant and the entity, respectively, for the fiscal year preceding the first fiscal year for which the applicant receives such a grant.

''(j) REPORTS TO SECRETARY.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees to submit to the Secretary such reports on the project carried out under such subsection as the Secretary may require.

''(k) EVALUATIONS AND DISSEMINATION OF INFORMATION.—The Secretary shall provide for evaluations of projects carried out under subsection (a), and for the collection and dissemination of information developed as a result of such projects and as a result of similar projects.

''(l) PLANNING GRANTS.—

''(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of developing plans to carry out projects under subsection (a). Such a grant may be made only if the applicant involved submits to the Secretary information—

''(A) providing a detailed statement of the proposal of the applicant for carrying out the project;

''(B) identifying the geographic area in which the project is to be carried out; and

''(C) demonstrating that the area is a qualified health service area and that the proposal otherwise is in accordance with the requirements established in this section for the receipt of a grant under subsection (a).

''(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made under paragraph (1) for the development of a plan under such paragraph may not exceed 1 year, and the amount of such payments may not exceed $100,000.

''(m) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) or (l) only if the applicant for the grant submits an application to the Secretary that—

''(1) contains any agreements, assurances, and information required in this section with respect to the grant; and

''(2) is in such form, is made in such manner, and contains such other agreements, assurances, and information as the Secretary determines to be nec-

essary to carry out the purpose for which the grant is to be provided.

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

''(1) The term 'designated population' means individuals described in subsection (b)(1)(C)(ii).

''(2) The term 'primary health services' includes preventive health services.

''(3) The term 'qualified health service area' means a geographic area described in subsection (b).

''(o) AUTHORIZATION OF APPROPRIATIONS.—

''(1) PLANNING FOR PROJECTS.—For the purpose of grants under subsection (l), there is authorized to be appropriated $5,000,000 for fiscal year 1995, to remain available until expended.

''(2) OPERATION OF PROJECTS.—For the purpose of grants under subsection (a), there is authorized to be appropriated an aggregate $10,000,000 for the fiscal years 1996 through 1999.''.

PART 3—COMMUNITY HEALTH NETWORKS

SEC. 1421. QUALIFICATIONS FOR COMMUNITY HEALTH NETWORKS.

(a) COMMUNITY HEALTH NETWORK DEFINED.—For purposes of part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 and this Act,

added by section 1211(a) of this title, the term ''community health network'' means an arrangement that—

(1) is organized by health care providers (including medical practitioners), community groups, or both, and such other organizations as may be designated by the arrangement, to provide health care services to an enrolled population in a service area,

(2) provides to its enrollees at least the benefits included in standard coverage (consistent with section 1102(c)),

(3) receives payment for such services on a prospective capitated basis, which may vary only by family composition, geographic area, and age,

(4) meets the requirements of subsection (b) (relating to public accountability),

(5) meets the requirements of subsection (c) (relating to coordination and integration of care),

(6) meets the requirements of subsection (d) to the extent the arrangement is organized as a nonprofit entity, and

(7) meets the requirements of section 707 of the Employee Retirement Income Security Act of 1974 (relating to maintenance of reserves), added by section 1211.

(b) PUBLIC ACCOUNTABILITY REQUIREMENTS.—The public accountability requirements of this subsection, with respect to a network, are as follows:

(1) PERFORMANCE MEASURES.—The network must establish and implement procedures for developing, compiling, evaluating, and reporting performance measures, statistics, and other information on—

(A) the cost and financial performance of network operations,

(B) the service utilization patterns of enrollees,

(C) the availability, accessibility, and acceptability of health care services to enrollees,

(D) ownership and governance of the network, and

(E) demographic characteristics of enrollees.

Such information shall be published annually and disseminated to enrollees and the public.

(2) QUALITY ASSURANCE PROGRAM.—The network must have an organizational arrangement for an ongoing quality assurance program for all health services it provides which—

(A) stresses health outcomes,

(B) to the maximum extent possible, relies primarily on evaluating and comparing practice patterns (rather than routine case-by-case review) to identify problems,

(C) provides review by physicians and other health professionals of the outcomes and process followed in the provision of health services, and

(D) makes the coverage and utilization review requirements of the plan, and the standards applied for such review, available to providers and the public.

(3) ENROLLMENT.—The network does not expel or refuse to enroll any applicant or limit coverage of services included in standard coverage for any applicant because of the health status or requirements for health services.

(4) CREDENTIALING.—The network must develop and implement a process for the credentialing (and renewal of credentials) of network providers (including practitioners).

(5) GRIEVANCE PROCESS.—The network must have an enrollee complaint and grievance resolution process which shall meet any requirements of applicable law.

(c) COORDINATION AND INTEGRATION OF CARE REQUIREMENTS.—The coordination and integration of care requirements of this subsection, with respect to a network, are as follows:

(1) COORDINATION AND INTEGRATION OF CARE.—The network must establish and implement mechanisms for coordinating the delivery of care across provider settings and over time, including at least mechanisms for—

(A) linking patient registration and medical record information so that it is accessible to all parts of the network and, consistent with State law, assures the confidentiality of patient information,

(B) assisting enrollees to obtain necessary care, including preventive services, and

(C) coordinating the services furnished to an enrollee when more than one practitioner or provider is involved.

(2) OUT-OF-AREA COVERAGE.—The network must provide care within a defined service area established by the arrangement and must provide for reimbursement for standard coverage (consistent with section 1102(c)) for enrollees who are temporarily outside such area.

(3) COMMON MALPRACTICE POLICY.—Providers (including practitioners) that provide standard coverage to network enrollees must be covered for malpractice in accordance with documented criteria established by the arrangement.

(4) RECORD KEEPING.—The network must use a unified patient registration system and medical records system that is accessible to all parts of the network and assures confidentiality of patient information, consistent with State law.

(d) REQUIREMENTS FOR NETWORKS ORGANIZED AS NONPROFIT ENTITIES.—The requirements of this subsection, with respect to a network, are as follows:

(1) COMMUNITY HEALTH STATUS IMPROVEMENT PROCESS.—The network develops and implements a community health status improvement process, in cooperation with other existing networks and community organizations from the same service area, that—

(A) provides for an assessment of community health status that identifies important health status problems in such area,

(B) implements measures to address such problems, and

(C) evaluates the efficiency and effectiveness of such measures in addressing such problems.

The results of evaluations made pursuant to subparagraph (C) shall be made publicly available on at least an annual basis.

(2) ENROLLMENT.—The network enrolls individuals who are broadly representative of the various age, social, and income groups within the area it serves.

Subtitle F—Improved Access to Rural Health Services

PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE

SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

''(D) The facility has entered into (or plans to enter into), with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receives data from and transmits data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as de-

termined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of

such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(B) in paragraph (1), by striking ''during a year before 1993'' and inserting ''during a year before the prospective payment system described in paragraph (2) is in effect'';

(C) in paragraph (1), by adding at the end the following:

''The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.'';

(D) in paragraph (2), by striking ''January 1, 1993,'' and inserting ''January 1, 1996,''; and

(E) by adding at the end the following new paragraph:

''(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

SEC. 1503. EFFECTIVE DATE.

The amendments made by sections 1501 and 1502 shall apply to fiscal years beginning on or after October 1, 1994.

PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT

SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

''(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including

a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

''(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

''(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

''(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

''(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

''(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

''(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are

effectively meeting the emergency medical needs of the populations they serve;

''(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

''(G) demonstrate that the State, in utilizing the grant proceeds, will—

''(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

''(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

''(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

''(I) contain such other information as the Secretary may determine appropriate.

''(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

''(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

''(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

''(d) STATE ADMINISTRATION AND USE OF GRANT.—

''(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provi-

sion of medical services to victims of medical emergencies or trauma.

''(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

''(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

''(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

''(f) REPORTS.—

''(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

''(A) a description of the manner in which the grant proceeds were utilized;

''(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

''(C) such other information as the Secretary may require.

''(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

''(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1996 and 1997.''.

PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS

SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in the heading for the title, by striking ''TRAUMA CARE'' and inserting ''EMERGENCY MEDICAL SERVICES'';

(2) in the heading for part A, by striking ''GENERAL'' and all that follows and inserting ''GENERAL AUTHORITIES AND DUTIES''; and

(3) by amending section 1201 to read as follows:

"SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

''(a) IN GENERAL.—The Secretary shall establish an office to be known as the Office of Emergency Medical Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

''(b) GENERAL AUTHORITIES AND DUTIES.—With respect to emergency medical services (including trauma care), the Secretary shall—

''(1) conduct and support research, training, evaluations, and demonstration projects;

''(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

''(3) sponsor workshops and conferences;

''(4) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

''(5) provide technical assistance to State and local agencies;

''(6) coordinate activities of the Department of Health and Human Services; and

''(7) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

''(c) CERTAIN REQUIREMENTS.—With respect to emergency medical services (including trauma care), the Secretary shall ensure that activities under subsection (b) are carried out regarding—

''(1) maintaining an adequate number of health professionals with expertise in the provision of the services, including hospital-based professionals and prehospital-based professionals;

''(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appro-

priate public and private entities, guidelines for the provision of such services (including, for various typical circumstances, guidelines on the number and variety of professionals, on equipment, and on training);

''(3) the appropriate use of available technologies, including communications technologies; and

''(4) the unique needs of underserved inner-city areas and underserved rural areas.

''(d) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

''(e) DEFINITIONS.—For purposes of this part:

''(1) The term 'hospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at a medical facility.

''(2) The term 'prehospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the med-

ical emergency or during transport to a medical facility.''.

SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

(a) TECHNICAL AMENDMENTS TO FACILITATE ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(A) by redesignating section 1239 as section 1235;

(B) by redesignating sections 1231 and 1233 as sections 1236 and 1237, respectively; and

(C) by redesignating sections 1211 through 1222 as sections 1221 through 1232, respectively.

(2) MODIFICATIONS IN FORMAT OF TITLE XII.—Title XII of the Public Health Service Act, as amended by paragraph (1) of this subsection, is amended—

(A) by striking ''PART B'' and all that follow through ''STATE PLANS'' and inserting the following:

''Subpart II—Formula Grants With Respect to Modifications of State Plans'';

(B) by striking ''PART C—GENERAL PROVISIONS'' and inserting the following:

''Subpart III—General Provisions'';

(C) by redesignating sections 1202 and 1203 as sections 1211 and 1212, respectively; and

(D) by inserting before section 1211 (as so redesignated) the following:

''PART B—TRAUMA CARE

''Subpart I—Advisory Council; Clearinghouse''.

(b) STATE OFFICES.—Title XII of the Public Health Service Act, as amended by subsection (a) of this section, is amended by inserting after section 1201 the following new section:

''SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

''(a) PROGRAM OF GRANTS.—The Secretary may make grants to States for the purpose of improving the availability and quality of emergency medical services through the operation of State offices of emergency medical services.

''(b) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

''(A) for the first fiscal year of payments under the grant, is not less than $1 for each $3 of Federal funds provided in the grant;

''(B) for any second fiscal year of such payments, is not less than $1 for each $1 of Federal funds provided in the grant; and

''(C) for any third fiscal year of such payments, is not less than $3 for each $1 of Federal funds provided in the grant.

''(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

''(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be in-

cluded in determining the amount of such non-Federal contributions.

''(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

''(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

''(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

''(c) CERTAIN REQUIRED ACTIVITIES.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

''(1) coordinating the activities carried out in the State that relate to emergency medical services;

''(2) activities regarding the matters described in paragraphs (1) through (4) section 1201(b); and

''(3) identifying Federal and State programs regarding emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

''(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will be provided with an annual budget of not less than $50,000.

''(e) CERTAIN USES OF FUNDS.—

''(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(A) if research with respect to emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

''(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

''(2) ESTABLISHMENT OF OFFICE.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

''(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

''(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''.

SEC. 1523. PROGRAMS FOR RURAL AREAS.

(a) IN GENERAL.—Title XII of the Public Health Service Act, as amended by section 1522, is amended—

(1) by transferring section 1204 to part A;

(2) by redesignating such section as section 1203;

(3) by inserting such section after section 1202; and

(4) in section 1203 (as so redesignated)—

(A) by redesignating subsection (c) as subsection (d); and

(B) by inserting after subsection (b) the following new subsection:

''(c) DEMONSTRATION PROGRAM REGARDING TELECOMMUNICATIONS.—

''(1) LINKAGES FOR RURAL FACILITIES.—Projects under subsection (a)(1) shall include demonstration projects to establish telecommunications between rural medical facilities and medical facilities that have expertise or equipment that can be utilized by the rural facilities through the telecommunications.

''(2) MODES OF COMMUNICATION.—The Secretary shall ensure that the telecommunications technologies demonstrated under paragraph (1) include interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimiles transmitted through such system.''.

(b) CONFORMING AMENDMENT.—Section 1203 of the Public Health Service Act, as redesignated by subsection (a)(2) of this section, is amended in the heading for the

section by striking ''**ESTABLISHMENT**'' and all that follows and inserting ''**PROGRAMS FOR RURAL AREAS**.''.

SEC. 1524. FUNDING.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) by redesignating parts C through F as parts D through G, respectively;

(2) by inserting after subpart III of part B the following:

''PART C—FUNDING'';

(3) by transferring section 1239 to part C (as so added); and

(4) in such section, by striking subsections (a) and (b) and inserting the following:

''(a) EMERGENCY MEDICAL SERVICES GENERALLY.—

''(1) IN GENERAL.—For the purpose of carrying out section 1201 other than with respect to trauma care, there are authorized to be appropriated $2,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

''(2) STATE OFFICES.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for fiscal year 1995, and

such sums as may be necessary for each of the fiscal years 1996 and 1997.

''(3) CERTAIN TELECOMMUNICATIONS DEMONSTRATIONS.—For the purpose of carrying out section 1203(c), there are authorized to be appropriated $10,000,000 for fiscal year 1995 and such sums as may be necessary for each of the fiscal years 1996 and 1997.

''(b) TRAUMA CARE AND CERTAIN OTHER ACTIVITIES.—

''(1) IN GENERAL.—For the purpose of carrying out part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), there are authorized to be appropriated $60,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

''(2) ALLOCATION OF FUNDS BY SECRETARY.—

''(A) For the purpose of carrying out subpart I of part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(B) For the purpose of carrying out section 1203 (other than subsection (c) of such section), the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(C)(i) For the purpose of making allotments under section 1221(a), the Secretary shall, subject to subsection (c), make available 80 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(ii) Amounts paid to a State under section 1221(a) for a fiscal year shall, for the purposes for which the amounts were paid, remain available for obligation until the end of the fiscal year immediately following the fiscal year for which the amounts were paid.''.

SEC. 1525. CONFORMING AMENDMENTS.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) in section 1203(b), by striking ''1214(c)(1)'' and inserting ''1224(c)(1)'';

(2) in section 1211(b)(3), by striking ''1213(c)'' and inserting ''1223(c)'';

(3) in section 1221—

(A) in subsection (a)—

(i) by striking ''1218'' and inserting ''1228''; and

(ii) by striking ''1217'' and inserting ''1227''; and

(B) in subsection (b)—

(i) by striking ''1233'' and inserting ''1237''; and

(ii) by striking ''1213'' and inserting ''1223'';

(4) in section 1222—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) in paragraph (2)(A), by striking ''1211(c)'' and inserting ''1221(c)''; and

(B) in subsection (b), by striking ''1211(a)'' and inserting ''1221(a)'';

(5) in section 1223—

(A) in subsection (a), by striking ''1211(b)'' and inserting ''1221(b)'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) in paragraph (3), by striking ''1211(a)'' and inserting ''1221(a)''; and

(C) in subsection (d), by striking ''1211(a)'' and inserting ''1221(a)'';

(6) in section 1224—

(A) in each of subsections (a) through (c), by striking ''1211(a)'' and inserting ''1221(a)''; and

(B) in subsection (b), by striking ''1213(a)(7)'' and inserting ''1223(a)(7)'';

(7) in section 1225—

(A) in subsection (a)—

(i) by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) by striking ''1233'' and inserting ''1237''; and

(B) in subsection (b), by striking ''1211(b)'' and inserting ''1221(b)'';

(8) in section 1226, in each of subsections (a) through (c), by striking ''1211(a)'' and inserting ''1221(a)'';

(9) in section 1227—

(A) by striking ''1211(a)'' and inserting ''1221(a)''; and

(B) by striking ''1214'' and inserting ''1224'';

(10) in section 1228—

(A) in each of subsections (a) through (c), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(B) in subsection (b), in each of paragraphs (2)(A) and (3)(A), by striking ''1232(a)'' and inserting ''1239(a)''; and

(C) in subsection (c)(2)—

(i) by striking ''1232(b)(3)'' and inserting ''1239(b)(3)''; and

(ii) by striking ''1217'' and inserting ''1227'';

(11) in section 1229(a), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(12) in section 1230(a), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(13) in section 1231—

(A) in each of subsections (a) and (b), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)''; and

(B) in each of subsections (a) and (b), by striking ''1211(b)'' and inserting ''1221(b)'';

(14) in section 1232, by striking ''1211'' and inserting ''1221'';

(15) in section 1236—

(A) in the matter preceding paragraph (1), by striking ''this title'' and inserting ''this part''; and

(B) in paragraph (1), by striking ''1213'' and inserting ''1223'';

(16) in section 1237—

(A) in each of subsections (a) and (b), by striking ''1211'' each place such term appears and inserting ''1221'';

(B) in subsection (b)—

(i) by striking ''part B'' and inserting ''subpart II''; and

(ii) by striking ''1214(c)(1)'' and inserting ''1224(c)(1)''; and

(C) in subsection (c), by striking ''1213'' and inserting ''1223''; and

(17) in section 1239(c)(1)—

(A) by striking ''1211(a)'' and inserting ''1221(a)'';

(B) by striking ''1218(a)(2)'' and inserting ''1228(a)(2)''; and

(C) by striking ''part B'' and inserting ''subpart II''.

SEC. 1526. EFFECTIVE DATE.

The amendments made by this part shall take effect October 1, 1994, or upon the date of the enactment of this Act, whichever occurs later.

PART 4—ADDITIONAL RURAL HEALTH CARE PROVISIONS

SEC. 1531. DEVELOPMENT OF COMMUNITY-OPERATED HEALTH PLANS IN RURAL AND FRONTIER AREAS.

(a) COMMUNITY-OPERATED HEALTH PLANS.—The Secretary of Health and Human Services (in this part referred to as the ''Secretary'') may make grants to public and nonprofit private entities for the purpose of carrying out projects to develop health plans to provide services exclusively in rural and frontier areas.

(b) COMMUNITY INVOLVEMENT.—The Secretary may make a grant under subsection (a) only if the applicant involved meets the following conditions:

(1) In developing the proposal of the applicant for a project under such subsection, the applicant has consulted with the local governments of the geographic area to be served by the health plan developed through the project, with individuals who reside in the area, and with a reasonable number and variety of health professionals who provide services in the area.

(2) The applicant agrees that the principal legal authority over the operation of the health plan will be vested in individuals who reside in such geographic area.

(3) In the proposal the applicant specifies how a full continuum of services will be provided.

(4) In the proposal the applicant specifies how the proposed health plan will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used for the following:

(A) To develop integrated health networks, utilizing existing local providers and facilities where appropriate, with community involvement.

(B) For information systems, including telecommunications.

(C) For transportation services.

(D) To develop rural emergency access care hospitals (as defined in section 1861(oo)(1) of the Social Security Act, as added by section 1501).

(2) LIMITATIONS.—Funds made available under this section shall not be used for the following:

(A) For a telecommunications system, unless the system is coordinated with, and does not duplicate, such a system existing in the area.

(B) For paying off existing debt.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $25,000,000 in each of fiscal years 1996, 1997, and 1998 to carry out this section.

SEC. 1532. PRIMARY HEALTH CARE FOR MEDICALLY UNDERSERVED RURAL COMMUNITIES; INCREASED CAPACITY OF HOSPITALS AND OUTPATIENT FACILITIES.

(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private hospitals in medically underserved rural communities, and to public and nonprofit outpatient facilities in such communities, for the purpose of carrying out projects to develop or increase the capacity of the hospitals and facilities to provide primary health services.

(b) MEDICALLY UNDERSERVED RURAL COMMUNITY.—For purposes of this section, the term ''medically underserved rural community'' means—

(1) a rural area that has a substantial number of individuals who are members of a medically underserved population, as defined in section 330 of the Public Health Service Act; or

(2) a rural area a significant portion of which is a health professional shortage area designated under section 332 of such Act.

(c) CERTAIN EXPENDITURES.—The purposes for which the Secretary may authorize a grant under subsection (a) to be expended include the renovation of facilities, the purchase of equipment, and the training of personnel.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) HOSPITALS.—There are authorized to be appropriated $50,000,000 in each of fiscal years 1996, 1997, and 1998 for the purpose of making grants to hospitals under subsection (a).

(2) OUTPATIENT FACILITIES.—There are authorized to be appropriated $25,000,000 in each of fiscal years 1996, 1997, and 1998 for the purpose of making grants to outpatient facilities under subsection (a).

SEC. 1533. INNOVATIVE APPROACHES TO DELIVERY OF HEALTH SERVICES IN RURAL AREAS.

(a) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Policy and Research, may make grants to public and nonprofit private entities for the purposes of conducting research and carrying out demonstration projects to develop innovative approaches to the delivery of health care in rural areas, such as the use of telemedicine and the use of mobile delivery units.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $15,000,000 in each of fiscal years 1996 through 2000 to carry out this section.

SEC. 1534. TRAINING OF RURAL HEALTH PROFESSIONALS OTHER THAN PHYSICIANS.

(a) FUNDING FOR PROGRAMS UNDER PUBLIC HEALTH SERVICE ACT.—With respect to programs of title VII or VIII of the Public Health Service Act that provide for the training of individuals as health professionals other than physicians, there are authorized to be appropriated, in addition to amounts otherwise authorized to be appropriated, $50,000,000 in each of fiscal years 1996 through 2000 for the purpose of the Secretary carrying out such programs through entities described in subsection (b).

(b) ELIGIBILITY.—With respect to a program referred to in subsection (a), an entity described in this subsection is an entity—

(1) that is eligible to receive grants or contracts under the program (as provided in the applicable provisions of title VII or VIII of the Public Health Service Act); and

(2) a substantial number of whose designated graduates are providing health services in a rural area.

(c) DEFINITION OF DESIGNATED GRADUATE.—For purposes of this section, the term ''designated graduate'', with respect to an entity, means an individual completing the training involved during the 5-year period preceding the fiscal year for which the entity is applying to receive a grant or contract under the applicable program referred to in subsection (a).

(d) RELATIONSHIP TO OTHER FUNDS.—The amounts made available in subsection (a) for carrying out programs referred to in such subsection are in addition to any other amounts that are available for carrying out the programs.

SEC. 1535. GENERAL PROVISIONS.

(a) APPLICATION FOR GRANT.—The Secretary may make a grant under any section of this part only if an

application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out the program involved.

(b) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of grants or contracts under this part with respect to the planning, development, and operation of activities under the grants or contracts.

Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance

SEC. 1601. ESTABLISHMENT OF STATE PROGRAMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

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

''(63) provide for a State program furnishing premium subsidies for needy children in accordance with section 1931.''.

(b) STATE PROGRAMS FOR PREMIUM SUBSIDIES FOR NEEDY CHILDREN.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''STATE PREMIUM SUBSIDY PROGRAMS FOR NEEDY CHILDREN

''SEC. 1931. (a) REQUIREMENT TO OPERATE STATE PROGRAM.—

''(1) IN GENERAL.—A State with a State plan approved under this title shall have in effect a premium subsidy program for furnishing premium subsidy under subsection (b) to premium subsidy eligible children in the State in fiscal years beginning with fiscal year 1997.

''(2) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this section.

''(b) ASSISTANCE WITH PREMIUMS FOR STANDARD HEALTH COVERAGE.—

''(1) ELIGIBILITY.—An eligible individual who has been determined by a State to be a premium subsidy eligible child (as defined in paragraph (2))

shall be entitled to premium subsidies in the amount determined under subsection (c).

''(2) PREMIUM SUBSIDY ELIGIBLE CHILD.—For purposes of this section, the term 'premium subsidy eligible child' means an individual who is provided certified standard health coverage (as defined in subsection (j)(1)) and—

''(A) who is under 20 years of age,

''(B) whose family has a family income determined under this section which does not exceed 240 percent (or such lesser percent as the Secretary shall specify so that the total Federal payments to States under this section for the fiscal year do not exceed the amount specified for the fiscal year under subsection (i)(1)) of the poverty line, and

''(C) except as provided in paragraph (3), who is not otherwise eligible for medical assistance under the State plan (or would be eligible for such assistance on the basis of the plan in effect as of the date of the enactment of the Affordable Health Care Now Act of 1994).

''(3) ELIGIBILITY OF CHILDREN BECOMING ELIGIBLE FOR MEDICAID.—At the option of the State, a premium subsidy eligible child may include an in-

dividual who meets the requirements of subparagraphs (A) and (B) of paragraph (2) and is eligible for medical assistance under the State plan if the individual was formerly a premium subsidy eligible child under paragraph (2). The exercise of such option shall not diminish the benefits to which such a child is otherwise entitled under the State plan.

''(4) ADDITIONAL CHILDREN USING STATE-ONLY FUNDS.—Nothing in this section shall be construed as preventing a State, using its own funds and without any Federal financial participation, from covering additional children as premium subsidy eligible children.

''(c) AMOUNT OF PREMIUM SUBSIDY.—

''(1) IN GENERAL.—

''(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percentage of 1/12th of the lesser of—

''(i) the annual premium for certified standard health coverage provided the child, or

''(ii) the actuarial value of the standard option, nationwide service benefit plan (taking into account cost sharing) made

available under chapter 89 of title, United States Code for the year, adjusted to reflect a premium for a single child of the age involved and adjusted to reflect the relative cost of premiums for health coverage of premium subsidy eligible children in the geographic area in which the child resides compared to the national average and adjusted to reflect the reduction in cost-sharing effected under subsection (j)(4).

''(B) SUBSIDY PERCENTAGE.—For purposes of paragraph (1), an individual's 'subsidy percentage' means 100 percent reduced (but not below zero percent) by 1.8 percentage points for each percentage point (or portion thereof) such individual's income equals or exceeds 185 percent of the poverty line.

''(d) PAYMENTS.—

''(1) IN GENERAL.—The amount of the premium subsidy available to a premium subsidy eligible child under subsection (b) shall be paid by the State in which the individual resides directly to the insurer that provides the coverage for the premium subsidy eligible child. Payments under the preceding sentence shall commence in the first month during

which the individual is provided coverage and determined under this section to be a premium subsidy eligible child.

''(2) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium subsidy paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

''(e) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this section with respect to determining eligibility for premium subsidy, including requirements with respect to—

''(A) application procedures;

''(B) information verification procedures;

''(C) timeliness of eligibility determinations;

''(D) procedures for applicants to appeal adverse decisions; and

''(E) any other matters determined appropriate by the Secretary.

''(2) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under

paragraph (1) shall include the following requirements:

''(A) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

''(B) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under this section.

''(C) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance through employers and appropriate public agencies.

''(D) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium subsidy based on such a revised application.

''(E) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this section. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(f) ADMINISTRATION OF STATE PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this section which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

''(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

''(A) be simple in form and understandable to the average individual;

''(B) require the provision of information necessary to make a determination as to whether an individual is a premium subsidy eligible child including a declaration of estimated in-

come by the individual based, at the election of the individual—

''(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made, or

''(ii) on estimated income for the entire year for which the application is submitted; and

''(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(3) OUTREACH ACTIVITIES.—A State operating a program under this section shall conduct such outreach activities as the Secretary determines appropriate.

''(4) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM SUBSIDIES.—A determination by a State that an individual is a premium subsidy eligible child shall be effective for the calendar year for which such determination is made unless a revised application submitted under paragraph (2) indicates that an individual is no longer eligible for premium subsidies.

''(5) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

''(A) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this section shall be liable to the Federal Government for the amount of any premium subsidy received by individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium subsidy received by individual on the basis of a misrepresentation.

''(B) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under subparagraph (A) and submit 50 percent of such amount to the Secretary in a timely manner.

''(g) END-OF-YEAR RECONCILIATION FOR PREMIUM SUBSIDY.—

''(1) IN GENERAL.—

''(A) REQUIREMENT TO FILE STATEMENT.—An individual who received premium subsidies under this section from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

''(B) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under subparagraph (A) at the end of the year to an individual who received premium subsidies under this part from such State in any month during the year.

''(2) RECONCILIATION OF PREMIUM SUBSIDY BASED ON ACTUAL INCOME.—

''(A) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under paragraph (1) with respect to an individual, the State shall compute the amount of premium subsidy that should have been provided under this section with respect to the individual for the year involved.

''(B) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium subsidy provided was greater than the amount computed under subparagraph (A), the individual is liable to the State to pay an amount equal to the amount of the excess payment. Any amount collected by a State under this subparagraph shall be submitted to the Secretary in a timely manner.

''(C) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium subsidy provided was less than the amount computed under subparagraph (A), the State shall pay to the individual an amount equal to the amount of the deficit.

''(D) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments or underpayments of premium subsidy determined under subparagraphs (A) and (B) with respect to an individual for a year may be collected or paid, as appropriate, through adjustments to the premium subsidy furnished to such individual in the succeeding year.

''(3) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this section, including return information disclosed to the state for such purpose under section 6103(l)(15) of the internal revenue code of 1986.

''(4) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this subsection in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium subsidy provided in such year shall be considered an excess amount under paragraph (2)(A) and such individual shall not be eligible for premium subsidy assistance under this section until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this paragraph if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

''(5) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under paragraph (1) is subject to the same penalties as are provided under subsection

(f)(5) for a misrepresentation of material fact described in such section.

''(h) SPECIAL RULES ON FEDERAL FINANCIAL PARTICIPATION.—

''(1) PREMIUM SUBSIDY.—In applying section 1903(a)(1) with respect to expenditures for premium subsidy (other than administrative expenses) under this section—

''(A) such expenditures shall be considered to be expenditures on medical assistance;

''(B) in the case of assistance for a premium subsidy eligible child not described in subsection (b)(3), the Federal medical assistance percentage is deemed to be 100 percent; and

''(C) the total amount of Federal financial participation with respect to any State for quarters in any fiscal year (with respect to premium subsidy eligible children not described in subsection (b)(3)) shall not exceed the State allotment under subsection (i)(2) for that year.

''(2) ADMINISTRATION EXPENSES.—The amount of expenditures that may be taken into account in computing amounts that are payable to a State under section 1903(a) (other than paragraph

(1)) with respect to the administration of the program under this section may not exceed 3 percent of the total expenditures.

''(i) TOTAL FEDERAL BUDGET FOR PROGRAM; ALLOTMENTS TO STATES.—

''(1) TOTAL FEDERAL BUDGET.—

''(A) FISCAL YEARS 1997 THROUGH 2004.—Subject to subparagraph (E)(iii), for purposes of this section, the total Federal payments to States under this section may not exceed the following:

''(i) For fiscal year 1997, $4.7 billion.

''(ii) For fiscal year 1998, $5.2 billion.

''(iii) For fiscal year 1999, $6.5 billion.

''(iv) For fiscal year 2000, $9.8 billion.

''(v) For fiscal year 2001, $12.3 billion.

''(vi) For fiscal year 2002, $15.3 billion.

''(vii) For fiscal year 2003, $20.0 billion.

''(viii) For fiscal year 2004, $24.4 billion.

''(B) SUBSEQUENT FISCAL YEARS.—For purposes of this section, the total Federal budget for State plans under this part for each fiscal year after fiscal year 2004 is the total Federal budget under this subsection for the preceding fiscal year multiplied by the Secretary's estimate of the percentage increase in private sector health expenditures for the year.

''(2) ALLOTMENTS TO STATES.—

''(A) IN GENERAL.—The amount of a State's allotment under this section for a fiscal year shall be equal to the product of—

''(i) the limit on the total amount of Federal payments for the year under paragraph (1)(A); and

''(ii) the State's allotment percentage under subparagraph (B).

''(B) STATE ALLOTMENT PERCENTAGE.—In subparagraph (A), a State's allotment percentage for a fiscal year is equal to the percentage of all premium subsidy eligible children in the United States who are residents of the

State (as estimated by the Secretary prior to the beginning of the fiscal year).

''(3) LIMITATION ON PREMIUM PAYMENTS FOR ABORTION SERVICES.—Notwithstanding any other provision of this title or the Affordable Health Care Now Act of 1994, none of the funds appropriated to carry out this section shall be expended to assist in the purchase, in whole or in part, of a health benefit package that includes abortion except in cases (A) where the life of the mother would be endangered if the fetus were carried to term, or (B) where the pregnancy is the result of rape or incest.

''(j) CERTIFIED STANDARD HEALTH COVERAGE DEFINED.—

''(1) IN GENERAL.—In this section, health insurance coverage is considered to provide certified standard health coverage if—

''(A) benefits under such coverage are provided within at least each of the required categories of benefits described in subparagraph (A) of paragraph (2) and consistent with such paragraph;

''(B) the actuarial value of the benefits meets the requirements of paragraph (3); and

''(C) the benefits comply with the minimum requirements specified in paragraph (4).

''(2) REQUIRED CATEGORIES OF COVERED BENEFITS.—

''(A) IN GENERAL.—The categories of covered benefits described in this subparagraph are the types of benefits specified in subparagraphs (A), (B), (C), (D), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees) and includes the category of preventive benefits.

''(B) COVERAGE OF OFF-LABEL USE.—An off-label use for a drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act shall be covered if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

''(C) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this subsection may be construed to require the coverage of any specific procedure or treatment or class of service in certified standard health coverage under this Act or through regulation.

''(3) STANDARD ACTUARIAL VALUE.—

''(A) IN GENERAL.—The actuarial value of the benefits under standard coverage in a rating area meets the requirements of this paragraph if such value is equivalent to the standard actuarial value described in subparagraph (B) for the area, as adjusted for inflation under subparagraph (D). The actuarial value of benefits under standard coverage shall be determined using the standardized population and set of standardized utilization and cost factors described in subparagraph (C). Such actuarial value shall be adjusted to reflect the reduction in cost-sharing effected under paragraph (4).

''(B) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this subparagraph for coverage in a geographic area is the actuarial value of bench-

mark coverage during 1994 in such area. Such actuarial value shall be determined using the standardized population and set of standardized utilization and cost factors described in subparagraph (C) and shall be adjusted to reflect the age of the population of premium subsidy eligible children under this section.

''(C) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this subparagraph—

''(i) for a standardized population shall be made by not taking into account individuals 65 years of age or older, employees of the United States Postal Service, and retirees; and

''(ii) for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under clause (i)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors.

''(D) ADJUSTMENT FOR INFLATION.—

''(i) IN GENERAL.—The adjustment under this paragraph for a year (beginning with 1995) is the FEHBP national rolling increase percentage for the year involved, compounded by such increase for each preceding year after 1994.

''(ii) FEHBP NATIONAL ROLLING INCREASE PERCENTAGE.—For purposes of this paragraph, the term 'FEHBP national rolling increase percentage' means, for a year, the 5-year average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the period ending with the previous year. Such increase shall be determined by the Secretary in consultation with the Director of Office of Personnel Management based on the best information available.

''(4) MINIMUM REQUIREMENTS.—Benefits offered under standard coverage within any category shall be not less than the narrowest scope and shortest duration of benefits within that category, in an

approved health benefits plan under chapter 89 of title 5, United States Code, except that under such coverage—

''(A) no cost-sharing may be imposed for preventive services (as specified by the Secretary); and

''(B) with respect to individuals with family income below 100 percent of the poverty line, any cost-sharing imposed for other items and services may only be nominal.

''(k) DEFINITIONS; DETERMINATIONS OF INCOME.—For purposes of this part:

''(1) DETERMINATIONS OF INCOME.—

''(A) FAMILY INCOME.—The term 'family income' means, with respect to an individual who—

''(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

''(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the

other individual's spouse, and dependents of the other individual.

''(B) DEPENDENT.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

''(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

''(D) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

''(ii) increased by—

''(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax, and

''(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

''(2) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'eligible individual' means any individual who is residing in the United States.

''(B) EXCLUSION.—The term 'eligible individual' does not include—

''(i) an alien who is ineligible for assistance under this title pursuant to section 2802 of the Affordable Health Care Now Act of 1994; or

''(ii) an individual who is an inmate of a public institution (except as a patient of a medical institution).

''(3) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as 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) that—

''(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

''(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

''(4) PREMIUM.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.

''(5) BENCHMARK COVERAGE.—The term 'benchmark coverage' means the standard option of the Blue Cross-Blue Shield plan offered under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code, as in effect during 1994.''.

Subtitle H—Medicaid Reform

PART 1—STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

SEC. 1701. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 1601, is further amended—

(1) by redesignating section 1932 as section 1933; and

(2) by inserting after section 1931 the following new section:

''STATE HEALTH ALLOWANCE PROGRAMS

''SEC. 1932. (a) TREATMENT OF EXPENDITURES UNDER HEALTH ALLOWANCE PROGRAMS AS MEDICAL ASSISTANCE UNDER STATE PLAN.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, for purposes of determining the amount to be paid to a State under section 1903(a)(1) for quarters in any fiscal year, amounts expended by an eligible State (as described in subsection (b)) during the fiscal year under a State health allowance program (as described in subsection (c)) shall be included in the total amount expended during the fiscal year as medical assistance under

the State plan (except as provided under paragraphs (2) and (3) and under subsection (d)(1)(C)).

''(2) FEDERAL PAYMENT RESTRICTED TO ACUTE CARE SERVICES.—No amounts expended under a State health allowance program that are attributable to medical assistance described in paragraphs (4), (14), (15), (23), or (24) of section 1905(a) shall be included in the total amount expended as medical assistance under the State plan.

''(3) AMOUNT OF FEDERAL PAYMENT BASED UPON UNUSED PREMIUM SUBSIDY PROGRAM ALLOTMENT.—In no case shall this subsection result in the total Federal payments to the State under this title (including payments attributable to this section and section 1923) for quarters in a fiscal year exceeding an amount equal to the difference between—

''(A) the State's allotment for the premium subsidy program for children under section 1931(i)(2) for such fiscal year; and

''(B) the amount paid to the State for such program for such fiscal year.

''(4) LIMITATION ON PREMIUM PAYMENTS FOR ABORTION SERVICES.—Notwithstanding any other provision of this title or the Affordable Health Care Now Act of 1994, none of the funds appropriated to

carry out this section shall be expended to assist in the purchase, in whole or in part, of a health benefit package that includes abortion except in cases (A) where the life of the mother would be endangered if the fetus were carried to term, or (B) where the pregnancy is the result of rape or incest.

''(b) ELIGIBILITY OF STATE.—A State is eligible for purposes of subsection (a) if the State submits (at such time and in such form as the Secretary may require) an application to the Secretary containing such information and assurances as the Secretary may require, including assurances that the State has adopted and is enforcing standards regarding quality assurance for group health plans participating in the State health allowance program, including standards regarding—

''(1) uniform reporting requirements for such plans relating to a minimum set of clinical data, patient satisfaction data, and other information that may be used by individuals to compare the quality of various plans; and

''(2) the establishment or designation of an entity of the State government to collect the data described in subparagraph (A) and to regularly report such data to the Secretary.

''(c) STATE HEALTH ALLOWANCE PROGRAM DESCRIBED.—

''(1) ENROLLMENT OF PARTICIPATING INDIVIDUALS IN APPROVED GROUP HEALTH PLANS.—In this section, a State health allowance program is a program in effect in all the political subdivisions of the State (except as provided in (c)) under which the State makes payments to a group health plan (approved under paragraph (2)) which provides coverage to the individual as an allowance towards the costs of providing the individual with benefits under the plan.

''(2) APPROVED PLANS DESCRIBED.—For purposes of paragraph (1), a State shall approve group health plans in accordance with such standards as the State may establish, except that—

''(A) the State may not approve a plan for a year unless the plan provides certified standard health coverage described in section 1931(j);

''(B) at least one of the plans approved by the State shall be a health maintenance organization or other plan under which payments are otherwise made on a capitated basis for provid-

ing medical assistance to individuals enrolled in the State plan under this title; and

''(C) in the case of an individual who is entitled to benefits under the State plan under this title as of the first month during which the State health allowance program is in effect, an approved plan may not require the individual to contribute a greater amount of cost-sharing than the individual would have been required to contribute under the State plan (except as may be imposed on an individual described in subparagraph (B) or subparagraph (C) of subsection (d)(1)).

In applying subparagraph (A), in determining the standard actuarial value, instead of adjustments made to reflect the population under section 1931 there shall be adjustments made to reflect the population covered under this section.

''(3) WAIVER OF STATEWIDENESS REQUIREMENT.—At the request of a State, the Secretary may waive for a period not to exceed 3 years (subject to one 3-year extension) the requirement under paragraph (1) that the State health allowance program be in effect in all political subdivisions of the State.

''(d) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE IN ALLOWANCE PROGRAM.—

''(1) AUTOMATIC ELIGIBILITY OF MEDICAID CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject to subsection (e), any individual to whom the State makes medical assistance available under the State plan under this title pursuant to clause (i) of section 1902(a)(10)(A) shall be eligible to participate in the State health allowance program.

''(2) MANDATORY ELIGIBILITY OF PREGNANT WOMEN WITH INCOME UNDER 150 PERCENT OF THE POVERTY LEVEL.—

''(A) IN GENERAL.—Subject to subsection (e) and subparagraph (B), an individual lawfully residing in the State shall be eligible to participate in the program if the individual is a pregnant woman and the income of the individual's family is equal to or less than 240 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1991) applicable to a family of the size involved.

''(B) EXCEPTION.—If the application of subparagraph (A) would result in—

''(i) the total State expenditures for a quarter under this title (including expenditures attributable to this section and section 1923, but not including expenditures under section 1931), exceeding

''(ii) the total State expenditures that the Secretary estimates would have been made under this title for the quarter if the State did not have a program under this section,

then there shall be substituted for 150 percent in subparagraph (A) such percent as would result in the amount described in clause (i) equaling the amount described in clause (ii).

''(C) PHASING OUT PREMIUM SUBSIDY FOR CERTAIN INDIVIDUALS.—

''(i) IN GENERAL.—In the case of an individual eligible to participate in the program pursuant to this paragraph who has income equal to or greater than 185 percent of the official poverty line applicable to a family of the size involved, the amount paid by the State under subsection (c)(1)

with respect to the individual shall be equal to the individual's subsidy percentage of the amount that would otherwise be paid under such subsection with respect to the individual but for this subparagraph.

''(ii) SUBSIDY PERCENTAGE DEFINED.—In clause (i), an individual's 'subsidy percentage' means 100 percent reduced (but not below zero percent) by 1.8 percentage points for each percentage point (or portion thereof) by which the individual's income equals or exceeds 185 percent of the official poverty line.

''(3) OPTIONAL ELIGIBILITY OF OTHER INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LEVEL.—

''(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make an individual lawfully residing in the State who is not described in paragraph (2) eligible to participate in the program if the income of the individual's family is not greater than 150 percent of such official poverty line.

''(B) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph and whose family income is greater than 100 percent of the official poverty line, the program may require such an individual to contribute all (or a portion) of the premiums for such a group health plan if the amount of such contribution is determined in accordance with a sliding scale based on the individual's family income.

''(4) RESTRICTION ON ELIGIBILITY OF OTHER MEDICAID BENEFICIARIES.—An individual is not eligible to participate in the program pursuant to paragraph (2) or paragraph (3) if the individual is eligible for medical assistance under the State plan under this title (or would be eligible for such assistance on the basis of the plan in effect as of the date of the enactment of the Affordable Health Care Now Act of 1994).

''(e) EXCLUSION AND USE OF RESOURCE STANDARD.—

''(1) EXCLUSION OF ELDERLY MEDICARE-ELIGIBLE INDIVIDUALS.—No individual shall be eligible to participate in the program if the individual is enti-

tled to benefits under title XVIII pursuant to section 226.

''(2) USE OF RESOURCE STANDARD.—A State may require an individual to meet a resource standard as a condition of eligibility to participate in the program only if the Secretary approves the State's use of such a standard.

''(f) CONSTRUCTION.—No provision of any Federal law shall prevent a State from enrolling any employee or other individual in accordance with this section. The previous sentence shall not be construed as permitting a State to require the employer of an individual participating in the program to contribute toward the individual's premium required for such participation.

''(g) EVALUATIONS AND REPORTS.—

''(1) EVALUATIONS.—Not later than 3 years after the date of the enactment of this section (and at such subsequent intervals as the Secretary considers appropriate), the Secretary shall evaluate the effectiveness of the State health allowance programs for which Federal financial participation is provided under this section, and the impact of such programs on increasing the number of individuals with health insurance coverage in participating States and in controlling the costs of health care in such States.

''(2) REPORTS.—Not later than 3 years after the date of the enactment of this section (and at such subsequent intervals as the Secretary considers appropriate), the Secretary shall submit a report on the program to Congress.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after October 1, 1996.

SEC. 1702. OPTIONAL USE OF PROGRAM TO OFFER COVERAGE TO SOME OR ALL STATE RESIDENTS.

Section 1932 of the Social Security Act, as inserted by section 1701(a)(2), is amended—

(1) in subsection (c)(2)(A), in the matter before clause (i), by inserting '', except as provided in subsection (d)(4)(B)(iii),'' after ''unless'', and

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

''(4) OPTIONAL ENROLLMENT OF OTHER INDIVIDUALS.—

''(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make any individual (or class of individuals) who is not described in paragraph (1), (2), or (3) and who is not offered coverage under an employer

group health plan eligible to participate in the program.

''(B) SPECIAL RULES.—

''(i) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph, the program may require such an individual to contribute all (or a portion) of the premiums and cost-sharing of such a group health plan.

''(ii) NO FEDERAL MATCHING PAYMENTS.—For purposes of payment to States under section 1903(a), no amounts expended by the State under the program during a fiscal year on behalf of an individual enrolled under subparagraph (A) may be included in the total amount expended during the fiscal year as medical assistance under the State plan.

''(5) OFFERING OF COVERAGE THROUGH OTHER PROGRAMS.—Nothing in this section shall be construed as preventing a State which—

''(A) does not operate a State health allowance program under this section from assuring that individuals in the State who are not of-

fered coverage under an employer group health plan are offered coverage under a health plan, or

''(B) does operate such a program from assuring that individuals in the State who are not described in paragraph (1), (2), or (3) and who are not offered coverage under an employer group health plan are offered coverage under a health plan other than through such program.''.

PART 2—MEDICAID PROGRAM FLEXIBILITY

SEC. 1711. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

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

''(m) COORDINATED CARE.—

''(1) PAYMENT CONDITIONED ON COMPLIANCE.—

''(A) GENERAL RULE.—No payment shall be made under this title to a State with respect to expenditures incurred by it for payment to a risk contracting entity or primary care case

management entity (as defined in subparagraph (B)), or with respect to an undertaking described in paragraph (6), unless the State and the entity or undertaking meet the applicable requirements of this subsection. For purposes of determining whether payment may be made under this section, the Secretary may reject a State's determination of compliance with any provision of this subsection.

''(B) GENERAL DEFINITIONS.—For purposes of this title:

''(i) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity that has a contract with the State agency under which the entity—

''(I) provides or arranges for the provision of health care items or services to individuals eligible for medical assistance under the State plan under this title, and

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

''(ii) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a State program under which individuals eligible for medical assistance under the State plan under this title are enrolled with primary care case management entities, and are entitled to receive specified health care items and services covered under such plan only as arranged for and approved by such entities.

''(iii) AT RISK.—An entity is 'at risk', for purposes of this subparagraph, if it has a contract with the State agency under which it is paid a fixed amount for providing or arranging for the provision of specified health care items or services to an individual eligible for medical assistance and enrolled with the entity, regardless of whether such items or services are furnished to such individual, and is liable for all or part of the cost of furnishing such items or services, regardless of whether or the extent to which such cost exceeds such fixed payment.

''(iv) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider (whether an individual or an entity) that, under a State primary care case management program meeting the requirements of paragraph (7), has a contract with the State agency under which the entity arranges for or authorizes the provision of health care items and services to individuals eligible for medical assistance under the State plan under this title, but is not at risk (as defined in clause (iv)) for the cost of such items or services provided to such individuals.

''(2) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

''(A) FEDERAL OR STATE QUALIFICATION.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it either—

''(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as deter-

mined by the Secretary pursuant to section 1312 of that Act, or

''(ii) is an entity which the State agency has determined—

''(I) affords, to individuals eligible for medical assistance under the State plan and enrolled with the entity, access to health care items and services furnished by the entity, within the area served by the entity, at least equivalent to the access such individuals would have to such health care items and services in such area if not enrolled with the entity, and

''(II) has made adequate provision against the risk of insolvency, and assures that individuals eligible for medical assistance under this title are not held liable for the entity's debts in case of the entity's insolvency.

''(B) INTERNAL QUALITY ASSURANCE.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it has in effect an internal quality assur-

ance program that meets the requirements of paragraph (9).

''(C) CONTRACT WITH STATE AGENCY.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if the entity has a written contract with the State agency that provides—

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

''(ii) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that payments to the entity under the contract shall not exceed 100 percent of expenditures that would have been made by the State agency in the absence of the contract;

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

''(I) to the ability of the entity to bear the risk of potential financial losses, or

''(II) to services performed or determinations of amounts payable under the contract;

''(iv) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

''(v)(I) that individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination (or at such times as required pursuant to paragraph (8)), and

''(II) for notification of each such individual, at the time of the individual's enrollment, of the right to terminate enrollment;

''(vi) for reimbursement, either by the entity or by the State agency, for medically necessary services provided—

''(I) to an individual eligible for medical assistance under the State plan and enrolled with the entity, and

''(II) other than through the entity because the services were immediately required due to an unforeseen illness, injury, or condition;

''(vii) for disclosure of information in accordance with paragraph (4);

''(viii) in the case of an entity that has entered into a contract with a Federally-qualified health center for the provision of services of such center—

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

''(II) that, at the election of such center, payments made by the entity to such center for services described in section 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);

''(ix) that any physician incentive plan that the entity operates meets the requirements of section 1876(i)(8);

''(x) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients; and

''(xi) that the entity complies with the requirement of section 1902(w) with respect to each enrollee.

''(3) EXCEPTIONS TO REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—The requirements of paragraph (2) (other than subparagraph (C)(viii)) do not apply to an entity that—

''(A)(i) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments

are to be made under this title, has been the recipient of a grant under either such section; and

''(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under the State plan, the services described in section 1905(a)(7);

''(B) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

''(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965), and

''(ii) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into dur-

ing a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation or other risk basis; or

''(C) which has contracted with the State agency for the provision of services (but not including inpatient hospital services) to persons eligible for medical assistance under this title on a prepaid risk basis prior to 1970.''; and

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

''(7) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT.—A State that elects in its State plan under this title to implement a primary care case management program under this subsection shall include in the plan methods for the selection and monitoring of participating primary care case management entities to ensure that—

''(A) the numbers, geographic locations, hours of operation, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance reasonable access to and choice among such entities;

''(B) such entities and their professional personnel are qualified to provide health care case management services, through methods including ongoing monitoring of compliance with applicable requirements for licensing of health care providers, providing training and certification of primary care case managers, and providing information and technical assistance; and

''(C) such entities are making timely and appropriate decisions with respect to enrollees' need for health care items and services, and are giving timely approval and referral to providers of adequate quality where such items and services are determined to be medically necessary.

''(8) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

''(A) MANDATORY ENROLLMENT OPTION.—A State plan may require an individual eligible for medical assistance under the State plan (other than a medicare qualified beneficiary) to enroll with a risk contracting entity or primary care case management entity, without regard to the requirement of section 1902(a)(1) (concerning statewideness), the requirements of section 1902(a)(10)(B) (concern-

ing comparability of benefits), or the requirements of section 1902(a)(23) (concerning freedom of choice of provider), if the individual is permitted a choice—

''(i) between or among two or more risk contracting entities,

''(ii) between a risk contracting entity and a primary care case management entity, or

''(iii) between or among two or more primary care case management entities.

''(B)(i) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—A State plan may restrict the period in which individuals enrolled with a qualifying risk contracting entity (as defined in clause (ii)) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in clause (iii)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

''(ii) For purposes of this subparagraph, the term 'qualifying risk contracting entity' means a risk contracting entity that is—

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

''(II) an eligible organization with a contract under section 1876;

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

''(IV) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965;

''(V) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for medical assistance under this title, and (II) (in the

case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity; or

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

''(iii) For purposes of this subparagraph, the term 'period of enrollment' means—

''(I) a period not to exceed 6 months in duration, or

''(II) a period not to exceed one year in duration, in the case of a State that, on the effective date of this subparagraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year

minimum period of enrollment with risk contracting entities.

''(C) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

''(i) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this subsection,

''(ii) in the next month (or next 2 months) is not eligible for such medical assistance, but

''(iii) in the succeeding month is again eligible for such benefits,

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

''(9) REQUIREMENTS FOR INTERNAL QUALITY ASSURANCE PROGRAMS.—The requirements for an internal quality assurance program of a risk contracting entity are that program is written and the program—

''(A) specifies a systematic process including ongoing monitoring, corrective action, and

other appropriate activities to achieve specified and measurable goals and objectives for quality of care, and including annual evaluation of the program;

''(B) identifies the organizational units responsible for performing specific quality assurance functions, and ensure that they are accountable to the governing body of the entity and that they have adequate supervision, staff, and other necessary resources to perform these functions effectively;

''(C) if any quality assistance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions, and has mechanisms to ensure that all quality assurance activities are carried out;

''(D) includes methods to ensure that physicians and other health care professionals under contract with the entity are qualified to perform the services they provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures;

''(E) includes policies addressing enrollee rights and responsibilities, including grievance mechanisms and mechanisms to inform enrollees about access to and use of services provided by the entity;

''(F) provides for continuous monitoring of the delivery of health care, including—

''(i) identification of clinical areas to be monitored,

''(ii) use of quality indicators and standards for assessing care delivered, including availability and accessibility of care,

''(iii) monitoring, through use of epidemiological data or chart review, the care of individuals, as appropriate, and patterns of care overall, and

''(iv) implementation of corrective actions; and

''(G) meets any other requirements prescribed by the Secretary after consultation with States.

''(10) INDEPENDENT REVIEW AND QUALITY ASSURANCE.—

''(A) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or primary care case management entity under this subsection shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

''(i) A toll-free telephone number for enrollee questions and grievances.

''(ii) A State-operated enrollee grievance procedure.

''(iii) Periodic notification of enrollees of their rights with respect to such entity or program.

''(iv) Periodic sample reviews of grievances registered with such entity or program or with the State.

''(v) Periodic survey and analysis of enrollee satisfaction with such entity or program.

''(B) STATE MONITORING OF RISK CONTRACTING ENTITIES' QUALITY ASSURANCE PROGRAMS.—A State contracting with a risk contracting entity under this subsection shall periodically review such entity's quality assurance

program to ensure that it meets the requirements of paragraph (9).

''(C) EXTERNAL INDEPENDENT REVIEW OF INTERNAL QUALITY ASSURANCE.—A State contracting with a risk contracting entity under this subsection shall provide for annual external independent review (by a utilization control and peer review organization with a contract under section 1153, or another organization unaffiliated with the State government approved by the Secretary) of such entity's internal quality assurance activities. Such independent review shall include—

''(i) review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of inappropriate utilization and treatment,

''(ii) review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine quality trends,

''(iii) review of the entity's internal quality assurance activities, and

''(iv) notification of the entity and the State, and appropriate followup activities, when the review under this subparagraph indicates inappropriate care or treatment.''.

(b) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(A) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a risk contracting entity (as defined in section 1903(m)(1)(B)(i)) responsible for the provision of inpatient hospital services and any other service described in paragraphs (2), (3), (4), (5), and (7) of section 1905(a),

''(ii) with any risk contracting entity (as so defined) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876 and who would'', and

(B) in subparagraph (B), by striking ''organization or'' each place it appears.

(c) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organizations'' and inserting ''risk contracting entities''.

(3) Section 1902(a)(25)(H) of such Act (42 U.S.C. 1396a(a)(25)(H)), as added by section 13622(b)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(4) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking all that precedes ''with the results'' and inserting ''pro-

vide for independent review and quality assurance of entities with contracts under section 1903(m), in accordance with paragraph (10) of such section,''.

(5) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization'' and inserting ''or risk contracting entity''.

(6) Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by sections 13623(a), 13625(a), and 13631(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(A) by striking ''and'' at the end of paragraph (61);

(B) by striking the period at the end of paragraph (62) and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(63) at State option, provide for a primary care case management program in accordance with section 1903(m)(7).''.

(7) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

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

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(2)(C)(xi)'', and

(B) in paragraph (2)(E), by striking ''health maintenance organization'' and ''the organization'' and inserting ''risk contracting entity'' and ''the entity'', respectively.

(9) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

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

(A) in the first sentence, by striking ''Each health maintenance organization'' and inserting ''Each risk contracting entity'',

(B) in the first sentence, by striking ''the organization'' each place it appears and inserting ''the entity'', and

(C) in the second sentence, by striking ''an organization'' and ''the organization'' and inserting ''a risk contracting entity'' and ''the risk contracting entity'', respectively.

(11) Section 1903(m)(4)(B) of such Act (42 U.S.C. 1396b(m)(4)(B)) is amended by striking ''organization'' and inserting ''risk contracting entity''.

(12) Section 1903(m)(5) of such Act (42 U.S.C. 1396b(m)(5)) is amended in paragraphs (A)(iii) and (B)(ii) by striking ''organization'' and inserting ''entity''.

(13) Section 1903(o) (42 U.S.C. 1396b(o)), as amended by section 13622(a)(2) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

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

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

(16) Section 1908(b) of such Act, as added by section 13623(b) of the Omnibus Budget Reconcili-

ation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(17) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

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

(A) in the heading, by striking ''HMO'' and inserting ''RISK CONTRACTING ENTITY'',

(B) by striking ''health maintenance organization'' and inserting ''risk contracting entity'' each place it appears, and

(C) by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(1)(B)(i)''.

(19) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations'' and inserting ''risk contracting entities''.

(20) Section 1927 of such Act (42 U.S.C. 1396s) is amended—

(A) in subsection (c)(1)(C)(i), as amended by section 13602(a)(1) of the Omnibus Budget Reconciliation Act of 1993, by striking ''health

maintenance organization'' and inserting ''risk contracting entity'', and

(B) in subsection (j)(1), by striking ''*** Health Maintenance Organizations, including those organizations'' and inserting ''risk contracting entities''.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

SEC. 1712. PERIOD OF CERTAIN WAIVERS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended by striking ''No waiver'' and all that follows through ''unless the Secretary'' and inserting ''A waiver under this section (other than under subsection (c), (d), or (e)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5 year periods unless the Secretary''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to waivers pursuant to applications which are approved, and with respect to continuations of waivers for which requests are made, later than 30 days after the date of the enactment of this Act.

SEC. 1713. ELIMINATION OF DUPLICATIVE PEDIATRIC IMMUNIZATION PROGRAM.

Effective as if included in the enactment of the 13621 of the Omnibus Budget Reconciliation Act of 1993, title XIX of the Social Security Act is amended as follows:

(1) Section 1902(a) is amended—

(A) by adding ''and'' at the end of paragraph (60),

(B) by striking ''; and'' at the end of paragraph (61) and inserting a period, and

(C) by striking paragraph (62).

(2) Section 1928 is repealed.

(3) Section 1903(i) is amended—

(A) by inserting ''or'' at the end of paragraph (12),

(B) by striking the semicolon at the end of paragraph (13) and inserting a period, and

(C) by striking paragraphs (14) and (15).

(4) Section 1902(a)(32)(D) is amended by striking ''before October 1, 1994''.

(5) Section 1902(a) is amended—

(A) in paragraph (11)(B)—

(i) by inserting ''and'' before ''(ii)'', and

(ii) by striking ''to the individual under section 1903, and

(iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services'' and inserting ''to him under section 1903'';

(B) in paragraph (11)(C), by striking '', including the provision of information and education on pediatric vaccinations and the delivery of immunization services,'' and

(C) in paragraph (43)(A), by striking ''and the need for age-appropriate immunizations against vaccine-preventable diseases''.

(6) Section 1905(r)(1) is amended—

(A) in subparagraph (A)(i), by striking ''and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines''; and

(B) in subparagraph (B)(iii), by striking ''(according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines)''.

PART 3—MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT

SEC. 1721. 25 PERCENT REDUCTION IN AMOUNT OF PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) IN GENERAL.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(h) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION FOR DISPROPORTIONATE SHARE ADJUSTMENTS.—Notwithstanding any other provision of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year shall not exceed—

''(1) for quarters in fiscal years 1995 and 1996, 88 percent of the amount otherwise determined under subsection (f); and

''(2) for quarters in fiscal year 1997 and each succeeding fiscal year, 75 percent of the amount otherwise determined under subsection (f).''.

(b) CONFORMING AMENDMENT.—Section 1923(c) of such Act (42 U.S.C. 1396r–4(c)) is amended in the matter preceding paragraph (1) by striking ''(f) and (g)'' and inserting ''(f), (g), and (h)''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to quarters in fiscal years beginning on or after October 1, 1996.

Subtitle I—Remedies and Enforcement With Respect to Group Health Plans

SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.''; and

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

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) IN GENERAL.—In addition to meeting the requirements of subsection (a), every group health plan shall afford a reasonable opportunity to any participant or beneficiary, whose request for a preauthorization, an emergency preauthorization, a utilization review determination, or an emergency utilization review determination has been denied, for a full and fair review by the appropriate fiduciary of the decision denying the request.

''(2) TIME LIMITS FOR DECIDING CLAIMS.—

''(A) INITIAL DECISIONS.—A group health plan shall issue an initial approval or denial of any claim for medical, surgical, or hospital benefits not later than 30 days after its filing completion date. Failure to approve or deny such a claim within such 30-day period shall be treated as a denial of the claim.

''(B) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under subparagraph (A) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial shall be treated as a final decision denying the claim.

''(3) TIME LIMIT FOR DECIDING REQUESTS FOR PREAUTHORIZATION.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B):

''(i) INITIAL DECISIONS.—If a request for preauthorization is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing comple-

tion date. Failure to approve or deny such a request within such 30-day period shall be treated as a denial of the request.

''(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

''(B) REQUESTS FOR EMERGENCY PREAUTHORIZATION.—

''(i) INITIAL DECISIONS.—In any case in which a request for preauthorization required under the terms of a group health plan is a request for emergency preauthorization, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such

10-day period (or 24-hour period) shall be treated as a denial of the request.

''(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

''(4) TIME LIMIT FOR DECIDING REQUESTS FOR UTILIZATION REVIEW DETERMINATIONS.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B):

''(i) INITIAL DECISIONS.—If a request for a utilization review determination is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing completion date. Failure to approve or deny such a request within such

30-day period shall be treated as a denial of the request.

''(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

''(B) REQUESTS FOR EMERGENCY UTILIZATION REVIEW DETERMINATIONS.—

''(i) INITIAL DECISIONS.—In any case in which a request for a utilization review determination required under the terms of a group health plan is a request for an emergency utilization review determination, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour pe-

riod) shall be treated as a denial of the request.

''(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) CLAIM FOR MEDICAL, SURGICAL, OR HOSPITAL BENEFITS.—The term 'claim for medical, surgical, or hospital benefits' means a request for payment by a group health plan of such benefits made by or on behalf of a participant or beneficiary after the expense for medical, surgical, or hospital care has been incurred.

''(B) UTILIZATION REVIEW DETERMINATION.—The term 'utilization review determina-

tion' means a determination under a group health plan solely that proposed medical, surgical, or hospital care is medically necessary (as defined in section 1131(7) of the Health Security Act). Unless otherwise expressly provided under the terms of the plan, any such determination shall not by itself constitute a guarantee that benefits under the plan will be provided.

''(C) PREAUTHORIZATION.—The term 'preauthorization' means a determination under a group health plan that proposed medical, surgical, or hospital care meets the plan's terms and conditions of coverage. Such a determination shall constitute a guarantee that benefits under the plan will be provided.

''(D) REQUEST FOR PREAUTHORIZATION.—The term 'request for preauthorization' means a request for preauthorization by a group health plan of medical, surgical, or hospital benefits made by or on behalf of a participant or beneficiary before the expense for such care has been incurred.

''(E) REQUEST FOR EMERGENCY PREAUTHORIZATION.—The term 'request for

emergency preauthorization' means a request for preauthorization.0 by a group health plan in any case in which the medical, surgical, or hospital benefits for which the expense is to be incurred constitutes urgent medical care or emergency medical care.

''(F) REQUEST FOR UTILIZATION REVIEW DETERMINATION.—The term 'request for a utilization review determination' means a request by or on behalf of a participant or beneficiary, made before an expense for medical, hospital, or surgical care has been incurred, for a utilization review determination by a plan.

''(G) REQUEST FOR EMERGENCY UTILIZATION REVIEW DETERMINATION.—The term 'request for an emergency utilization review determination' means a request for a utilization review determination in any case in which the medical, hospital, or surgical care to be incurred constitutes urgent medical care or emergency medical care.

''(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in

writing that failure to provide the participant or beneficiary with such care within 45 days will result in either—

''(i) the death of the participant or beneficiary within 120 days, or

''(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary within 120 days which will significantly increase the reasonable likelihood of death of the participant or beneficiary.

''(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

''(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the

health of the woman or her unborn child) in serious jeopardy,

''(II) serious impairment to bodily functions, or

''(III) serious dysfunction of any bodily organ or part,

or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(J) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required to make an initial decision to approve or deny a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

''(K) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a

group health plan, the date as of which the appropriate fiduciary is in receipt of all information reasonably required to make a decision upon a full and fair review of the denial, in whole or in part, of a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

''(L) APPROPRIATE FIDUCIARY.—The term 'appropriate fiduciary' means with respect to any determination under a group health plan a person designated by the plan to make such determination. One or more appropriate fiduciaries shall be designated under each group health plan for making determinations under the plan.''.

(b) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

''(42) The term 'group health plan' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of

1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.''.

(2) CONFORMING AMENDMENT.—Section 607 of such Act (29 U.S.C. 1167) is amended by striking paragraph (1).

SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by inserting below the heading for part 5 the following:

''Subpart A—In General'';

and

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

''Subpart B—Mediation of Group Health Plan Claims

''SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.

''(a) IN GENERAL.—The Secretary shall establish a mediation program under this subpart (hereinafter in this subpart referred to as the 'mediation program') for the purpose of facilitating mediation of disputes meeting the requirements specified in subsection (b). At the time notice is provided to any participant or beneficiary of a group health plan's denial of any claim for benefits pursuant to section 503, the plan shall provide reasonable notice

in writing to the participant or beneficiary whose claim for benefits under the plan has been denied of the availability of mediation under this subpart at the election of either the claimant or the plan.

''(b) DISPUTE CRITERIA.—A dispute may be submitted for mediation under the mediation program only if the following requirements are met with respect to such dispute:

''(1) PARTIES.—The dispute consists of an assertion by a participant, a beneficiary, or the duly authorized representative of a participant or beneficiary (or, in the case of an assignment, the assignee) of one or more claims under a group health plan, and a denial of such claims, or a denial of appropriate reimbursement based on such claims, by such plan or an appropriate fiduciary.

''(2) NATURE OF CLAIM.—The claim consists of a claim for benefits for medical, surgical, or hospital expenses under a group health plan which consist of benefits described in section 3(1).

''(3) SUBMISSION AFTER EXHAUSTION OF PLAN REMEDIES.—The claimant has received a final determination regarding the claim under the plans' claims procedure under section 503, or has otherwise ex-

hausted all remedies under the plan provided pursuant to section 503.

''(4) APPROPRIATE FIDUCIARY.—For purposes of this subpart, the term 'appropriate fiduciary' has the meaning provided in section 503(b)(5)(K).

"**SEC. 522. FACILITATORS.**

''(a) ROSTER.—The Secretary shall maintain a list of individuals with appropriate expertise to serve as facilitators in proceedings under the mediation program.

''(b) CRITERIA.—In identifying individuals to serve as facilitators, the Secretary shall consider the following:

''(1) The individual's experience in dispute resolution.

''(2) The individual's ability to act impartially.

''(3) The individual's ability to perform evaluations quickly and to present them in nontechnical terms.

''(4) The individual's experience in employee medical, hospital, and surgical benefits.

''(c) APPOINTMENT OF FACILITATOR.—Within 15 days after either party files with the Secretary an election of mediation with respect to a dispute, the Secretary shall propose a facilitator, selected under a random selection procedure prescribed in regulations, and notify the parties of such selection. Within 10 days after receipt of the noti-

fication of the selection of a facilitator, either party may reject the proposed facilitator. If neither party objects to the Secretary's proposed facilitator within such 10-day period, the appointment shall become final. If either party objects to the Secretary's proposed facilitator, the procedure set forth in the preceding provisions of this subsection shall be repeated. Each party is limited to 1 objection to the Secretary's proposed facilitator for each mediation.

"SEC. 523. ROLE OF ATTORNEYS.

''Parties may represent themselves or be represented by attorneys throughout the mediation process.

"SEC. 524. INITIATION OF MEDIATION.

''(a) CLAIMANT INITIATION.—A claimant may initiate mediation of a dispute under this subpart only if no action has been commenced by the claimant under section 502 with respect to any claim involved. To initiate mediation, a claimant shall file an election for mediation with the Secretary (and shall file a copy of the election with the plan or the appropriate fiduciary) within 30 days after a final determination regarding the claim pursuant to section 503.

''(b) PLAN INITIATION.—A participant or beneficiary may not commence an action under section 502 with respect to any claim until the participant or beneficiary has

provided to the plan or the appropriate fiduciary 10 days advance notice of the filing of such action. Within the earlier of (1) 25 days after receipt of such a notice with respect to any claim or (2) the date preceding the date on which such claim is filed in court, the plan or the appropriate fiduciary may elect mediation of a dispute under this subpart involving such claim by filing an election for mediation with the Secretary (and a copy of the election with the claimant). Upon a timely election of mediation by the plan or the appropriate fiduciary, the claimant's right to pursue the claim under section 502 shall be suspended until the earlier of 75 days after the date of the filing of the election of mediation or the termination of the mediation proceedings.

''(c) ELECTION FOR MEDIATION.—An election by any party for mediation under this subpart shall be in such form and manner as the Secretary shall prescribe by regulation.

''(d) PARTICIPATION.—The claimant and the plan shall participate in the mediation. Each party shall provide the facilitator a written summary of its position with respect to the dispute accompanied by supporting documentation.

''(e) FILING FEE.—The party initiating mediation under this section shall include with any election for medi-

ation under this subpart a reasonable nonrefundable filing fee payable to the Secretary. The filing fee shall be determined pursuant to regulations prescribed by the Secretary.

''(f) TOLLING OF STATUTES OF LIMITATIONS.—The applicable statute of limitations with respect to any claim involved in a dispute subject to mediation proceedings under this subpart shall be tolled for the period commencing with the 10-day notice period required under subsection (b) and ending with the termination of the mediation proceedings with respect to such dispute. In no event shall the applicable statute of limitations be tolled beyond the 60-day-time limit for completion of mediation provided under section 526.

"**SEC. 525. MEDIATION PROCEDURE.**

''(a) IN GENERAL.—Mediation proceedings under this subpart shall be conducted, at locations convenient to complainants, by facilitators recruited and assigned by the Secretary under section 522.

''(b) DUTIES OF FACILITATOR.—The Secretary shall prescribe by regulation the duties and role of the facilitator during the mediation process. Such regulations may require the facilitator to identify parties, establish a schedule, request position papers from the parties, and evaluate positions of the parties. Such regulations shall

provide that the mediation will be informal, convenient, inexpensive, and expeditious for all parties.

''(c) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

"SEC. 526. MEDIATION TIME LIMIT.

''Any mediation proceedings commenced under this subpart shall be completed within 60 days from the final appointment of a facilitator pursuant to section 522(c).

"SEC. 527. COST OF MEDIATION.

''All reasonable costs of the mediation process under this subpart with respect to any dispute, including the cost of the facilitator, shall be divided equally among the parties. Facilitators shall be compensated at a rate established by the Secretary by regulation. The Secretary shall prescribe regulations specifying reasonable mediation costs and alternative means of allocating the costs in cases of hardship on the part of the claimant.

"SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROGRAM.

''(a) NONBINDING MEDIATION.—The results of any mediation under this subpart shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties shall not be affected by participation in the mediation program.

''(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a dispute is settled through participation in the mediation program, the facilitator shall, upon the request of either party, assist the parties in drawing up a settlement agreement between the parties.

"SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.

''(a) IN GENERAL.—All documents and communications made during or generated in connection with the mediation program, as well as any settlement offers or agreements made or entered into under such program—

''(1) shall be privileged and confidential, and

''(2) shall not be admissible as evidence in any Federal or State judicial proceeding unless all parties to the mediation consent in writing.

''(b) EXECUTION OF PRIVILEGE.—Any individual or entity involved in the mediation (including any party or facilitator or other individual who acts on behalf of a party or who provides information or an opinion in connection with the mediation) receiving a subpoena or other lawful process seeking disclosure of any information or documents rendered privileged and confidential under subsection (a) shall assert the privilege provided under subsection (a) and promptly notify all parties to the mediation proceedings of the request for disclosure. The privilege provided for in this section shall be in addition to any at-

torney-client privilege or other privilege which may be asserted by a party and nothing in this section shall constitute a waiver of such attorney-client privilege or other privilege.''.

(b) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended—

(1) by inserting after the item relating to the heading for part 5 of subtitle B of title I the following new item:

''Subpart A—General Provisions'';

and

(2) by inserting after the item relating to section 514 the following new items:

''Subpart B—Mediation of Group Health Plan Claims

''Sec. 521. Eligibility for submission to mediation.
''Sec. 522. Facilitators.
''Sec. 523. Role of attorneys.
''Sec. 524. Initiation of mediation.
''Sec. 525. Mediation procedure.
''Sec. 526. Mediation time limit.
''Sec. 527. Cost of mediation.
''Sec. 528. Legal effect of participation in mediation program.
''Sec. 529. Confidentiality and admissibility.''.

SEC. 1803. AVAILABLE COURT REMEDIES.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new paragraphs:

''(5) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group

health plan in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in a failure to provide an item or service, or payment therefor, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for provision of such item or service, or payment therefor, upon finding in favor of the plaintiff, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act,

''(ii) to provide the item or service, or payment therefor, and to otherwise comply with the terms of the plan and the applicable requirements of this title,

''(iii) to pay to the plaintiff prejudgment interest on the actual costs incurred in obtaining any item or service, or payment therefor, at issue in the complaint, and

''(iv) to pay to the plaintiff a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the action on the charges on which the plaintiff prevails.

The remedies provided under this paragraph shall be in addition to remedies otherwise provided under this section.

''(6)(A) The Secretary may assess a civil penalty against the plan administrator of, or the appropriate fiduciary (as defined in section 503(b)(5)(K)) of, one or more group health plans for any pattern or practice thereof of repeated failures to provide benefits under the terms of the plan or plans without any reasonable basis or repeated violations thereby of the requirements of section 503 with respect to such plan or plans. Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(B) Such penalty shall be in an amount not to exceed the lesser of—

''(i) 20 percent of the aggregate value of claims shown by the Secretary to have been denied, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(ii) $1,000,000.

''(C) The plan administrator or the appropriate fiduciary of any group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involve-

ment, with respect to such plan or plans, for a period of not less than 7 years.

''(D) For purposes of this paragraph, the phrase 'without any reasonable basis' means, in connection with any denial of claims for benefits under a group health plan, that such denial does not have any reasonable basis, support, or justification under—

''(i) the facts regarding such claim which were reasonably available to the plan administrator or the appropriate fiduciary at the time the claim was denied, and

''(ii) the terms of the plan.''.

(b) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by inserting ''or (c)(6)'' after ''(c)(2)''.

SEC. 1804. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

Subtitle J—Delivery of Health Care Services to Illegal Immigrants

SEC. 1901. STUDY ON THE DELIVERY OF HEALTH CARE SERVICES TO ILLEGAL IMMIGRANTS.

(a) IN GENERAL.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a detailed study of health care in the United States to populations of individuals immigrating to the United States illegally, including the effect of illegal immigration on levels of health costs and the shifting of health costs.

(b) MATTERS TO BE ANALYZED.—In conducting the study under this section, the Secretary shall analyze—

(1) the extent to which individuals illegally immigrating into the United States obtain health care services in the United States,

(2) the costs of such services,

(3) the means currently used to finance such costs,

(4) the means currently used for identifying, evaluating, preventing, and resolving health problems of populations comprised of such individuals,

(5) the extent of efforts currently being undertaken to prevent or resolve such health problems,

(6) the extent of efforts currently being undertaken to educate populations comprised of such individuals concerning such health problems and to coordinate such efforts,

(7) the programs currently in place for carrying out the activities described in paragraphs (3) through (6), and

(8) the extent of intergovernmental cooperation currently in place between the United States and other countries in dealing with health problems described in the preceding provisions of this subsection.

SEC. 1902. REPORT.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to each House of the Congress a final report on the matters analyzed in the study conducted under section 1801. The Secretary shall include in such report any recommendations derived by the Secretary regarding appropriate means of—

(1) alleviating the health problems peculiar to populations of individuals who have immigrated to the United States illegally,

(2) financing health care provided to such populations, and

(3) increasing intergovernmental cooperation and coordination of efforts between the United States and other countries to alleviate such health problems and to finance such efforts.

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

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Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) 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 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 claim or action.

(b) PREEMPTION.—The provisions of this subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) 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.

(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 section 1331 or 1337 of title 28, United States Code.

SEC. 2002. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under this subtitle 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, and any person on whose behalf such a claim is alleged, including the decedent in the case

of an action brought through or on behalf of an estate.

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

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

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(6) 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 the

laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

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

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a civil action brought in a State or Federal court against a health care provider or health care professional in which the plaintiff alleges a medical malpractice liability claim, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) 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 or the use of a medical product.

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section

201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual 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.

(12) PUNITIVE DAMAGES; EXEMPLARY DAMAGES.—The terms ''punitive damages'' and ''exemplary damages'' mean compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

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

(14) 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. 2003. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and section 2017(c), 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—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 2032(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 2032(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless

the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process estab-

lished by the Attorney General under such subparagraph.

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

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

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

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

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

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

(d) LEGAL EFFECT OF UNCONTESTED 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. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.

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

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) BASIS FOR RECOVERY.—Punitive or exemplary damages shall not be awarded in a medical malpractice liability action unless the claimant establishes by clear and convincing evidence that the injury suffered was the direct result of conduct manifesting a malicious, wanton, willful, or excessively reckless disregard of the safety of others.

(2) NO AWARD AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

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

(A) IN GENERAL.—Any punitive or exemplary damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided.

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

ers 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.—

(1) GENERAL RULE.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) WAIVER.—A court may waive the application of paragraph (1) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

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

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

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury 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 such individual to pay costs of or compensate such individual for the injury that was the subject of the claim or action; minus

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

SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a medical malpractice liability claim may not charge, demand, receive, or collect for services rendered in connection with such claim in excess of the following amount recovered by judgment or settlement under such claim:

(A) 25 percent of the first $150,000 (or portion thereof) recovered, plus

(B) 10 percent of any amount in excess of $150,000 recovered.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action 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 under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action does not exceed the amount of damages awarded to the party under the ADR system by at least 10 percent; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not at least 10 per-

cent less than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling 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 ruling was based on an error of law;

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an

undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) REQUIREMENT FOR PERFORMANCE BOND.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to post a performance bond (in such amount and consisting of such funds and assets as the court determines to be appropriate), except that the court may waive the application of such requirement to a party if the court determines that the posting of such a bond is not necessary to ensure that the party shall meet the requirements of this subsection to pay the opposing party the costs incurred by the opposing party under the action.

(4) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency

fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(5) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 2014. JOINT AND SEVERAL LIABILITY.

A defendant may be held severally but not jointly liable in a medical malpractice action. A person found liable for damages in any such action may be found liable, if at all, only for those damages directly attributable to the person's proportionate share of fault or responsibility for the injury, and may not be found liable for damages attributable to the proportionate share of fault or responsibility of any other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

SEC. 2015. STATUTE OF LIMITATIONS.

A medical malpractice liability claim may not be brought after the expiration of the 7-year period that begins on the date the alleged injury that is the subject of the claim occurred. If the commencement of such an action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

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. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, if the health care professional against whom the claim is brought did not previously treat the individual alleged to have been injured for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care profes-

sional unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another health care professional.

(c) EFFECTIVE DATE.—This section shall apply with respect 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.

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

SEC. 2031. BASIC REQUIREMENTS.

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

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

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

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

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

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

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

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

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

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

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 2 shall apply with respect to claims

brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) 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.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 2031.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims

during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 2031(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year—

(A) the State shall reimburse the United States (at such time and in such manner as the Secretary may require) for the costs incurred by the United States during the year as a result of the application of the system with respect to the State; and

(B) notwithstanding any other provision of law, no funds may be paid to the State (or to any unit of local government in the State) or to any entity in the State pursuant to the Public Health Service Act.

SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 2032(b).

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

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

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

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

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

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 2041. 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.

SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOLUNTARY SERVICE BY PHYSICIANS.

(a) STUDY.—The Secretary shall conduct a study analyzing the existence and effectiveness of incentives adopted by State and local governments, insurers, medical societies, and other entities to encourage physicians (whether practicing or retired) to volunteer to provide health care services in medically underserved areas.

(b) REPORTS.—(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit an interim report to Congress on the study conducted under subsection (a), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

(2) Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a final report

to the Congress on the study conducted under subsection (a) (taking into account the effects of this subtitle on the incidence and costs of medical malpractice), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PROGRAMS.

(a) REQUIREMENTS FOR PROVIDERS.—Each State shall require each health care professional and health care provider providing services in the State to participate in a risk management program to prevent and provide early warning of practices which may result in injuries to patients or which otherwise may endanger patient safety.

(b) REQUIREMENTS FOR INSURERS.—Each State shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

(1) establish risk management programs based on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other entities; and

(2) require each such professional or provider, as a condition of maintaining insurance, to partici-

pate in one program described in paragraph (1) at least once in each 3-year period.

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

SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.

(a) RESEARCH ON MEDICAL INJURY PREVENTION AND COMPENSATION.

(1) IN GENERAL.—The Secretary shall make grants for the conduct of basic research in the prevention of and compensation for injuries resulting from health care professional or health care provider malpractice, and research of the outcomes of health care procedures.

(2) PREFERENCE FOR RESEARCH ON CERTAIN ACTIVITIES.—In making grants under paragraph (1), the Secretary shall give preference to applications for grants to conduct research on the behavior of health care providers and health care professionals in carrying out their professional duties and of other participants in systems for compensating individuals injured by medical malpractice, the effects of financial and other incentives on such behavior, the determinants of compensation system outcomes, and the costs and benefits of alternative compensation policy options.

(3) APPLICATION.—The Secretary may not make a grant under paragraph (1) unless an applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary may require.

(b) GRANTS FOR LICENSING AND DISCIPLINARY ACTIVITIES.—

(1) IN GENERAL.—The Secretary shall make grants to States to assist States in improving the State's ability to license and discipline health care professionals.

(2) USES FOR GRANTS.—A State may use a grant awarded under subsection (a) to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States receiving grants under paragraph (1) to assist them in evaluating their medical practice acts and procedures and to encourage the use of efficient and effective early warning systems and other mechanisms for detecting practices which endanger patient safety and for disciplining health care professionals.

(4) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

(1) IN GENERAL.—The Secretary shall make grants to States and to local governments, private nonprofit organizations, and health professional schools (as defined in paragraph (3)) for—

(A) educating the general public about the appropriate use of health care and realistic expectations of medical intervention;

(B) educating the public about the resources and role of health care professional licensing and disciplinary boards in investigating claims of incompetence or health care malpractice; and

(C) developing programs of faculty training and curricula for educating health care professionals in quality assurance, risk management, and medical injury prevention.

(2) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such

time, in such form, in such manner, and containing such information as the Secretary shall require.

(3) HEALTH PROFESSIONAL SCHOOL DEFINED.—In paragraph (1), the term ''health professional school'' means a school of nursing (as defined in section 853(2) of the Public Health Service Act) or a school or program under section 799(1) of such Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated not more than $15,000,000 for each of the first 5 fiscal years beginning on or after the date of the enactment of this Act for grants under this section.

Subtitle B—Administrative Cost Savings and Fair Health Information Practices

PART 1—ADMINISTRATIVE COST SAVINGS

SEC. 2100. PURPOSE.

It is the purpose of this part to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the adoption of standards and the

establishment of requirements for the electronic transmission of certain health information.

SEC. 2101. DEFINITIONS.

For purposes of this part:

(1) CODE SET.—The term ''code set'' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term ''coordination of benefits'' means determining and coordinating the financial obligations of plan sponsors when health care benefits are payable by more than one such sponsor.

(3) EMPLOYER.—The term ''employer'' has the meaning given such term in section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) HEALTH INFORMATION.—The term ''health information'' means any information that relates to the past, present, or future physical or mental health or condition or functional status of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual.

(5) HEALTH INFORMATION NETWORK.—The term ''health information network'' means the health

information system that is formed through the application of the requirements and standards established under this part.

(6) HEALTH INFORMATION NETWORK SERVICE.—The term ''health information network service''—

(A) means a private entity or an entity operated by a State that enters into contracts—

(i) to process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) to provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this part, including the holding of standard data elements of health information;

(iii) to provide authorized access to health information through the health information network; or

(iv) to provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information protection service.

(7) HEALTH INFORMATION PROTECTION SERVICE.—The term ''health information protection service'' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

(8) HEALTH PROVIDER.—The term ''health provider'' includes a provider of services (as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of such Act), and any other person (other than a plan sponsor) furnishing health care items or services.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not protected health information (as defined in part 2).

(10) PLAN SPONSOR.—The term ''plan sponsor'' means—

(A) a plan (as defined in section 1033(6)(B));

(B) an insurer (as defined in section 1131(6)) providing health insurance coverage (as defined in section 1131(4)); and

(C) a State, or the Federal Government, acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to that of an insurer.

(11) PURCHASING ARRANGEMENT.—The term ''purchasing arrangement'' means a voluntary health purchasing arrangement described in part 3 of subtitle B of title I.

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

(13) STANDARD.—The term ''standard'', when used with reference to a transaction or to data elements of health information, means that the transaction or data elements meet any standard adopted by the Secretary under subpart A that applies to the transaction or data elements.

Subpart A—Standards for Data Elements and Transactions

SEC. 2103. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this part that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted, developed, or modified by the standard-setting organizations accredited by the American National Standard Institute.

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subpart.

(c) PROTECTION OF COMMERCIAL INFORMATION.—In adopting standards under this part, the Secretary may not require disclosure of trade secrets and confidential commercial information by any person.

SEC. 2104. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary shall adopt standards necessary to make uniform and compatible for electronic transmission through the health information network the data elements of any health information that the Secretary determines is appropriate for transmission in connection with a transaction described in section 2111.

(b) ADDITIONS.—The Secretary may make additions to any set of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that

minimizes the disruption and cost of compliance with such additions.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall establish a system to provide for a standard unique health identifier for each individual, employer, plan sponsor, and health provider for use in the health care system.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to code sets.

SEC. 2105. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards that are consistent with part 2 relating to the method by which standard data elements of health information may be transmitted electronically, including standards with respect to the format in which such data elements may be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standard adopted by the Secretary under paragraph (1) that relates to coordination of benefits shall provide that a claim for reimbursement for health services furnished shall be tested, by an algorithm specified by the Secretary, against all records of enrollment and eligibility for the individual who received such services that are available to the recipient of the claim through the health information network to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy State and Federal statutory requirements for written signatures with respect to transactions described in section 2111 and written signatures on health records and prescriptions.

(d) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards under this section shall provide that claims for clinical laboratory tests for which benefits are payable by a plan sponsor shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the sponsor in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

SEC. 2106. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 2104(a) not later than 9 months after the date of the enactment of this Act (except in the case of standards with respect to data elements for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act); and

(2) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 2105 not later than 9 months after the date of the enactment of this Act

(except in the case of standards for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act).

(c) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subpart and shall adopt modified standards as determined appropriate, but not more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or purchasing arrangement that is required to comply with subpart B.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this subpart during the 12-month period beginning on the date the standard is adopted, unless the Secretary determines that the modification is necessary in order to permit a plan spon-

sor, a health provider, or a purchasing arrangement to comply with subpart B.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or purchasing arrangement that is required to comply with subpart B.

(d) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subpart.

Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

Subpart B—Requirements With Respect to Certain Transactions and Information

SEC. 2111. STANDARD TRANSACTIONS AND INFORMATION.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the sponsor to the provider or by the provider to the sponsor in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS WITH SPONSORS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with another plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by either sponsor in connection with the trans-

action shall be in the form of standard data elements.

(3) TRANSACTIONS.—The transactions referred to in paragraphs (1) and (2) are the following:

(A) Verification of eligibility for benefits.

(B) Coordination of benefits.

(C) Claim submission.

(D) Claim attachment submission.

(E) Claim status notification.

(F) Claim status verification.

(G) Claim adjudication.

(H) Payment and remittance advice.

(I) Certification or authorization of a referral to a health provider who is not part of the defined set of providers providing items and services under a network plan (as defined in section 1131(5)).

(b) TRANSACTIONS BY PURCHASING ARRANGEMENTS.—

(1) IN GENERAL.—If a purchasing arrangement conducts any of the transactions described in paragraph (2) with a plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the arrangement to the sponsor or by the sponsor to the arrangement in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1) are the following:

(A) Enrollment and disenrollment.

(B) Premium payment.

(c) USE OF HEALTH INFORMATION NETWORK SERVICES.—A plan sponsor, a health provider, or a purchasing arrangement may comply with any provision of this section by entering into an agreement or other arrangement with a health information network service certified under section 2121 pursuant to which the service undertakes the duties applicable to the sponsor, provider, or arrangement under the provision.

SEC. 2112. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

(a) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

(1) IN GENERAL.—A health information protection service that is certified under section 2121 shall make available to a Federal or State agency, pursuant to a cost-type contract (as defined under the

Federal Acquisition Regulation), any non-identifiable health information, including non-identifiable health information that is derived from protected health information, that—

(A) is held by the service or may be obtained by the service under paragraph (2) or subsection (b);

(B) consists of data elements that are subject to a standard under subpart A; and

(C) is requested by the agency to fulfill a requirement under this Act.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection service requires health information consisting of data elements that are subject to a standard under subpart A from a plan sponsor or a health provider in order to comply with a request made by a Federal or State agency under paragraph (1), the sponsor or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information.

(b) PROCUREMENT RULE FOR INFORMATION PROTECTION SERVICES.—A health information protection service that makes non-identifiable health information available to a Federal or State agency under subsection

(a) shall make such non-identifiable information available, for a charge that does not exceed the reasonable cost of transmitting the information, to any other health information protection service that—

(A) is certified under section 2121; and

(B) requests the information.

SEC. 2113. ENSURING AVAILABILITY OF INFORMATION.

The Secretary shall establish a procedure under which a plan sponsor or health provider that does not have the ability to transmit standard data elements directly, and does not have access to a health information network service certified under section 2121, may comply with the provisions of this subpart.

SEC. 2114. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

(a) INITIAL COMPLIANCE.—

(1) IN GENERAL.—Not later than 12 months after the date on which standards are adopted under subpart A with respect to a type of transaction, or data elements for a type of health information, a plan sponsor, health provider, or purchasing arrangement shall comply with the requirements of this subpart with respect to such transaction or information.

(2) ADDITIONAL DATA ELEMENTS.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under section 2104, a plan sponsor, health provider, or purchasing arrangement shall comply with the requirements of this subpart using such data elements.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Secretary adopts a modified standard under section 2106(c), a plan sponsor, health provider, or purchasing arrangement shall comply with the modified standard at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification.

(2) SPECIAL RULE.—In the case of a modification to a standard that does not occur within the 12-month period beginning on the date the standard is adopted, the time determined appropriate by the Secretary under paragraph (1) may not be—

(A) earlier than the last day of the 90-day period beginning on the date the modified standard is adopted; or

(B) later than the last day of the 12-month period beginning on the date the modified standard is adopted.

Subpart C—Miscellaneous Provisions

SEC. 2121. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that such services—

(1) develop, operate, and cooperate with one another to form the health information network;

(2) meet all of the requirements under part 2 that are applicable to the services;

(3) make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

(4) have security procedures that are consistent with the requirements under part 2, including secure methods of accessing and transmitting data; and

(5) if they are part of a larger organization, have policies and procedures in place which isolate

their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

(b) CERTIFICATION BY THE SECRETARY.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this part and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a manner that minimizes the costs and delays of operations for such services.

(2) APPLICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this part, part 2, and

the standards established by the Secretary under this section.

(4) RECERTIFICATION.—A health information network service shall be recertified under this subsection at least every 3 years.

(c) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—Except as provided in paragraph (2), if a health information network service violates a requirement imposed on such service under part 2, its certification under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

(2) CONDITIONAL CERTIFICATION.—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraph (1). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

(d) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under

this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

(e) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under this section loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another health information network service certified under this section that has been designated by the Secretary.

SEC. 2122. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c), after the Secretary has established standards under section 2104 that are necessary to make uniform and compatible for electronic transmission the data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subpart B, an individual or entity may not require an individual or entity, to provide in any manner any additional data element in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(b) TRANSMISSION METHOD.—Except as provided in subsection (c), after the Secretary has established standards under section 2105 relating to the method by which data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subpart B may be transmitted electronically, an individual or entity may not require an individual or entity to transmit any data element in a manner inconsistent with the standards in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(c) EXCEPTION.—Subsections (a) and (b) do not apply if—

(1) an individual or entity voluntarily agrees to provide the additional data element; or

(2) a waiver is granted under subsection (d) to permit the requirement.

(d) CONDITIONS FOR WAIVERS.—

(1) IN GENERAL.—An individual or entity may request a waiver from the Secretary in order to impose on an individual or entity a requirement otherwise prohibited under subsection (a) or (b).

(2) CONSIDERATION OF WAIVER REQUESTS.—A waiver may not be granted under this subsection to impose an otherwise prohibited requirement unless

the Secretary determines that the value of any additional information to be provided under the requirement for research or other purposes significantly outweighs the administrative cost of the imposition of the requirement, taking into account the burden of the timing of the imposition of the requirement.

(3) ANONYMOUS REPORTING.—If an individual or entity attempts to impose on an individual or entity a requirement prohibited under subsection (a) or (b), the individual or entity on whom the requirement is being imposed may contact the Secretary. The Secretary shall develop a procedure under which an individual or entity that contacts the Secretary under the preceding sentence shall remain anonymous. The Secretary shall notify the individual or entity imposing the requirement that the requirement may not be imposed unless the other individual or entity voluntarily agrees to such requirement or a waiver is obtained under this subsection.

SEC. 2123. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as otherwise provided in this section, a provision, requirement, or standard under this part shall supersede any contrary provision of State law.

(b) STATE ''QUILL AND PEN'' LAWS.—A State may not establish, continue in effect, or enforce any provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

(c) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(d) PUBLIC USE FUNCTIONS.—Nothing in this part shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use.

(e) PAYMENT FOR HEALTH CARE SERVICES OR PREMIUMS.—Nothing in this part shall be construed to prohibit a consumer from paying for health care items or services, or plan or health insurance coverage premiums, by debit, credit, or other payment cards or numbers or other electronic payment means.

SEC. 2124. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this section for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary regarding the following:

(A) USE OF EXISTING TECHNOLOGY.—Funds received under this section will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this section will be used—

(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

(C) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

(c) GEOGRAPHIC DIVERSITY.—In making any grants under this section, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this section with the provisions of this

section. The Secretary shall establish a procedure for determining whether such a person has failed to comply substantially within the provisions of this section and the sanctions to be imposed for any such noncompliance.

(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this section.

Subpart D—Assistance to the Secretary

SEC. 2131. GENERAL REQUIREMENT ON SECRETARY.

In complying with any requirements imposed on the Secretary under this part, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 2132 and shall consult with appropriate Federal agencies.

SEC. 2132. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

(b) DUTY.—

(1) IN GENERAL.—The committee shall—

(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part and part 2;

(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall receive technical assistance from appropriate Federal agencies.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered

terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the commit-

tee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

(A) the status of the health information network established under this part, including whether the network is fulfilling the purpose described in section 2100;

(B) the savings and costs of the network;

(C) the activities of health information network services certified under section 2121, health providers, and plan sponsors under this part;

(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this part and working together to form an integrated network that meets the needs of its users;

(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of part 2;

(F) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under this Act;

(G) any problems with respect to implementation of the network;

(H) the extent to which timetables under this part for the adoption and implementation of standards are being met; and

(I) any legislative recommendations related to the health information network.

(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under

paragraph (1) shall be made available to the public, unless such information may not be disclosed by law.

(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

PART 2—FAIR HEALTH INFORMATION PRACTICES

SEC. 2140. DEFINITIONS.

(a) DEFINITIONS RELATING TO PROTECTED HEALTH INFORMATION.—For purposes of this part:

(1) DISCLOSE.—The term ''disclose'', when used with respect to protected health information that is held by a health information trustee, means to provide access to the information, but only if such access is provided by the trustee to a person other than—

(A) the trustee or an officer or employee of the trustee;

(B) an affiliated person of the trustee; or

(C) a protected individual who is a subject of the information.

(2) DISCLOSURE.—The term ''disclosure'' means the act or an instance of disclosing.

(3) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any in-

formation, whether oral or recorded in any form or medium—

(A) that is created or received in a State by—

(i) a health care provider;

(ii) a health benefit plan sponsor;

(iii) a health oversight agency;

(iv) a health information service organization; or

(v) a public health authority;

(B) that relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual, the provision of health care to a protected individual, or payment for the provision of health care to a protected individual; and

(C) that—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(4) PROTECTED INDIVIDUAL.—The term ''protected individual'' means an individual who, with respect to a date—

(A) is living on the date; or

(B) has died within the 2-year period ending on the date.

(5) USE.—The term ''use'', when used with respect to protected health information that is held by a health information trustee, means—

(A) to use, or provide access to, the information in any manner that does not constitute a disclosure; or

(B) any act or instance of using, or providing access, described in subparagraph (A).

(b) DEFINITIONS RELATING TO HEALTH INFORMATION TRUSTEES.—For purposes of this part:

(1) CARRIER.—The term ''carrier'' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of the Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits.

(2) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) any contract of health insurance, including any hospital or medical service policy or

certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier; and

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(3) HEALTH BENEFIT PLAN SPONSOR.—The term ''health benefit plan sponsor'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a carrier providing a health benefit plan;

(B) any other provider of a health benefit plan, including any public entity that provides payments for health care items and services under a health benefit plan that are equivalent to payments provided by a private person under such a plan; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession;

(B) a Federal or State program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(5) HEALTH INFORMATION SERVICE ORGANIZATION.—The term ''health information service organization'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person, other than an affiliated person, who performs specific functions for which the Secretary has authorized (by means of a

designation or certification) the person to receive access to health care data in electronic or magnetic form that are regulated by this Act; or

(B) an officer or employee of a person described in subparagraph (A).

(6) HEALTH INFORMATION TRUSTEE.—The term ''health information trustee'' means—

(A) a health care provider;

(B) a health information service organization;

(C) a health oversight agency;

(D) a health benefit plan sponsor;

(E) a public health authority;

(F) a health researcher;

(G) a person who, with respect to a specific item of protected health information, is not described in subparagraphs (A) through (F) but receives the information—

(i) pursuant to—

(I) section 2157 (relating to emergency circumstances);

(II) section 2158 (relating to judicial and administrative purposes);

(III) section 2159 (relating to law enforcement); or

(IV) section 2160 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(7) HEALTH OVERSIGHT AGENCY.—The term ''health oversight agency'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers;

(B) a person who—

(i) performs or oversees the performance of an audit, assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of, legal, fiscal, medical, or

scientific standards or aspects of performance related to the delivery of, or payment for, health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a State or Federal statute regulating the assessment, evaluation, determination, or investigation; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(8) HEALTH RESEARCHER.—The term ''health researcher'' means a person who, with respect to a specific item of protected health information, receives the information—

(A) pursuant to section 2156 (relating to health research); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

(9) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or dis-

closes the information while acting in whole or in part in the capacity of—

(A) an authority of the United States, a State, or a political subdivision of a State that is responsible for public health matters;

(B) a person acting under the direction of such an authority; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(c) OTHER DEFINITIONS.—For purposes of this part:

(1) AFFILIATED PERSON.—The term ''affiliated person'' means a person who—

(A) is not a health information trustee;

(B) is a contractor, subcontractor, associate, or subsidiary of a person who is a health information trustee; and

(C) pursuant to an agreement or other relationship with such trustee, receives, creates, uses, maintains, or discloses protected health information.

(2) APPROVED HEALTH RESEARCH PROJECT.—The term ''approved health research project'' means a biomedical, epidemiological, or health services research or statistics project, or a research project on behavioral and social factors affecting health, that

has been approved by a certified institutional review board.

(3) CERTIFIED INSTITUTIONAL REVIEW BOARD.—The term ''certified institutional review board'' means a board—

(A) established by an entity to review research involving protected health information and the rights of protected individuals conducted at or supported by the entity;

(B) established in accordance with regulations of the Secretary under section 2156(e)(1); and

(C) certified by the Secretary under section 2156(e)(2).

(4) HEALTH CARE.—The term ''health care''—

(A) means—

(i) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition, or functional status, of an individual; or

(II) affecting the structure or function of the human body or any

part of the human body, including banking of blood, sperm, organs, or any other tissue; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of maintaining or improving the health of an individual.

(5) LAW ENFORCEMENT INQUIRY.—The term ''law enforcement inquiry'' means a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(6) PERSON.—The term ''person'' includes an authority of the United States, a State, or a political subdivision of a State.

Subpart A—Duties of Health Information Trustees

SEC. 2141. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (b), a health information trustee described in subsection (g)—

(1) shall permit a protected individual to inspect any protected health information about the individual that the trustee maintains, any accounting with respect to such information required under section 2144, and any copy of an authorization required under section 2152 that pertains to such information;

(2) shall provide the protected individual with a copy of the information upon request by the individual and subject to any conditions imposed by the trustee under subsection (d);

(3) shall permit a person who has been designated in writing by the protected individual to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) EXCEPTIONS.—A health information trustee is not required by this section to permit inspection or copying of protected health information by a protected individual if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psycho-

logical, or mental health treatment notes about the individual, the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the notes would cause sufficient harm to the protected individual so as to outweigh the desirability of permitting access, and the trustee does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual, other than the protected individual or a health care provider, and the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reasonably be expected to endanger the life or physical safety of an individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of

confidentiality to a health care provider concerning a protected individual who is a subject of the information.

(5) ADMINISTRATIVE PURPOSES.—The information—

(A) is used by the trustee solely for administrative purposes and not in the provision of health care to a protected individual who is a subject of the information; and

(B) is not disclosed by the trustee to any person.

(6) DUPLICATIVE INFORMATION.—The information duplicates information available for inspection under subsection (a).

(7) INFORMATION COMPILED IN ANTICIPATION OF LITIGATION.—The information is compiled principally—

(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

(B) for use in such an action or proceeding.

(c) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health information trustee shall permit inspection and copying under subsection (a) of any reasonably

segregable portion of a record after deletion of any portion that is exempt under subsection (b).

(d) CONDITIONS.—A health information trustee may—

(1) require a written request for the inspection and copying of protected health information under this section; and

(2) charge a reasonable cost-based fee for—

(A) permitting inspection of information under this section; and

(B) providing a copy of protected health information under this section.

(e) STATEMENT OF REASONS FOR DENIAL.—If a health information trustee denies in whole or in part a request for inspection or copying under this section, the trustee shall provide the protected individual who made the request with a written statement of the reasons for the denial.

(f) DEADLINE.—A health information trustee shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date the trustee receives the request.

(g) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 2142. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health information trustee described in subsection (f) shall, within the 45-day period beginning on the date the trustee receives from a protected individual about whom the trustee maintains protected health information a written request that the trustee correct or amend the information, complete the duties described in one of the following paragraphs:

(1) CORRECTION OR AMENDMENT AND NOTIFICATION.—The trustee shall—

(A) make the correction or amendment requested;

(B) inform the protected individual of the amendment or correction that has been made;

(C) make reasonable efforts to inform any person who is identified by the protected individual, who is not an employee of the trustee, and to whom the uncorrected or unamended portion of the information was previously dis-

closed of the correction or amendment that has been made; and

(D) at the request of the individual, make reasonable efforts to inform any known source of the uncorrected or unamended portion of the information about the correction or amendment that has been made.

(2) REASONS FOR REFUSAL AND REVIEW PROCEDURES.—The trustee shall inform the protected individual of—

(A) the reasons for the refusal of the trustee to make the correction or amendment;

(B) any procedures for further review of the refusal; and

(C) the individual's right to file with the trustee a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the trustee.

(b) STANDARDS FOR CORRECTION OR AMENDMENT.—A trustee shall correct or amend protected health information in accordance with a request made under subsection (a) if the trustee determines that the information is not accurate, relevant, timely, or complete for the pur-

poses for which the information may be used or disclosed by the trustee.

(c) STATEMENT OF DISAGREEMENT.—After a protected individual has filed a statement of disagreement under subsection (a)(2)(C), the trustee, in any subsequent disclosure of the disputed portion of the information, shall include a copy of the individual's statement and may include a concise statement of the trustee's reasons for not making the requested correction or amendment.

(d) CONSTRUCTION.—This section may not be construed to require a health information trustee to conduct a hearing or proceeding concerning a request for a correction or amendment to protected health information the trustee maintains.

(e) CORRECTION.—For purposes of subsection (a), a correction is deemed to have been made to protected health information when—

(1) information that is not timely, accurate, relevant, or complete is clearly marked as incorrect; or

(2) supplementary correct information is made part of the information and adequately cross-referenced.

(f) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 2143. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF NOTICE.—A health information trustee described in subsection (d) shall prepare a written notice of information practices describing the following:

(1) The rights under this part of a protected individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(2) The procedures established by the trustee for the exercise of such rights.

(3) The uses and disclosures of protected health information that are authorized under this part.

(b) DISSEMINATION OF NOTICE.—A health information trustee—

(1) shall, upon request, provide any person with a copy of the trustee's notice of information practices (described in subsection (a)); and

(2) shall make reasonable efforts to inform persons in a clear and conspicuous manner of the existence and availability of such notice.

(c) MODEL NOTICES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model notices of information practices for use by health information trustees under this section.

(d) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization; or

(4) a health oversight agency.

SEC. 2144. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—Except as provided in subsection (b) and section 2154, each health information trustee shall create and maintain, with respect to any protected health information the trustee discloses, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom the disclosure was made;

(3) the address of the person to whom the disclosure was made or the location to which the disclosure was made; and

(4) where practicable, a description of the information disclosed.

(b) REGULATIONS.—Not later than July 1, 1996, the Secretary shall promulgate regulations that exempt a health information trustee from maintaining a record under subsection (a) with respect to protected health information disclosed by the trustee for purposes of peer review, licensing, certification, accreditation, and similar activities.

SEC. 2145. SECURITY.

(a) IN GENERAL.—Each health information trustee who receives or creates protected health information that is subject to this part shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of the information;

(2) to protect against any reasonably anticipated—

(A) threats or hazards to the security or integrity of the information; and

(B) unauthorized uses or disclosures of the information; and

(3) otherwise ensure compliance with this part by the trustee and the officers and employees of the trustee.

(b) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the implementation of this section. The guidelines shall take into account—

(1) the technical capabilities of record systems used to maintain protected health information;

(2) the costs of security measures;

(3) the need for training persons who have access to protected health information; and

(4) the value of audit trails in computerized record systems.

Subpart B—Use and Disclosure of Protected Health Information

SEC. 2151. GENERAL LIMITATIONS ON USE AND DISCLOSURE.

(a) USE.—Except as otherwise provided under this part, a health information trustee may use protected health information only for a purpose—

(1) that is compatible with and directly related to the purpose for which the information—

(A) was collected; or

(B) was received by the trustee; or

(2) for which the trustee is authorized to disclose the information under this part.

(b) DISCLOSURE.—A health information trustee may disclose protected health information only as authorized under this part.

(c) SCOPE OF USES AND DISCLOSURES.—

(1) IN GENERAL.—A use or disclosure of protected health information by a health information trustee shall be limited, when practicable, to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

(2) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall issue guidelines to implement paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting use and disclosure.

(d) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—Except with respect to protected health information that is disclosed under section 2154 (relating to next of kin and directory information), a health information trustee may disclose protected

health information only if the recipient has been notified that the information is protected health information that is subject to this part.

(e) AGREEMENT TO LIMIT USE OR DISCLOSURE.—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict use or disclosure of the information to a greater extent than otherwise would be required under this part shall comply with the terms of the agreement, except where use or disclosure of the information in violation of the agreement is required by law. A trustee who fails to comply with the preceding sentence shall be subject to section 2191 (relating to civil actions) with respect to such failure.

(f) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this part shall be construed to require a health information trustee to disclose protected health information not otherwise required to be disclosed by law.

SEC. 2152. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health information trustee, other than a health information service organization, may disclose protected health information pursuant to an authorization executed by the protected individ-

ual who is the subject of the information, if each of the following requirements is satisfied:

(1) WRITING.—The authorization is in writing, signed by the individual, and dated on the date of such signature.

(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) STATEMENT OF INTENDED USES AND DISCLOSURES RECEIVED.—The authorization contains an acknowledgment that the individual has received a statement described in subsection (b) from such person.

(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

(7) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

(8) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

(b) STATEMENT OF INTENDED USES AND DISCLOSURES.—

(1) IN GENERAL.—A person who wishes to receive from a health information trustee protected health information about a protected individual pursuant to an authorization executed by the individual shall supply the individual, in writing and on a form that is distinct from the authorization, with a statement of the uses for which the person intends the information and the disclosures the person intends to make of the information. Such statement shall be supplied before the authorization is executed.

(2) ENFORCEMENT.—If the person uses or discloses the information in a manner that is inconsistent with such statement, the person shall be subject to section 2191 (relating to civil actions) with respect to such failure, except where such use or disclosure is required by law.

(3) MODEL STATEMENTS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model statements of intended uses and disclosures of the type described in paragraph (1).

(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(7), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to—

(i) a health benefit plan sponsor;

(ii) a health care provider;

(iii) a health oversight agency;

(iv) a public health authority;

(v) a health researcher; or

(vi) a person who provides counseling or social services to individuals; or

(B) the 30-day period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a

person other than a person described in subparagraph (A).

(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(8), a disclosure is timely made if it occurs before—

(A) the date or event (if any) specified in the authorization upon which the authorization expires; and

(B) the expiration of the 6-month period beginning on the date the trustee receives the authorization.

(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

(1) IN GENERAL.—A protected individual in writing may revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except insofar as—

(A) disclosure of protected health information has been authorized to permit validation of expenditures based on health condition by a government authority; or

(B) action has been taken in reliance on the authorization.

(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health infor-

mation in reliance on an authorization that has been revoked shall not be subject to any liability or penalty under this part if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this section.

(e) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this section.

(f) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

(g) CONSTRUCTION.—This section may not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(h) SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.—If a health information trustee discloses pro-

tected health information pursuant to an authorization in order to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena, warrant, or search warrant; and

(2) shall otherwise meet the requirements in this section.

SEC. 2153. TREATMENT, PAYMENT, AND OVERSIGHT.

(a) DISCLOSURES BY PLANS, PROVIDERS, AND OVERSIGHT AGENCIES.—A health information trustee described in subsection (d) may disclose protected health information to a health benefit plan sponsor, health care provider, or health oversight agency if the disclosure is—

(1) for the purpose of providing health care and a protected individual who is a subject of the information has not previously objected to the disclosure in writing;

(2) for the purpose of providing for the payment for health care furnished to an individual; or

(3) for use by a health oversight agency for a purpose that is described in subparagraph (A) or (B)(i) of section 2140(b)(7).

(b) DISCLOSURES BY CERTAIN OTHER TRUSTEES.—A health information trustee may disclose protected health information to a health care provider if—

(1) the disclosure is for the purpose described in subsection (a)(1); and

(2) the trustee—

(A) is a public health authority;

(B) received protected health information pursuant to section 2157 (relating to emergency circumstances); or

(C) is an officer or employee of a trustee described in subsection (B).

(c) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A health information service organization.

SEC. 2154. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health information trustee who is a health care provider, who received protected health information pursuant to section 2157 (relating to emergency circumstances), or who is an officer or employee of such a recipient may orally disclose protected health information about a protected individual to the next of kin of the individual (as defined under State law), or to a person with whom the individual has a close personal relationship, if—

(1) the trustee has no reason to believe that the individual would consider the information especially sensitive;

(2) the individual has not previously objected to the disclosure;

(3) the disclosure is consistent with good medical or other professional practice; and

(4) the information disclosed is limited to information about health care that is being provided to the individual at or about the time of the disclosure.

(b) DIRECTORY INFORMATION.—

(1) IN GENERAL.—A health information trustee who is a health care provider, who received protected health information pursuant to section 2157 (relat-

ing to emergency circumstances), or who is an officer or employee of a such a recipient may disclose to any person the information described in paragraph (2) if—

(A) a protected individual who is a subject of the information has not objected in writing to the disclosure;

(B) the disclosure is otherwise consistent with good medical and other professional practice; and

(C) the information does not reveal specific information about the physical or mental condition or functional status of a protected individual or about the health care provided to a protected individual.

(2) INFORMATION DESCRIBED.—The information referred to in paragraph (1) is the following:

(A) The name of an individual receiving health care from a health care provider on a premises controlled by the provider.

(B) The location of the individual on such premises.

(C) The general health status of the individual, described in terms of critical, poor, fair,

stable, satisfactory, or terms denoting similar conditions.

(c) NO ACCOUNTING REQUIRED.—A health information trustee who discloses protected health information under this section is not required to maintain an accounting of the disclosure under section 2144.

(d) RECIPIENTS.—A person to whom protected health information is disclosed under this section shall not, by reason of such disclosure, be subject to any requirement under this part.

SEC. 2155. PUBLIC HEALTH.

(a) IN GENERAL.—A health information trustee who is a health care provider or a public health authority may disclose protected health information to—

(1) a public health authority for use in legally authorized—

(A) disease or injury reporting;

(B) public health surveillance; or

(C) public health investigation or intervention; or

(2) an individual who is authorized by law to receive the information in a public health intervention.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A public health authority who receives protected health information

about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except where the use or disclosure is authorized by law for protection of the public health.

(c) INDIVIDUAL RECIPIENTS.—An individual to whom protected health information is disclosed under subsection (a)(2) shall not, by reason of such disclosure, be subject to any requirement under this part.

SEC. 2156. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information to a person if—

(1) the person is conducting an approved health research project;

(2) the information is to be used in the project; and

(3) the project has been determined by a certified institutional review board to be—

(A) of sufficient importance so as to outweigh the intrusion into the privacy of the protected individual who is the subject of the information that would result from the disclosure; and

(B) impracticable to conduct without the information.

(b) DISCLOSURES BY HEALTH INFORMATION SERVICE ORGANIZATIONS.—A health information service organization may disclose protected health information under subsection (a) only if the certified institutional review board referred to in subsection (a)(3) has been certified as being qualified to make determinations under such subsection with respect to disclosures by such organizations.

(c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGATIONS OF RECIPIENT.—A health researcher who receives protected health information about a protected individual pursuant to subsection (a)—

(1) may use the information solely for purposes of an approved health research project;

(2) may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual; and

(3) shall remove or destroy, at the earliest opportunity consistent with the purposes of the approved health research project in connection with which the disclosure was made, information that would enable an individual to be identified, unless a certified institutional review board has determined that there is a health or research justification for re-

tention of such identifiers and there is an adequate plan to protect the identifiers from use and disclosure that is inconsistent with this part.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any health information trustee other than a person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(1) pursuant to—

(A) section 2158 (relating to judicial and administrative purposes);

(B) paragraph (1), (2), or (3) of section 2159(a) (relating to law enforcement); or

(C) section 2160 (relating to subpoenas, warrants, and search warrants); or

(2) while acting in whole or in part in the capacity of an officer or employee of a person described in paragraph (1).

(e) REQUIREMENTS FOR INSTITUTIONAL REVIEW BOARDS.—

(1) REGULATIONS.—Not later than July 1, 1996, the Secretary, after opportunity for notice and comment, shall promulgate regulations establishing requirements for certified institutional review boards under this part. The regulations shall be based on

regulations promulgated under section 491(a) of the Public Health Service Act and shall ensure that certified institutional review boards are qualified to assess and protect the confidentiality of research subjects. The regulations shall include specific requirements for certified institutional review boards that make determinations under subsection (a)(3) with respect to disclosures by health information service organizations.

(2) CERTIFICATION.—The Secretary shall certify that an institutional review board satisfies the requirements of the regulations promulgated under paragraph (1).

SEC. 2157. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health information trustee may disclose protected health information if the trustee believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation

arising out of and related to receipt of health care or payment for health care.

SEC. 2158. JUDICIAL AND ADMINISTRATIVE PURPOSES.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which a protected individual who is a subject of the information is a party and in which the individual has placed the individual's physical or mental condition or functional status in issue;

(2) if directed by a court in connection with a court-ordered examination of an individual; or

(3) to assist in the identification of a dead individual.

(b) WRITTEN STATEMENT.—A person seeking protected health information about a protected individual held by health information trustee under—

(1) subsection (a)(1)—

(A) shall notify the protected individual or the attorney of the protected individual of the request for the information;

(B) shall provide the trustee with a signed document attesting—

(i) that the protected individual is a party to the litigation or proceedings for which the information is sought;

(ii) that the individual has placed the individual's physical or mental condition or functional status in issue; and

(iii) the date on which the protected individual or the attorney of the protected individual was notified under subparagraph (A); and

(C) shall not accept any requested protected health information from the trustee until the termination of the 10-day period beginning on the date notice was given under subparagraph (A); or

(2) subsection (a)(3) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) USE AND DISCLOSURE.—A person to whom protected health information is disclosed under this section may use and disclose the information only to accomplish the purpose for which the disclosure was made.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(A) pursuant to—

(i) section 2157 (relating to emergency circumstances); or

(ii) section 2160 (relating to subpoenas, warrants, and search warrants); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

SEC. 2159. LAW ENFORCEMENT.

(a) IN GENERAL.—A health information trustee, other than a health information service organization, may disclose protected health information to a law enforcement agency, other than a health oversight agency—

(1) if the information is disclosed for use in an investigation or prosecution of a health information trustee;

(2) in connection with criminal activity committed against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or

(3) if the information is needed to determine whether a crime has been committed and the nature of any crime that may have been committed (other than a crime that may have been committed by the protected individual who is the subject of the information).

(b) ADDITIONAL AUTHORITY OF CERTAIN TRUSTEES.—A health information trustee who is not a health information service organization, a public health authority, or a health researcher may disclose protected health information to a law enforcement agency (other than a health oversight agency)—

(1) to assist in the identification or location of a victim, fugitive, or witness in a law enforcement inquiry;

(2) pursuant to a law requiring the reporting of specific health care information to law enforcement authorities; or

(3) if the information is specific health information described in paragraph (2) and the trustee is operated by a Federal agency;

(c) CERTIFICATION.—Where a law enforcement agency requests a health information trustee to disclose protected health information under subsection (a) or (b)(1), the agency shall provide the trustee with a written certification that—

(1) is signed by a supervisory official of a rank designated by the head of the agency;

(2) specifies the information requested; and

(3) states that the information is needed for a lawful purpose under this section.

(d) RESTRICTIONS ON DISCLOSURE AND USE.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information—

(1) in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) otherwise unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not prohibited by any other provision of law.

SEC. 2160. SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) IN GENERAL.—A health information trustee described in subsection (g) may disclose protected health information if the disclosure is pursuant to any of the following:

(1) A subpoena issued under the authority of a grand jury and the trustee is provided a written certification by the grand jury that the grand jury has complied with the applicable access provisions of section 2171.

(2) An administrative subpoena or warrant or a judicial subpoena or search warrant and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 2171 or 2173(a).

(3) An administrative subpoena or warrant or a judicial subpoena or search warrant and the disclosure otherwise meets the conditions of one of sections 2153 through 2159.

(b) AUTHORITY OF ALL TRUSTEES.—Any health information trustee may disclose protected health information if the disclosure is pursuant to subsection (a)(3).

(c) RESTRICTIONS ON USE AND DISCLOSURE.—Protected health information about a protected individual that is disclosed by a health information trustee pursuant to—

(1) subsection (a)(2) may not be otherwise used or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained; and

(2) subsection (a)(3) may not be used or disclosed by the recipient unless the recipient complies with the conditions and restrictions on use and disclosure with which the recipient would have been required to comply if the disclosure by the trustee had been made under the section referred to in subsection (a)(3) the conditions of which were met by the disclosure.

(d) RESTRICTIONS ON GRAND JURIES.—Protected health information that is disclosed by a health information trustee under subsection (a)(1)—

(1) shall be returnable on a date when the grand jury is in session and actually presented to the grand jury;

(2) shall be used only for the purpose of considering whether to issue an indictment or report by that grand jury, or for the purpose of prosecuting a crime for which that indictment or report is issued,

or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule;

(3) shall be destroyed or returned to the trustee if not used for one of the purposes specified in paragraph (2); and

(4) shall not be maintained, or a description of the contents of such information shall not be maintained, by any government authority other than in the sealed records of the grand jury, unless such information has been used in the prosecution of a crime for which the grand jury issued an indictment or presentment or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule.

(e) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the inquiry for which the information was obtained;

(f) CONSTRUCTION.—Nothing in this section shall be construed as authority for a health information trustee to

refuse to comply with a valid administrative subpoena or warrant or a valid judicial subpoena or search warrant that meets the requirements of this part.

(g) APPLICABILITY.—A health information trustee referred to in subsection (a) is any trustee other than the following:

(1) A health information service organization.

(2) A public health authority.

(3) A health researcher.

SEC. 2161. HEALTH INFORMATION SERVICE ORGANIZATIONS.

A health information trustee may disclose protected health information to a health information service organization for the purpose of permitting the organization to perform a function for which the Secretary has authorized (by means of a designation or certification) the organization to receive access to health care data in electronic or magnetic form that are regulated by this Act.

Subpart C—Access Procedures and Challenge Rights

SEC. 2171. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about a protected individual from a health informa-

tion trustee under paragraph (1) or (2) of section 2160(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS AND SEARCH WARRANTS.—A government authority that obtains protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a warrant or search warrant shall, not later than 30 days after the date the warrant was served on the trustee, serve the individual with, or mail to the last known address of the individual, a copy of the warrant.

(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served by hand delivery upon the individual, or mailed to the last known address of the individual, on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 2175(1)) of the

individual's right to challenge the subpoena in accordance with section 2172, and—

(1) 30 days have passed from the date of service, or 30 days have passed from the date of mailing, and within such time period the individual has not initiated a challenge in accordance with section 2172; or

(2) disclosure is ordered by a court under section 2172.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply to an appropriate court to delay (for an initial period of not longer than 90 days) serving a copy of a subpoena and a notice otherwise required under subsection (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying, or extending the delay of, the notice and an order prohibiting the trustee from revealing the request for, or the disclosure of,

the protected health information being sought if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority;

(C) the government authority's need for the information outweighs the privacy interest of the protected individual who is the subject of the information; and

(D) there are reasonable grounds to believe that receipt of a notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought; or

(iv) intimidation of potential witnesses.

(4) SERVICE OF APPLICATION ON INDIVIDUAL.—Upon the expiration of a period of delay of notice under this subsection, the government authority shall serve upon the individual, with the service of the subpoena and the notice, a copy of any applications filed and approved under this subsection.

SEC. 2172. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—Within 30 days of the date of service, or 30 days of the date of mailing, of a subpoena of a government authority seeking protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 2160(a) (except a subpoena to which section 2173 applies), the individual may file (without filing fee) a motion to quash the subpoena—

(1) in the case of a State judicial subpoena, in the court which issued the subpoena;

(2) in the case of a subpoena issued under the authority of a State that is not a State judicial subpoena, in a court of competent jurisdiction;

(3) in the case of a subpoena issued under the authority of a Federal court, in any court of the United States of competent jurisdiction; or

(4) in the case of any other subpoena issued under the authority of the United States, in—

(A) the United States district court for the district in which the individual resides or in which the subpoena was issued; or

(B) another United States district court of competent jurisdiction.

(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by delivery of registered or certified mail.

(c) AFFIDAVITS AND SWORN DOCUMENTS.—The government authority may file with the court such affidavits and other sworn documents as sustain the validity of the subpoena. The individual may file with the court, within 5 days of the date of the authority's filing, affidavits and sworn documents in response to the authority's filing. The court, upon the request of the individual, the government authority, or both, may proceed in camera.

(d) PROCEEDINGS AND DECISION ON MOTION.—The court may conduct such proceedings as it deems appropriate to rule on the motion. All such proceedings shall be completed, and the motion ruled on, within 10 calendar days of the date of the government authority's filing.

(e) EXTENSION OF TIME LIMITS FOR GOOD CAUSE.—The court, for good cause shown, may at any

time in its discretion enlarge the time limits established by subsections (c) and (d).

(f) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds that there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds that the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need established by the government authority for the information.

(g) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (f) whether an individual's privacy interest outweighs the government authority's need for the information, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(h) ATTORNEY'S FEES.—In the case of any motion brought under subsection (a) in which the individual has substantially prevailed, the court, in its discretion, may assess against a government authority a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

(i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be deemed a final order and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protected health information disclosed.

SEC. 2173. ACCESS AND CHALLENGE PROCEDURES FOR OTHER SUBPOENAS.

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under circumstances described in section 2171(a)) may not ob-

tain protected health information about a protected individual from a health information trustee pursuant to a subpoena under section 2160(a)(2) unless—

(1) a copy of the subpoena has been served upon the individual or mailed to the last known address of the individual on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 2175(2)) of the individual's right to challenge the subpoena, in accordance with subsection (b); and

(2) either—

(A) 30 days have passed from the date of service or 30 days have passed from the date of the mailing and within such time period the individual has not initiated a challenge in accordance with subsection (b); or

(B) disclosure is ordered by a court under such subsection.

(b) MOTION TO QUASH.—Within 30 days of the date of service or 30 days of the date of mailing of a subpoena seeking protected health information about a protected individual from a health information trustee under subsection (a), the individual may file (without filing fee) in any court of competent jurisdiction, a motion to quash the

subpoena, with a copy served on the person seeking the information. The individual may oppose, or seek to limit, the subpoena on any grounds that would otherwise be available if the individual were in possession of the information.

(c) STANDARD FOR DECISION.—The court shall grant an individual's motion under subsection (b) if the person seeking the information has not sustained the burden of demonstrating that—

(1) there are reasonable grounds to believe that the information will be relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the person for the information outweighs the privacy interest of the individual.

(d) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (c) whether the need of the person for the information outweighs the privacy interest of the individual, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other factor deemed relevant by the court.

(e) ATTORNEY'S FEES.—In the case of any motion brought under subsection (b) by an individual against a person in which the individual has substantially prevailed, the court, in its discretion, may assess against the person a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

SEC. 2174. CONSTRUCTION OF SUBPART; SUSPENSION OF STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Nothing in this subpart shall affect the right of a health information trustee to challenge a request for protected health information. Nothing in this subpart shall entitle a protected individual to assert the rights of a health information trustee.

(b) EFFECT OF MOTION ON STATUTE OF LIMITATIONS.—If an individual who is the subject of protected health information files a motion under this subpart which has the effect of delaying the access of a government authority to such information, the period beginning on the date such motion was filed and ending on the date on

which the motion is decided shall be excluded in computing any period of limitations within which the government authority may commence any civil or criminal action in connection with which the access is sought.

SEC. 2175. RESPONSIBILITIES OF SECRETARY.

Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate brief, clear, and easily understood model notices—

(1) for use under subsection (c) of section 2171, detailing the rights of a protected individual who wishes to challenge, under section 2172, the disclosure of protected health information about the individual under such subsection; and

(2) for use under subsection (a) of section 2173, detailing the rights of a protected individual who wishes to challenge, under subsection (b) of such section, the disclosure of protected health information about the individual under such section.

Subpart D—Miscellaneous Provisions

SEC. 2181. PAYMENT CARD AND ELECTRONIC PAYMENT TRANSACTIONS.

(a) PAYMENT FOR HEALTH CARE THROUGH CARD OR ELECTRONIC MEANS.—If a protected individual pays a health information trustee for health care by presenting

a debit, credit, or other payment card or account number, or by any other electronic payment means, the trustee may disclose to a person described in subsection (b) only such protected health information about the individual as is necessary for the processing of the payment transaction or the billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using the card, number, or other electronic payment means.

(b) TRANSACTION PROCESSING.—A person who is a debit, credit, or other payment card issuer, is otherwise directly involved in the processing of payment transactions involving such cards or other electronic payment transactions, or is otherwise directly involved in the billing or collection of amounts paid through such means, may only use or disclose protected health information about a protected individual that has been disclosed in accordance with subsection (a) when necessary for—

(1) the authorization, settlement, billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using a debit, credit, or other payment card or account number, or by other electronic payment means;

(2) the transfer of receivables, accounts, or interest therein;

(3) the audit of the credit, debit, or other payment card account information;

(4) compliance with Federal, State, or local law; or

(5) a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities.

SEC. 2182. ACCESS TO PROTECTED HEALTH INFORMATION OUTSIDE OF THE UNITED STATES.

(a) IN GENERAL.—Notwithstanding the provisions of subpart B, and except as provided in subsection (b), a health information trustee may not permit any person who is not in a State to have access to protected health information about a protected individual unless one or more of the following conditions exist:

(1) SPECIFIC AUTHORIZATION.—The individual has specifically consented to the provision of such access outside of the United States in an authorization that meets the requirements of section 2152.

(2) EQUIVALENT PROTECTION.—The provision of such access is authorized under this part and the Secretary has determined that there are fair information practices for protected health information in the jurisdiction where the access will be provided that provide protections for individuals and pro-

tected health information that are equivalent to the protections provided for by this part.

(3) ACCESS REQUIRED BY LAW.—The provision of such access is required under—

(A) a Federal statute; or

(B) a treaty or other international agreement applicable to the United States.

(b) EXCEPTIONS.—Subsection (a) does not apply where the provision of access to protected health information—

(1) is to a foreign public health authority;

(2) is authorized under section 2154 (relating to next of kin and directory information), 2156 (relating to health research), or 2157 (relating to emergency circumstances); or

(3) is necessary for the purpose of providing for payment for health care that has been provided to an individual.

SEC. 2183. STANDARDS FOR ELECTRONIC DOCUMENTS AND COMMUNICATIONS.

(a) STANDARDS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment and in consultation with appropriate private standard-setting organizations and other interested parties, shall establish standards with respect to the creation,

transmission, receipt, and maintenance, in electronic and magnetic form, of each type of written document specifically required or authorized under this part. Where a signature is required under any other provision of this part, such standards shall provide for an electronic or magnetic substitute that serves the functional equivalent of a signature.

(b) TREATMENT OF COMPLYING DOCUMENTS AND COMMUNICATIONS.—An electronic or magnetic document or communication that satisfies the standards established under subsection (a) with respect to such document or communication shall be treated as satisfying the requirements of this part that apply to an equivalent written document.

SEC. 2184. DUTIES AND AUTHORITIES OF AFFILIATED PERSONS.

(a) REQUIREMENTS ON TRUSTEES.—

(1) PROVISION OF INFORMATION.—A health information trustee may provide protected health information to a person who, with respect to the trustee, is an affiliated person and may permit the affiliated person to use such information, only for the purpose of conducting, supporting, or facilitating an activity that the trustee is authorized to undertake.

(2) NOTICE TO AFFILIATED PERSON.—A health information trustee shall notify a person who, with respect to the trustee, is an affiliated person of any duties under this part that the affiliated person is required to fulfill and of any authorities under this part that the affiliated person is authorized to exercise.

(b) DUTIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person shall fulfill any duty under this part that—

(A) the health information trustee with whom the person has an agreement or relationship described in section 2140(c)(1)(C) is required to fulfill; and

(B) the person has undertaken to fulfill pursuant to such agreement or relationship.

(2) CONSTRUCTION OF OTHER SUBPARTS.—With respect to a duty described in paragraph (1) that an affiliated person is required to fulfill, the person shall be considered a health information trustee for purposes of this part. The person shall be subject to subpart E (relating to enforcement) with respect to any such duty that the person fails to fulfill.

(3) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not relieve a health information trustee of any duty or liability under this part.

(b) AUTHORITIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person may only exercise an authority under this part that the health information trustee with whom the person is affiliated may exercise and that the person has been given by the trustee pursuant to an agreement or relationship described in section 2140(c)(1)(C). With respect to any such authority, the person shall be considered a health information trustee for purposes of this part. The person shall be subject to subpart E (relating to enforcement) with respect to any act that exceeds such authority.

(2) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not affect the authority of a health information trustee under this part.

SEC. 2185. AGENTS AND ATTORNEYS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), a person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to act as an agent, attorney, proxy,

or other legal representative for a protected individual or the estate of a protected individual, or otherwise to exercise the rights of the individual or estate, may, to the extent authorized, exercise and discharge the rights of the individual or estate under this part.

(b) HEALTH CARE POWER OF ATTORNEY.—A person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to make decisions about the provision of health care to an individual who is incapacitated may exercise and discharge the rights of the individual under this part to the extent necessary to effectuate the terms or purposes of the grant of authority.

(c) NO COURT DECLARATION.—If a health care provider determines that an individual, who has not been declared to be legally incompetent, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure under section 2152 may be exercised and discharged in the best interest of the individual by—

(1) a person described in subsection (b) with respect to the individual;

(2) a person described in subsection (a) with respect to the individual, but only if a person de-

scribed in paragraph (1) cannot be contacted after a reasonable effort;

(3) the next of kin of the individual, but only if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or

(4) the health care provider, but only if a person described in paragraph (1), (2), or (3) cannot be contacted after a reasonable effort.

SEC. 2186. MINORS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual, except as provided in section 2185; or

(2) who, acting alone, has the legal capacity to apply for and obtain health care and has sought such care, the individual shall exercise all rights of an individual under this part with respect to protected health information relating to such care.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this part shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the right of inspection (under section 2141), the right of amendment (under section 2142), and the right to authorize disclosure of protected health information (under section 2152) of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

SEC. 2187. MAINTENANCE OF CERTAIN PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A State shall establish a process under which the protected health information described in subsection (b) that is maintained by a person described in subsection (c) is delivered to, and maintained by, the State or an individual or entity designated by the State.

(b) INFORMATION DESCRIBED.—The protected health information referred to in subsection (a) is protected health information that—

(1) is recorded in any form or medium;

(2) is created by—

(A) a health care provider; or

(B) a health benefit plan sponsor that provides benefits in the form of items and services to enrollees and not in the form of reimbursement for items and services; and

(3) relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual or the provision of health care to a protected individual.

(c) PERSONS DESCRIBED.—A person referred to in subsection (a) is any of the following:

(A) A health care facility previously located in the State that has closed.

(B) A professional practice previously operated by a health care provider in the State that has closed.

(C) A health benefit plan sponsor that—

(i) previously provided benefits in the form of items and services to enrollees in the State; and

(ii) has ceased to do business.

Subpart E—Enforcement

SEC. 2191. CIVIL ACTIONS.

(a) IN GENERAL.—Any individual whose right under this part has been knowingly or negligently violated—

(1) by a health information trustee, or any other person, who is not described in paragraph (2), (3), (4), or (5) may maintain a civil action for actual damages and for equitable relief against the health information trustee or other person;

(2) by an officer or employee of the United States while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the United States;

(3) by an officer or employee of any government authority of a State that has waived its sovereign immunity to a claim for damages resulting from a violation of this part while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the State government;

(4) by an officer or employee of a government of a State that is not described in paragraph (3) may maintain a civil action for actual damages and for equitable relief against the officer or employee; or

(5) by an officer or employee of a government authority while the officer or employee was not acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the officer or employee.

(b) KNOWING VIOLATIONS.—Any individual entitled to recover actual damages under this section because of

a knowing violation of a provision of this part (other than subsection (c) or (d) of section 2151) shall be entitled to recover the amount of the actual damages demonstrated or $5000, whichever is greater.

(c) ACTUAL DAMAGES.—For purposes of this section, the term ''actual damages'' includes damages paid to compensate an individual for nonpecuniary losses such as physical and mental injury as well as damages paid to compensate for pecuniary losses.

(d) PUNITIVE DAMAGES; ATTORNEY'S FEES.—In any action brought under this section in which the complainant has prevailed because of a knowing violation of a provision of this part (other than subsection (c) or (d) of section 2151), the court may, in addition to any relief awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(e) LIMITATION.—A civil action under this section may not be commenced more than 2 years after the date on which the aggrieved individual discovered the violation or the date on which the aggrieved individual had a rea-

sonable opportunity to discover the violation, whichever occurs first.

(f) INSPECTION AND AMENDMENT.—If a health information trustee has established a formal internal procedure that allows an individual who has been denied inspection or amendment of protected health information to appeal the denial, the individual may not maintain a civil action in connection with the denial until the earlier of—

(1) the date the appeal procedure has been exhausted; or

(2) the date that is 4 months after the date on which the appeal procedure was initiated.

(g) NO LIABILITY FOR PERMISSIBLE DISCLOSURES.—A health information trustee who makes a disclosure of protected health information about a protected individual that is permitted by this part and not otherwise prohibited by State or Federal statute shall not be liable to the individual for the disclosure under common law.

(h) NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.—If the members of a certified institutional review board have in good faith determined that an approved health research project is of sufficient importance so as to outweigh the intrusion into the privacy of an individual pursuant to section 2156(a)(1), the members, the board, and the parent institution of the board

shall not be liable to the individual as a result of such determination.

(i) GOOD FAITH RELIANCE ON CERTIFICATION.—A health information trustee who relies in good faith on a certification by a government authority or other person and discloses protected health information about an individual in accordance with this part shall not be liable to the individual for such disclosure.

SEC. 2192. CIVIL MONEY PENALTIES.

(a) VIOLATION.—Any health information trustee who the Secretary determines has demonstrated a pattern or practice of failure to comply with the provisions of this part shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such failure. In determining the amount of any penalty to be assessed under the procedures established under subsection (b), the Secretary shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this part and the gravity of the violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect

to the imposition of a penalty under section 1128A of such Act.

SEC. 2193. ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—Not later than July 1, 1996, the Secretary shall, by regulation, develop alternative dispute resolution methods for use by individuals, health information trustees, and other persons in resolving claims under section 2191.

(b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), the regulations established under subsection (a) may provide that an individual alleging that a right of the individual under this part has been violated shall pursue at least one alternative dispute resolution method developed under such subsection as a condition precedent to commencing a civil action under section 2191.

(2) LIMITATION.—Such regulations may not require an individual to refrain from commencing a civil action to pursue one or more alternative dispute resolution method for a period that is greater than 6 months.

(3) SUSPENSION OF STATUTE OF LIMITATIONS.—The regulations established by the Secretary under subsection (a) may provide that a pe-

riod in which an individual described in paragraph (1) pursues (as defined by the Secretary) an alternative dispute resolution method under this section shall be excluded in computing the period of limitations under section 2191(e).

(c) METHODS.—The methods under subsection (a) shall include at least the following:

(1) ARBITRATION.—The use of arbitration.

(2) MEDIATION.—The use of mediation.

(3) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties make early offers of settlement.

(d) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subsection (a), the Secretary shall ensure that the methods promote the resolution of claims in a manner that—

(1) is affordable for the parties involved;

(2) provides for timely and fair resolution of claims; and

(3) provides for reasonably convenient access to dispute resolution for individuals.

SEC. 2194. AMENDMENTS TO CRIMINAL LAW.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 89 the following:

"CHAPTER 90—PROTECTED HEALTH INFORMATION

''Sec.
''1831. Definitions.
''1832. Obtaining protected health information under false pretenses.
''1833. Monetary gain from obtaining protected health information under false pretenses.
''1834. Knowing and unlawful obtaining of protected health information.
''1835. Monetary gain from knowing and unlawful obtaining of protected health information.
''1836. Knowing and unlawful use or disclosure of protected health information.
''1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information.

"§ 1831. Definitions

''As used in this chapter—

''(1) the term 'health information trustee' has the meaning given such term in section 2140(b)(6) of the Affordable Health Care Now Act of 1994;

''(2) the term 'protected health information' has the meaning given such term in section 2140(a)(3) of such Act; and

''(3) the term 'protected individual' has the meaning given such term in section 2140(a)(4) of such Act.

"§ 1832. Obtaining protected health information under false pretenses

''Whoever under false pretenses—

''(1) requests or obtains protected health information from a health information trustee; or

''(2) obtains from a protected individual an authorization for the disclosure of protected health in-

formation about the individual maintained by a health information trustee;

shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1833. Monetary gain from obtaining protected health information under false pretenses

''Whoever under false pretenses—

''(1) requests or obtains protected health information from a health information trustee with the intent to sell, transfer, or use such information for profit or monetary gain; or

''(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee with the intent to sell, transfer, or use such authorization for profit or monetary gain;

and knowingly sells, transfers, or uses such information or authorization for profit or monetary gain shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1834. Knowing and unlawful obtaining of protected health information

''Whoever knowingly obtains protected health information from a health information trustee in violation of

part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such obtaining is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1835. Monetary gain from knowing and unlawful obtaining of protected health information

''Whoever knowingly—

''(1) obtains protected health information from a health information trustee in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such obtaining is unlawful and with the intent to sell, transfer, or use such information for profit or monetary gain; and

''(2) knowingly sells, transfers, or uses such information for profit or monetary gain;

shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1836. Knowing and unlawful use or disclosure of protected health information

''Whoever knowingly uses or discloses protected health information in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such use or disclosure is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information

''Whoever knowingly sells, transfers, or uses protected health information in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such sale, transfer, or use is unlawful, shall be fined under this title or imprisoned not more than 10 years, or both.''.

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 89 the following:

"90. Protected health information ..... 1831".

Subpart F—Amendments to Title 5, United States Code

SEC. 2195. AMENDMENTS TO TITLE 5, UNITED STATES CODE.

(a) NEW SUBSECTION.—Section 552a of title 5, United States Code, is amended by adding at the end the following:

''(w) MEDICAL EXEMPTIONS.—The head of an agency that is a health information trustee (as defined in section 2140(b)(6) of the Affordable Health Care Now Act of 1994) shall promulgate rules, in accordance with the requirements (including general notice) of subsections

(b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this title, to exempt a system of records within the agency, to the extent that the system of records contains protected health information (as defined in section 2140(a)(3) of such Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and (E) through (I) of subsection (e)(4), and subsections (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and (u).''.

(b) REPEAL.—Section 552a(f)(3) of title 5, United States Code, is amended by striking ''pertaining to him,'' and all that follows through the semicolon and inserting ''pertaining to the individual;''.

Subpart G—Regulations, Research, and Education; Effective Dates; Applicability; and Relationship to Other Laws

SEC. 2196. REGULATIONS; RESEARCH AND EDUCATION.

(a) REGULATIONS.—Not later than July 1, 1996, the Secretary shall prescribe regulations to carry out this part.

(b) RESEARCH AND TECHNICAL SUPPORT.—The Secretary may sponsor—

(1) research relating to the privacy and security of protected health information;

(2) the development of consent forms governing disclosure of such information; and

(3) the development of technology to implement standards regarding such information.

(c) EDUCATION.—The Secretary shall establish education and awareness programs—

(1) to foster adequate security practices by health information trustees;

(2) to train personnel of health information trustees respecting the duties of such personnel with respect to protected health information; and

(3) to inform individuals and employers who purchase health care respecting their rights with respect to such information.

SEC. 2197. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this part, and the amendments made by this part, shall take effect on January 1, 1997.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—A provision of this part shall take effect on the date of the enactment of this Act if the provision—

(1) imposes a duty on the Secretary to develop, establish, or promulgate regulations, guidelines, notices, statements, or education and awareness programs; or

(2) authorizes the Secretary to sponsor research or the development of forms or technology.

SEC. 2198. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as provided in subsections (b) and (c), the provisions of this part shall apply to any protected health information that is received, created, used, maintained, or disclosed by a health information trustee in a State on or after January 1, 1997, regardless of whether the information existed or was disclosed prior to such date.

(b) EXCEPTION.—

(1) IN GENERAL.—The provisions of this part shall not apply to a trustee described in paragraph (2), except with respect to protected health information that is received by the trustee on or after January 1, 1997.

(2) APPLICABILITY.—A trustee referred to in paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific protected health information, received the information—

(i) pursuant to—

(I) section 2157 (relating to emergency circumstances);

(II) section 2158 (relating to judicial and administrative purposes);

(III) section 2159 (relating to law enforcement); or

(IV) section 2160 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(c) AUTHORIZATIONS FOR DISCLOSURES.—An authorization for the disclosure of protected health information about a protected individual that is executed by the individual before January 1, 1997, and is recognized and valid under State law on December 31, 1996, shall remain valid and shall not be subject to the requirements of section 2152 until January 1, 1998, or the occurrence of the date or event (if any) specified in the authorization upon which the authorization expires, whichever occurs earlier.

SEC. 2199. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as otherwise provided in subsections (b), (c), (d), and (f), a State may not establish, continue in effect, or enforce any State law to the extent that the law is inconsistent with, or imposes additional requirements with respect to, any of the following:

(1) A duty of a health information trustee under this part.

(2) An authority of a health information trustee under this part to disclose protected health information.

(3) A provision of subpart C (relating to access procedures and challenge rights), subpart D (miscellaneous provisions), or subpart (E) (relating to enforcement).

(b) LAWS RELATING TO PUBLIC HEALTH AND MENTAL HEALTH.—This part does not preempt, supersede, or modify the operation of any State law regarding public health or mental health to the extent that the law prohibits or regulates a disclosure of protected health information that is permitted under this part.

(c) CRIMINAL PENALTIES.—A State may establish and enforce criminal penalties with respect to a failure to comply with a provision of this part.

(d) PRIVILEGES.—A privilege that a person has under law in a court of a State or the United States or under the rules of any agency of a State or the United States may not be diminished, waived, or otherwise affected by—

(1) the execution by a protected individual of an authorization for disclosure of protected health information under this part, if the authorization is ex-

ecuted for the purpose of receiving health care or providing for the payment for health care; or

(2) any provision of this part that authorizes the disclosure of protected health information for the purpose of receiving health care or providing for the payment for health care.

(e) DEPARTMENT OF VETERANS AFFAIRS.—The limitations on use and disclosure of protected health information under this part shall not be construed to prevent any exchange of such information within and among components of the Department of Veterans Affairs that determine eligibility for or entitlement to, or that provide, benefits under laws administered by the Secretary of Veterans Affairs.

(f) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This part shall not be construed to preempt, supersede, or modify the operation of any of the following:

(1) Any law that provides for the reporting of vital statistics such as birth or death information.

(2) Any law requiring the reporting of abuse or neglect information about any individual.

(3) Subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases).

(4) The Americans with Disabilities Act of 1990.

(5) Any Federal or State statute that establishes a privilege for records used in health professional peer review activities.

(g) SECRETARIAL AUTHORITY.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—A provision of this part does not preempt, supersede, or modify the operation of section 543 of the Public Health Service Act, except to the extent that the Secretary of Health and Human Services determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 543.

(2) SECRETARY OF VETERANS AFFAIRS.—A provision of this part does not preempt, supersede, or modify the operation of section 7332 of title 38, United States Code, except to the extent that the Secretary of Veterans Affairs determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 7332.

Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts

SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM GROSS INCOME FOR COST OF CATASTROPHIC HEALTH PLAN.

(a) IN GENERAL.—Subsection (a) of section 62 of the Internal Revenue Code of 1986, as amended by title I, is amended by inserting after paragraph (16) the following new paragraph:

''(17) MEDICAL EXPENSES ATTRIBUTABLE TO CATASTROPHIC HEALTH PLAN COVERAGE.—

''(A) IN GENERAL.—The deduction allowed by section 213 to the extent attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to coverage of an individual who has coverage described in section 220(c)(1)(B)(i).''.

(b) COORDINATION WITH DEDUCTION FOR OTHER MEDICAL EXPENSES.—Subsection (a) of section 213 of such Code is amended to read as follows:

''(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the tax-

able year, not compensated by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152) in an amount equal to the sum of—

''(1) the portion of such expenses attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)), and

''(2) the excess of such expenses (other than expenses described in paragraph (1)) over 7.5 percent of the adjusted gross income of the taxpayer.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 2202. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

''SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction the applicable percentage of the amounts paid in cash during the taxable year by or on behalf of such indi-

vidual to a medical savings account for the benefit of such individual and (if any) such individual's spouse and dependents if such spouse and dependents are eligible individuals.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

''(A) 25 percent for taxable years beginning in 1994 or 1995,

''(B) 50 percent for taxable years beginning in 1996 or 1997, and

''(C) 100 percent for taxable years beginning after 1997.

''(b) LIMITATIONS.—

''(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by the Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent of such individual or spouse if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

''(2) DOLLAR LIMITATION.—The amount allowable as a deduction under subsection (a) for the tax-

able year shall not exceed whichever of the following is the least:

''(A) The lowest deductible under any catastrophic health plan providing coverage to any beneficiary of the medical savings account.

''(B) $2,500 ($5,000 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual).

''(C) The excess of—

''(i) the applicable target actuarial value for standard coverage established under section 1102(c)(2) of the Affordable Health Care Now Act of 1994, over

''(ii) the deduction allowed by section 213 for the taxable year to the extent attributable to coverage under a catastrophic health plan.

Under rules of the Secretary, the target actuarial value under subparagraph (C)(i) shall be made applicable to individual and family coverage. A beneficiary of such account who has attained age 65 before the close of the taxable year shall not be taken into account in determining the limitation under the preceding sentence.

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

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means any individual who is covered under a catastrophic health plan throughout the calendar year in which or with which the taxable year ends.

''(B) LIMITATIONS.—Such term does not include—

''(i) an individual who is 65 years of age or older, unless the individual is covered under a catastrophic health plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of the Social Security Act); and

''(ii) an individual who has coverage under a group health plan or health insurance plan (other than a plan described in 1131(4)(B) of the Affordable Health Care Now Act of 1994) that has either a deductible that is less than the minimum deductible required under a catastrophic health plan (as defined in paragraph (2)) or has an actuarial value that is greater than the value for MedAccess catastrophic

coverage (as provided in section 1102(d) of such Act).

''(C) DEDUCTION NOT ALLOWED BEFORE 1999 TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—In the case of any taxable year beginning before January 1, 1999, such term does not include an individual—

''(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

''(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

The rules of subparagraphs (B) and (C) of section 213(f)(3) shall apply for purposes of this preceding sentence.

''(2) CATASTROPHIC HEALTH PLAN.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The term 'catastrophic health plan' means a health plan covering specified expenses incurred by an individual for medical care for such individual and the spouse and dependents (as defined in section

152) of such individual only to the extent such expenses covered by the plan for any calendar year exceed $1,800 ($3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

''(B) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1994, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year.

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

''(d) MEDICAL SAVINGS ACCOUNTS.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—

''(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the medical expenses of the beneficiaries of such trust, but only if the writ-

ten governing instrument creating the trust meets the following requirements:

''(i) Except in the case of a rollover contribution described in subsection (e)(4), no contribution will be accepted unless it is in cash, and contributions will not be accepted in excess of the amount allowed as a deduction under this section for the taxable year (or would be allowed as such a deduction but for subsection (c)(1)(C)).

''(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(iii) No part of the trust assets will be invested in life insurance contracts.

''(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(v) The interest of an individual in the balance in his account is nonforfeitable.

''(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

''(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—For purposes of this section, an account held by an insurance company in the United States shall be treated as a medical savings account (and such company shall be treated as a bank) if—

''(i) such account is part of a health insurance plan that includes a catastrophic health plan (as defined in subsection (c)(2)),

''(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such catastrophic health plan, and

''(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

''(2) MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for—

''(i) medical care (as defined in section 213), or

''(ii) long-term care (as defined in paragraph (3)),

for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan.

''(ii) EXCEPTION.—Clause (i) shall not apply—

''(I) in the case of coverage of an individual under 65 years of age under a catastrophic health plan or under a long-term care insurance plan, or

''(II) in the case of coverage of an individual 65 years of age or older under a medicare supplemental policy or under a long-term care insurance plan or for payment of premiums under part A or part B of title XVIII of the Social Security Act.

''(3) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services which are required by, and provided to, a chronically ill individual, which have as their primary purpose the direct provision of needed assistance with 1 or more activities of daily living (or the alleviation of the conditions necessitating such assistance) that the individual is certified under subparagraph (B) as being unable to perform, and which are provided in a setting other than an acute care unit of a hos-

pital pursuant to a continuing plan of care prescribed by a physician or registered professional nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the maintenance of a household or participation in community life, such as case management, transportation or legal services, or the performance of home maintenance or household chores.

''(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' means an individual who is certified by a physician or registered professional nurse as being unable to perform at least 3 activities of daily living without substantial assistance from another individual. For purposes of this paragraph, the term 'activities of daily living' means bathing, dressing, eating, toileting, transferring, and walking.

''(4) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the medical expenses of such individual.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount allowable as a deduction under subsection (a) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

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

''(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used to pay the medical expenses of the individual for whose benefit the account was established shall be increased by 10 percent of the amount of such payment or distribution which is includible in gross income under paragraph (1).

''(B) ACCOUNT BALANCE LIMITATION.—If—

''(i) the tax imposed by this chapter is required to be increased under subparagraph (A) by reason of a distribution, and

''(ii) after such distribution, the aggregate balance of all medical savings accounts established for the benefit of the individual, is less than the amount of the deductible under the catastrophic health plan covering such individual,

subparagraph (A) shall be applied by substituting '50 percent' for '10 percent'.

''(4) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which he received the payment or distribution.

''(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

''(A) IN GENERAL.—If during any taxable year—

''(i) there is a payment of a mandatory distribution expense incurred by a beneficiary of a medical savings account, and

''(ii) the person making such payment is not reimbursed for such payment with a distribution from such account before the 60th day after such payment,

the taxpayer's tax imposed by this chapter for such taxable year shall be increased by 100 percent of the excess of the amount of such pay-

ment over the amount of reimbursement made before such 60th day.

''(B) MANDATORY DISTRIBUTION EXPENSE.—For purposes of subparagraph (A), the term 'mandatory distribution expense' means—

''(i) any expense incurred which may be counted towards a deductible, or for a copayment or coinsurance, under the catastrophic health plan covering such beneficiary, and

''(ii) in the case of a beneficiary who has attained age 65, any expense for coverage described in subsection (d)(2)(B)(ii)(II) and any expense incurred which may be counted toward a deductible, or for a copayment or coinsurance, under title XVIII of the Social Security Act.

''(f) TAX TREATMENT OF ACCOUNTS.—

''(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by sec-

tion 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was estab-

lished uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay medical expenses.

''(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

''(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this

subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new paragraph:

''(18) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) DISTRIBUTIONS FROM MEDICAL SAVINGS ACCOUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 of such Code is amended by adding at the end thereof the following new subsection:

''(g) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the distributions from any medical savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for medical care.''

(d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT TAXES.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of such Code is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

''(10) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'',

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

''(21) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

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

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross income under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(e)(2) applies shall be treated as an amount not contributed.''

(f) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medi-

cal savings account by reason of the application of section 220(e)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 220(d)'' in subsection (e)(1) after ''described in section 408(a)''.

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(h) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.
''Sec. 221. Cross reference.''

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

> ''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''

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

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

Subtitle D—Anti-Fraud

PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

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

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

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

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

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

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

(d) REGULATIONS.—

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

(2) INFORMATION STANDARDS.—

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

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

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of

duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

SEC. 2302. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such sums as may be necessary to enable the Attorney General to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 2301 in a fiscal year.

SEC. 2303. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

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

vided in this part and section 1128A(f)(3) of the Social Security Act.

(b) MANAGEMENT.—

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

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

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

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

(4) The interest on, and the proceeds from the sale or redemption of, any obligations held in the

Trust Fund shall be credited to and form a part of the Trust Fund.

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

(c) USE OF FUNDS.—Of the amounts in the Trust Fund—

(1) not less than 60 percent shall be used to support educational activities to prevent the occurrence of violations of anti-fraud and abuse laws, including the issuance of advisory opinions under section 1129 and 1877(i) of the Social Security Act (as added by part 4) and fraud alerts, seminars for providers, and program updates; and

(2) any amounts remaining after use for activities under paragraph (1) shall be used to assist the Attorney General in carrying out the all-payor fraud

and abuse control program established under section 2301(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 2303(a) of the Affordable Health Care Now Act of 1994''.

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

PART 2—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 2311. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

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

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service on or after the date of the enactment of this paragraph, or with respect to any act or omission on or after such date in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

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

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

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

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

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

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

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

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

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

SEC. 2312. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care

is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

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

SEC. 2313. REVISIONS TO CRIMINAL PENALTIES.

(a) CLARIFICATION OF DISCOUNT EXCEPTION TO ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(A)) is amended—

(1) by inserting ''(regardless of its timing or availability)'' after ''in price''; and

(2) by striking ''program;'' and inserting ''program and is not paid in the form of currency or coin;''.

(b) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if—

''(i) the item or service is provided through an organization described in section 1877(b)(3), or

''(ii) the item or service is provided through such an organization on behalf of another entity (including but not limited to a self-insured employer or indemnity plan) that assumes financial risk for the provision of the item or service.''.

(c) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)), as amended by subsection (b), is further amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any amount in a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to that amount or financial relationship.''.

SEC. 2314. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (D).

(b) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

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

''(4) SHARED FACILITY SERVICES.—

''(A) IN GENERAL.—In the case of a shared facility service of a shared facility—

''(i) that is furnished—

''(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

''(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(III) to a patient of a shared facility physician; and

''(ii) that is billed by the referring physician.

''(B) SHARED FACILITY RELATED DEFINITIONS.—

''(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(ii) SHARED FACILITY.—The term 'shared facility' means an entity that fur-

nishes shared facility services under a shared facility arrangement.

''(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

''(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(c) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking ''substantially all'' and inserting ''not less than 75 percent (as determined in accordance with regulations of the Secretary)''.

(d) CLARIFICATION OF REFERRALS BY NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking ''and a request'' and inserting ''a request'';

(2) by inserting after ''radiation therapy,'' the following: ''and a request by a nephrologist for items or services related to renal dialysis,''; and

(3) by striking ''or radiation oncologist'' and inserting ''radiation oncologist, or nephrologist''.

(e) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn(f)) is amended—

(1) by striking ''Each entity'' and all that follows through paragraph (2) and inserting the following: ''The Secretary may require each entity (other than a physician or physician group practice) provid-

ing designated health services to provide the Secretary with the following information concerning the entity's ownership, investment, and compensation arrangements:

''(1) the designated health services provided by the entity; and

''(2) the names and unique physician identifier numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) or with a compensation interest (as described in subsection (a)(2)(B)) in the entity, or whose immediate relatives have such an ownership, investment, or compensation interest in the entity.''; and

(2) by striking the fifth sentence.

(f) EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of such Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) by striking ''or'' at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting a comma; and

(3) by adding at the end the following new subparagraphs:

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)); or

''(F) which meets State regulatory requirements applicable to health maintenance organizations and which—

''(i) provides designated health services directly or through contractual arrangements with providers;

''(ii) assumes financial risk for the provision of services or provides services on behalf of another individual or entity (including but not limited to a self-insured employer, indemnity plan, physician, or physician group) that assumes financial risk for the provision of the item or service; and

''(iii) subjects the services to a program of utilization review offered by an organization described in a preceding subparagraph, an organization meeting State regulatory requirements applicable to utilization review, or an organization accredited to perform utilization review considered appropriate by the Secretary.''.

(g) PREEMPTION OF STATE LAW.—Section 1877(g) of such Act (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

''(6) PREEMPTION OF STATE LAW.—The provisions of this section shall supersede any State law to the extent State law prohibits a physician from making a referral, or an entity from presenting a bill, for the furnishing of a service which is not subject to the restrictions applicable under paragraph (1).''.

(h) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

''(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

''(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

''(C) the requirements of section 1877(c)(2) of the Social Security Act (as

amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

''(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

''(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

''(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made on or after January 1, 1995, except that the amendments made by sub-

section (h) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993.

SEC. 2315. MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) STUDY ON COSTS OF PEER REVIEW CONTRACTS FOR MEDICARE HMOS.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of the Social Security Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary of Health and Human Services to assess the quality of services provided by such eligible organizations.

(b) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subsection (a).

SEC. 2316. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect January 1, 1996.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 2321. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

''(b) In determining the amount or scope of any penalty or assessment, the court shall take into account—

''(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

''(2) the degree of culpability and history of prior offenses by the convicted health care provider;

''(3) the extent to which restitution is paid; and

''(4) such other matters as justice may require.

''(c) A principal is liable for penalties and assessments under this section for the acts of the principal's agents acting within the scope of the agency.

''(d) For purposes of this section, the term 'health care plan' means a Federally-funded public program or private program for the delivery of or payment for health care items or services.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 2322. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1347.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment.

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and

independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

SEC. 2323. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting ''or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier,'' after ''Postal Service,''; and

(2) by inserting ''or such carrier'' after ''causes to be delivered by mail''.

PART 4—ADVISORY OPINIONS

SEC. 2331. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS UNDER TITLE XI.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''ADVISORY OPINIONS

''SEC. 1129. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

''(5) Whether an arrangement, activity or proposed arrangement or proposed activity violates any other provision of this Act.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(2) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(e) REGULATIONS.—The Secretary within 180 days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(1) the procedure to be followed by a party applying for an advisory opinion;

''(2) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(3) the interval in which the Secretary shall respond;

''(4) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(5) the manner in which advisory opinions will be made available to the public.

''(f) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed 30 days.''.

SEC. 2332. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by the addition of the following new subsection:

''(i) ADVISORY OPINIONS.—

''(1) IN GENERAL.—The Secretary shall issue advisory opinions on whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of this section.

''(2) EFFECT OF ADVISORY OPINIONS.—

''(A) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of this section.

''(3) REGULATIONS.—The Secretary within one hundred and eighty days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond;

''(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(E) the manner in which advisory opinions will be made available to the public.

''(4) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed thirty days.''.

SEC. 2333. EFFECTIVE DATE.

Unless otherwise specified, the amendments made by this part shall be effective upon the enactment of this Act.

Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Reforms

PART 1—INCREASED MEDICARE BENEFICIARY CHOICE

SEC. 2401. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS UNDER MEDICARE.

(a) USE OF METROPOLITAN STATISTICAL AREAS TO DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—Section 1876(a)(4) of such Act (42 U.S.C. 1395mm(a)(4)) is amended by striking ''in a geographic area served by an eligible organization or in a similar area'' and inserting ''in the metropolitan statistical area (as defined by the Office of Management and Budget) in which the individual resides, or in the entire portion of the State in which the individual resides which is not located in a metropolitan statistical area in the case of an

individual who does not reside in a metropolitan statistical area''.

(b) DETERMINATION OF MODEL ADDITIONAL HEALTH BENEFIT PACKAGES.—Section 1876(g) of such Act (42 U.S.C. 1395mm(g)) is amended by inserting after paragraph (3) the following new paragraph:

''(4) The Secretary shall develop the following model packages of additional health benefits (referred to in paragraph (3)(B)) which an eligible organization may provide (at its option) under paragraph (2):

''(A) Coverage for catastrophic illness (subject to a limit on out-of-pocket expenditures).

''(B) Coverage for prescription drugs.

''(C) Coverage for preventive services.''.

(c) REVISION OF MEMBERSHIP LIMITATION.—Section 1876(f) of the Social Security Act (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1), by striking ''one-half'' and inserting ''25 percent''; and

(2) in paragraph (2)(A), by striking ''50 percent'' and inserting ''75 percent''.

(d) ENROLLMENT PERIODS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.—

(1) UNIFORM OPEN ENROLLMENT PERIOD.—Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.

1395mm(c)(3)(A)(i)) is amended by striking ''must have'' and all that follows through ''and including'' and inserting the following: ''shall have open enrollment during an annual uniform open enrollment period established by the Secretary for all eligible organizations, together with''.

(2) OPEN ENROLLMENT FOR CERTAIN DISENROLLED INDIVIDUALS.—Section 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C. 1395mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: ''Each eligible organization with a risk-sharing contract under this section shall have an open enrollment period for individuals residing in the organization's service area who disenroll from another eligible organization with a risk-sharing contract under this section on the grounds that the individual's primary care physician is no longer a member of the organization's provider network or for cause (in accordance with such standards, and as demonstrated through an appeals process that meets such requirements, as the Secretary may establish).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 2402. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as ''OBRA–1990'') is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA–1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition

and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except

in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

''(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such

individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I), and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall

be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1994 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1994 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

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

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

ary 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2403. INCLUDING NOTICE OF AVAILABLE HEALTH MAINTENANCE ORGANIZATIONS IN ANNUAL NOTICE TO BENEFICIARIES.

Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) by striking ''and'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '', and''; and

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

''(4) with respect to the area in which the individual receiving the notice resides, a description of the eligible organizations under section 1833(a)(1) or section 1876 and the carriers offering a medicare supplemental policy described in section 1882(t)(1) which serve the area in which the individual receiving the notice resides.''.

SEC. 2404. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the enrollment of medicare beneficiaries in private health insurance plans (including medisave coverage described in section 1102(e)).

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a private health insurance plan.

SEC. 2405. OPTIONAL INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN PRIVATE HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a private health insurance plan on behalf of enrolled medicare beneficiaries who choose to enroll in such a plan.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a private health insurance plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act; or

(ii) the monthly premium charged the individual for coverage under the private health insurance plan.

(B) SOURCE OF PAYMENT.—The payment to a private health insurance plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the private plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the plan the difference between the monthly premium charged the individual for coverage under the plan and the amount specified in paragraph (1)(A)(i).

(3) BUDGET-NEUTRALITY.—The total amount of payments made by the Secretary under this sec-

tion with respect to a beneficiary for a year may not exceed the amount of payment that would have been made under title XVIII of the Social Security Act during the year if the beneficiary did not choose to enroll in a private health insurance plan during the year.

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42 U.S.C. (42 U.S.C. 1395b–2), as amended by section 2403, is amended

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting '', and''; and

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

''(5) a description of the option provided pursuant to section 2405 of the Affordable Health Care Now Act of 1994 for payment to be made by the

Secretary on the individual's behalf for enrollment in a private health insurance plan.''.

PART 2—MEDICARE PART B PREMIUM; OTHER MEDICARE PAYMENT CHANGES

SEC. 2411. EXTENSION OF CURRENT RULES FOR COMPUTING MEDICARE PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''January 1999'' and inserting ''January 2005''; and

(2) in paragraph (2), by striking ''January 1998'' and inserting ''January 2004''.

SEC. 2412. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

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

"PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

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

"SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the

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

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

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

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

''(1) IN GENERAL.—The Medicare part B premium tax for any month is ⅔ the amount equal to the excess of—

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

''(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) PHASEIN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by less than $50,000, the Medicare part B premium tax for any month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to $50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $100,000,

''(B) $125,000 in the case of a joint return, and

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

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

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

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

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

''(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''

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

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1994 in taxable years ending after December 31, 1994.

SEC. 2413. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) including over a 5-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

SEC. 2414. EXTENSION OF MEDICARE SECONDARY PAYMENT PROVISIONS.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking ''1998'' and inserting ''2004''.

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking ''1998'' and inserting ''2004'',

(B) in clause (ii)(I), by striking ''1997'' and inserting ''2003'', and

(C) in clause (ii)(II), by striking ''1998'' and inserting ''2004''.

(b) EXTENSION OF MEDICARE SECONDARY PAYER TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) of such Act (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking ''1998'' and inserting ''2004''.

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking ''1998'' and inserting ''2004''.

Subtitle F—Health Care Antitrust Improvements

SEC. 2501. PROTECTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) PROTECTIONS DESCRIBED.—An activity relating to the provision of health care services shall receive the following protection from the antitrust laws:

(1) If the activity is within a safe harbor designated by the Attorney General under section 2502, the safe harbor shall be a defense to all antitrust claims, except for claims for injunctive relief asserted by the Attorney General or the Chair of the Federal Trade Commission in extraordinary circumstances.

(2) If the activity is specified in and in compliance with the terms of a certificate of review issued by the Attorney General under section 2503 and the activity occurs while the certificate is in effect, the certificate shall be a defense to antitrust claims, other than claims for injunctive relief.

(b) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(1) IN GENERAL.—If any person brings an action alleging a claim under the antitrust laws and the activity on which the claim is based is found by the court to be protected from such laws under subsection (a), the court shall, at the conclusion of the action—

(A) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(B) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 2502. DESIGNATION OF SAFE HARBORS.

(a) IN GENERAL.—

(1) DESIGNATION BY ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary of Health and Human Services and the Chair, shall develop and designate pursuant to paragraph (C) safe harbors for purposes of section 2501(a)(1) relating to—

(A) each category of activities referred to in paragraph (2); and

(B) such other categories of activities as the Attorney General may designate in accordance with the process described in this section.

(2) REQUIRED CATEGORIES OF ACTIVITIES SUBJECT TO SAFE HARBORS.—The categories of activities referred to in this paragraph are as follows:

(A) JOINT PURCHASING OF HEALTH CARE SERVICES.—Providing the terms under which consumers of health care services (patients or others acting on their behalf) may jointly negotiate and purchase health care services.

(B) SMALL HOSPITAL MERGERS.—Providing for small hospitals lawfully to merge under the antitrust laws without undue delay or review, taking into account the special needs and circumstances of rural health care markets.

(C) NETWORK FORMATION AND OPERATION.—Permitting activities related to the startup and operation of collaborations between State-licensed providers through partial or full integration, including multi-provider networks, hospital networks, physician-hospital organizations, and other efforts to provide health care services more efficiently.

(D) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—Permitting standard setting and enforcement activities by medical self-regulatory entities (such as hospital boards and medical societies) to promote health care quality, except that a safe harbor under this paragraph may not provide protection for any activity undertaken for financial gain or for anti-competitive reasons.

(E) PROVISION OF INFORMATION TO BUYERS AND CONSUMERS.—Permitting health care providers collectively to supply non-price medical information to buyers and consumers relating to the type, quality and efficiency of treatment, including joint views on procedures that should be covered by purchasers and medical protocols, except that a safe harbor under this subparagraph may not provide protection for any collective refusals to deal or collective attempts at coercion.

(F) PARTICIPATION IN SURVEYS.—Providing the terms under which health care providers may lawfully participate in written surveys of prices of services, reimbursements received, employee compensation, and other relevant areas.

(G) HIGH-TECHNOLOGY AND TERTIARY CARE JOINT VENTURES.—Permitting activities of health care joint ventures to purchase or use new or existing high technology or costly equipment, or to provide advanced tertiary care services.

(H) MARKET POWER SCREENS.—Providing market power screens at appropriate levels below which combinations of health care providers are too small to pose a realistic antitrust threat. There may be different levels for different activities and markets, taking into account the special needs of rural health care markets.

(I) JOINT PURCHASING ARRANGEMENTS.—Providing the terms under which health care providers may make joint purchases of products and services.

(J) GOOD FAITH NEGOTIATIONS.—Providing the terms under which health care providers may engage in discussions relating to legitimate collaborative activities contemplated by the safe harbors.

(b) PROCESS FOR DESIGNATION OF ADDITIONAL CATEGORIES OF ACTIVITIES.—

(1) SOLICITATION OF PROPOSALS.—Not later than 30 days after the date of the enactment of this Act, the Attorney General shall publish a notice in the Federal Register soliciting proposals for safe harbors.

(2) REVIEW OF PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall review the proposed safe harbors submitted under paragraph (1) and include a description of the safe harbors in the report under subsection (d).

(3) ADDITIONAL SAFE HARBORS.—After submitting the report under subsection (d), the Attorney General (in consultation with the Secretary and the Chair) may from time to time add additional safe harbors in accordance with the procedures described in this subsection.

(c) EFFECTIVE DATE OF SAFE HARBORS.—

(1) PUBLICATION.—Not later than 180 days after the date of the enactment of this Act, the Attorney General shall publish in the Federal Register for public comment the safe harbors proposed for designation under this section. Not later than 180 days after publishing such proposed safe harbors in

the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(2) EFFECTIVE DATE.—The safe harbors established under the final rules issued under paragraph (1) shall take effect 90 days after issuance, unless disapproved by the Congress.

(d) REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall submit a report to Congress describing the proposals from subsections (a) and (b)(1) to be included in the publication of safe harbors described in subsection (c)(1) and the proposals from subsection (b)(1) that are not to be so included, together with explanations therefor.

(e) MODIFICATION OR REMOVAL OF SAFE HARBORS.—The Attorney General (in consultation with the Secretary and the Chair) may modify or remove a safe harbor following notice and comment upon a determination that the safe harbor does not meet the criteria of subsection (f).

(f) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under this section, the Attorney General shall take into account the following:

(1) The extent to which a competitive or collaborative activity will accomplish any of the following:

(A) An increase in access to health care services.

(B) The enhancement of the quality of health care services.

(C) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(D) An increase in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(E) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(2) Whether the designation of an activity as a safe harbor will result in the following outcomes:

(A) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to ne-

gotiate payment and service arrangements which will reduce costs to consumers.

(B) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(C) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in paragraph (1).

(D) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

SEC. 2503. CERTIFICATES OF REVIEW.

(a) ESTABLISHMENT OF PROGRAM.—In consultation with the Secretary, the Attorney General shall (not later than 180 days after the date of the enactment of this Act) issue certificates of review in accordance with this section for providers of health care services and advise and assist any person with respect to applying for such a certificate of review.

(b) PROCEDURES FOR APPLICATION FOR CERTIFICATE.—

(1) SUBMISSION OF APPLICATION.—

(A) FORM; CONTENT.—To apply for a certificate of review, a person shall submit to the Attorney General a written application which—

(i) specifies the activities relating to the provision of health care services which satisfy the criteria described in section 2502(e) and which will be included in the certificate; and

(ii) is in a form and contains any information, including information pertaining to the overall market in which the applicant operates, required by rule or regulation promulgated under section 2506.

(B) FILING FEE.—The Attorney General may require a filing fee to be submitted with the application to cover the cost of publication and the cost of review required by this section. The amount of the filing fee shall be determined on a sliding scale established by the Attorney General (based on the monetary size of the transaction involved), except that such fee may not exceed $5,000.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney

General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this title. Under such procedures the Attorney General, in consultation with the Secretary, shall approve an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 2502(f) for safe harbors designated under such section and that the benefits of the issuance of the certificate will outweigh any disadvantages that may result from reduced competition. If the Attorney General, with the concurrence of the Secretary, determines that the requirements for a certificate are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems necessary to assure compliance with the applicable procedures described in paragraph (3).

(4) TIMING FOR DECISION ON APPLICATION.—Within 90 days after the Attorney General receives an application for a certificate of review, the Attorney General shall determine whether to grant or deny the certificate.

(5) NOTIFICATION OF DECISION.—The Attorney General shall notify the applicant of the Attorney General's determination and if the application is denied, the reasons for the denial.

(6) FRAUDULENT PROCUREMENT.—A certificate of review shall be void ab initio with respect to any health care market activities for which the certificate was procured by fraud.

(c) AMENDMENT AND REVOCATION OF CERTIFICATES.—

(1) NOTIFICATION OF CHANGES.—Any applicant who receives a certificate of review—

(A) shall promptly report to the Attorney General any change relevant to the matters specified in the certificate; and

(B) may submit to the Attorney General an application to amend the certificate to reflect the effect of the change on the conduct specified in the certificate.

(2) AMENDMENT TO CERTIFICATE.—An application for an amendment to a certificate of review shall be treated as an application for the issuance of a certificate. The effective date of an amendment shall be the date on which the application for the amendment is received by the Attorney General.

(3) REVOCATION.—

(A) GROUNDS FOR REVOCATION.—In accordance with this paragraph, the Attorney General, in consultation with the Secretary, may revoke in whole or in part a certificate of review issued under this section. There shall be considered as grounds for the revocation of a certificate the fact that—

(i) after the expiration of the 2-year period beginning on the date a person's

certificate is issued, the activities of the person have not substantially accomplished the purposes for the issuance of the certificate;

(ii) the person has failed to comply with any of the terms or conditions imposed under the certificate by the Attorney General or the Secretary under subsection (b)(4); or

(iii) the activities covered under the certificate no longer satisfy the criteria set forth in section 2502(f).

(B) REQUEST FOR COMPLIANCE INFORMATION.—If the Attorney General or the Secretary has reason to believe that any of the grounds for revocation of a certificate of review described in subparagraph (A) may apply to a person holding the certificate, the Attorney General shall request such information from such person as the Attorney General or the Secretary deems necessary to resolve the matter of compliance. Failure to comply with such request shall be grounds for revocation of the certificate under this paragraph.

(C) PROCEDURES FOR REVOCATION.—If the Attorney General or the Secretary determines that any of the grounds for revocation of a certificate of review described in subparagraph (A) apply to a person holding the certificate, or that such person has failed to comply with a request made under subparagraph (B), the Attorney General shall give written notice of the determination to such person. The notice shall include a statement of the circumstances underlying, and the reasons in support of, the determination. In the 60-day period beginning 30 days after the notice is given, the Attorney General shall revoke the certificate or modify it as the Attorney General or the Secretary deems necessary to cause the certificate to apply only to activities that meet the criteria set forth in section 2502(f).

(D) INVESTIGATION AUTHORITY.—For purposes of carrying out this paragraph, the Attorney General may conduct investigations in the same manner as the Attorney General conducts investigations under section 3 of the Antitrust Civil Process Act, except that no civil investigative demand may be issued to a person

to whom a certificate of review is issued if such person is the target of such investigation.

(d) REVIEW OF DETERMINATIONS.—

(1) AVAILABILITY OF REVIEW FOR CERTAIN ACTIONS.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or modifies a certificate pursuant to paragraph (3), the applicant or certificate holder (as the case may be) may, within 30 days of the denial or revocation, bring an action in the United States District Court for the District of Columbia to set aside the determination on the ground that such determination is clearly erroneous.

(2) NO OTHER REVIEW PERMITTED.—Except as provided in paragraph (1), no action by the Attorney General, the Chair, or the Secretary pursuant to this subtitle shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or amends a certificate, neither the negative determination nor the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial pro-

ceeding, concerning any claim under the antitrust laws.

(e) PUBLICATION OF DECISIONS.—The Attorney General shall publish a notice in the Federal Register on a timely basis of each decision made with respect to an application for a certificate of review under this section or the amendment or revocation of such a certificate, in a manner that protects the confidentiality of any proprietary information relating to the application.

(f) ANNUAL REPORTS.—Every person to whom a certificate of review is issued shall submit to the Attorney General an annual report, in such form and at such time as the Attorney General may require, that contains any necessary updates to the information required under subsection (b) and a description of the activities of the holder under the certificate during the preceding year.

(g) RESTRICTIONS ON DISCLOSURE OF INFORMATION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS UNDER ADMINISTRATIVE PROCEDURE ACT.—Information submitted by any person in connection with the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under section 552 of title 5, United States Code.

(2) RESTRICTIONS ON DISCLOSURE OF COMMERCIAL OR FINANCIAL INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no officer or employee of the United States shall disclose commercial or financial information submitted in connection with the issuance, amendment, or revocation of a certificate of review if the information is privileged or confidential or if disclosure of the information would cause harm to the person who submitted the information.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply with respect to information disclosed—

(i) upon a request made by the Congress or any committee of the Congress,

(ii) in a judicial or administrative proceeding, subject to appropriate protective orders,

(iii) with the consent of the person who submitted the information,

(iv) in the course of making a determination with respect to the issuance, amendment, or revocation of a certificate of review, if the Attorney General deems

disclosure of the information to be necessary in connection with making the determination,

(v) in accordance with any requirement imposed by a statute of the United States, or

(vi) in accordance with any rule or regulation promulgated under subsection (i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a person is entitled to the protections provided by such a certificate.

SEC. 2504. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE JOINT VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care joint venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is later, file with the Attorney General a written notification disclosing—

(A) the identities of the parties to such venture,

(B) the nature and objectives of such venture, and

(C) such additional information as the Attorney General may require by regulation.

(2) FILING FEE.—The Attorney General may require a filing fee to be submitted with the notification to cover the cost of publication and the cost of administering this section, except that the amount of such fee shall not exceed $250.

(3) SUBMISSION OF ADDITIONAL INFORMATION.—

(A) REQUEST OF ATTORNEY GENERAL.—At any time after receiving a notification filed under paragraph (1), the Attorney General may require the submission of additional information or documentary material relevant to the proposed health care joint venture.

(B) PARTIES TO VENTURE.—Any party to a health care joint venture may submit such additional information on the venture's behalf as may be appropriate to ensure that the venture will receive the protections provided under subsection (b).

(C) REQUIRED SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care joint venture for which a notification is in effect under this section shall submit information on any change in the membership of the venture not later than 90 days after such change occurs.

(4) PUBLICATION OF NOTIFICATION.—

(A) INFORMATION MADE PUBLICLY AVAILABLE.—Not later than 30 days after receiving a notification with respect to a venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with re-

spect to the venture that identifies the parties to the venture and generally describes the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the parties to the venture.

(B) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information and documentary material submitted pursuant to this section and all information obtained by the Attorney General in the course of any investigation or case with respect to a potential violation of the antitrust laws by the health care joint venture (other than information and material described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies except in a judicial proceeding in which such information and material is subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4).

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—Except as provided in subsection (c), the provisions of paragraphs (2), (3), (4), and (5) shall apply with respect to any action under the antitrust laws challenging conduct within the scope of a notification which is in effect pursuant to subsection (a)(1).

(B) TIMING OF PROTECTIONS.—The protections described in this subsection shall apply to the venture that is the subject of a notification under subsection (a)(1) as of the earlier of—

(i) the date of the publication in the Federal Register of the notice published with respect to the notification; or

(ii) if such notice is not published during the period required under subsection (a)(4), the expiration of the 30-day period

that begins on the date the Attorney General receives any necessary information required to be submitted under subsection (a)(1) or any additional information required by the Attorney General under subsection (a)(3)(A).

(2) APPLICABILITY OF RULE OF REASON STANDARD.—In any action under the antitrust laws, the conduct of any person which is within the scope of a notification filed under subsection (a) shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including, but not limited to, effects on competition in relevant markets.

(3) LIMITATION ON RECOVERY TO ACTUAL DAMAGES AND INTEREST.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending

on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

(4) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(A) IN GENERAL.—In any action under the antitrust laws brought against a health care joint venture for conduct that is within the scope of a notification filed under subsection (a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant

to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

(A) IN GENERAL.—Any information disclosed in a notification submitted under subsection (a)(1) and the fact of the publication of a notification by the Attorney General under subsection (a)(4) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a party to a health care joint venture is entitled to the protections described in this subsection.

(B) ACTIONS OF ATTORNEY GENERAL.—No action taken by the Attorney General pursuant to this section shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

(c) EXCEPTION FOR CERTAIN ACTIVITIES.—

(1) ACTIVITIES DESCRIBED.—The protections described in subsection (b) shall not apply to conduct which constitutes price-fixing, bid-rigging, or market allocation, unless such conduct is related to procompetitive aspects of a health care joint venture (as determined in accordance with the process described in paragraph (2)).

(2) PROCESS.—If conduct of a health care joint venture which is subject to a notification under subsection (a)(1) is challenged for price-fixing, bid-rigging, or market allocation, any party to the joint venture shall be entitled to show the procompetitive aspects of such conduct. The protections described in subsection (b) shall not apply to the conduct if the party is unable to show that the conduct is not mere price-fixing, bid-rigging, or market allocation.

SEC. 2505. REVIEW AND REPORTS ON SAFE HARBORS, CERTIFICATES OF REVIEW, AND NOTIFICATIONS.

(a) IN GENERAL.—The Attorney General, in consultation with the Secretary and the Chair, shall periodically review the safe harbors designated under section 2502, the certificates of review issued under section 2503, and notification received under section 2504, and—

(1) with respect to the safe harbors, issue modifications to such safe harbors in such manner as the

Attorney General considers appropriate in accordance with the requirements of section 2502, which modifications shall take effect 90 days after issuance, unless disapproved by the Congress; and

(2) with respect to the certificates of review and notifications, submit a report to Congress on the issuance of such certificates and receipt of notifications, including a description of the effect of such certificates and notifications on increasing access to high quality health care services at reduced costs.

(b) RECOMMENDATIONS FOR LEGISLATION.—The Attorney General shall include in the reports submitted under subsection (a)(2) any recommendations of the Attorney General for legislation to improve the programs for the issuance of certificates of review and receipt of notifications established under this subtitle.

SEC. 2506. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, in consultation with the Secretary and the Chair, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 2502, 2503, and 2504.

(b) GUIDANCE FOR PROVIDERS.—

(1) IN GENERAL.—To promote greater certainty regarding the application of the antitrust laws

to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate safe harbors under section 2502 and grant certificates of review under section 2503, publish guidelines—

(A) to define or provide assistance in determining relevant geographic and product markets for health care services and providers of health care services;

(B) to further collaborative activities which may be helpful to enhance services in underserved and geographically disadvantaged areas such as rural markets and inner cities;

(C) to assist collaboration between providers (such as hospital networks, physician-hospital organizations, and other groups of providers) which will help provide health care services more efficiently;

(D) to further activities by which public health clinics (including community health centers and migrant health centers under title III of the Public Health Service Act) may participate in networks and other collaborative activi-

ties in order to enhance services in underserved areas;

(E) to assist providers of health care services in analyzing whether the activities of such providers may be subject to a safe harbor under section 2502;

(F) to provide clarification for activities in the general subject matter areas described in the safe harbors in section 2502, but which fall outside the safe harbors; and

(G) to describe specific types of activities which would meet the requirements for issuance of a certificate of review under section 2503, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) PERIODIC UPDATE.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) WAIVER OF ADMINISTRATIVE PROCEDURE ACT.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 2507. ESTABLISHMENT OF HHS OFFICE OF HEALTH CARE COMPETITION POLICY.

(a) IN GENERAL.—There is established within the Department of Health and Human Services an Office to be known as the Office of Health Care Competition Policy (hereafter in this section referred to as the ''Office''). The Office shall be headed by a director, who shall be appointed by the Secretary.

(b) DUTIES.—The Office shall coordinate the responsibilities of the Secretary under this subtitle and otherwise assist the Secretary in developing policies relating to the competitive and collaborative activities of providers of health care services.

SEC. 2508. DEFINITIONS.

In this subtitle:

(1) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term ''Chair'' means the Chair of the Federal Trade Commission.

(3) The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, or a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974) which provides benefits with respect to health care services.

(4) The term ''health care joint venture'' means a joint venture of 2 or more persons formed for the purpose of providing health care services, including attempts to enter into or perform a contract or agreement to provide such services.

(5) The term ''health care services'' means any services for which payment may be made under a health benefit plan, including services related to the delivery or administration of such services.

(6) The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(7) The term ''person'' includes a State or unit of local government.

(8) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

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

(10) The term ''specialty group'' means a medical specialty or subspecialty in which a provider of health care services may be licensed to practice by a State (as determined by the Secretary in consultation with the certification boards for such specialties and subspecialties).

(11) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee

thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities

PART 1—APPLICATION OF THE CLAYTON ACT TO MEDICAL SELF-REGULATORY ENTITIES

SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES.

(a) IN GENERAL.—(1) Except as provided in paragraph (2), no damages, interest on damages, cost of suit, or attorney's fee may be recovered under section 4, 4A, or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or under any State law similar to such section, from any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in standard setting or enforcement activities that are—

(A) designed to promote the quality of health care provided to patients, and

(B) not conducted for purposes of financial gain.

(2) Paragraph (1) shall not prohibit the recovery of actual damages, interest on damages, the cost of suit, or a reasonable attorney's fee under section 4 or 4A of the Clayton Act (15 U.S.C. 15, 15a), or under any State law similar to such section, by a State or the United States from a medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) for injury sustained as a result of engaging in the conduct described in such paragraph.

(b) FEES.—In any action under section 4, 4C, or 16 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a similar State law, brought against any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in conduct described in subsection (a)(1), the court shall award the cost of suit, including a reasonable attorney's fee, to a substantially prevailing defendant.

SEC. 2602. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff.

(2) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the quality of health care provided by a medical professional.

PART 2—CONSULTATION BY FEDERAL AGENCIES

SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGULATORY ENTITIES RESPECTING MEDICAL PROFESSIONAL GUIDELINES AND STANDARDS.

Any Federal agency engaged in the establishment of medical professional standards shall consult with appropriate medical societies or associations, specialty boards, or recognized accrediting agencies, if available, in carrying out medical professional standard setting and guidelines or standards relating to the practice of medicine.

Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests

SEC. 2701. ELIMINATING CLIA REQUIREMENT FOR CERTIFICATE OF WAIVER FOR SIMPLE LABORATORY EXAMINATIONS AND PROCEDURES.

(a) IN GENERAL.—Section 353 of the Public Health Service Act (42 U.S.C. 263a) is amended—

(1) in subsection (b), by inserting before the period at the end the following: ''or unless the laboratory is exempt from the certificate requirement under subsection (d)(2)'';

(2) by amending paragraph (2) of subsection (d) to read as follows:

''(2) EXEMPTION FROM CERTIFICATE REQUIREMENT FOR LABORATORIES PERFORMING ONLY SIMPLE EXAMINATIONS AND PROCEDURES.—A laboratory which performs only laboratory examinations and procedures described in paragraph (3) is not required to have in effect a certificate under this section.'';

(3) by striking paragraph (4) of subsection (d); and

(4) in subsection (m)(1), by striking ‘‘, except that the Secretary’’ and all that follows and inserting a period.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month beginning after the date of the enactment of this Act.

SEC. 2702. AMENDMENT RELATED TO SIMPLE LABORATORY EXAMINATIONS.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263) is amended by striking paragraph (3) and inserting the following:

‘‘(3) EXAMINATIONS AND PROCEDURES.—The examinations and procedures identified in paragraph (2) are simple laboratory examinations and procedures which have an insignificant risk of an erroneous result and include those which—

‘‘(A) have been approved by the Food and Drug Administration for home use,

‘‘(B) employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible,

‘‘(C) the Secretary has determined pose no reasonable risk of serious harm to the patient if performed incorrectly, or

''(D)(i) are performed by or under the direction or supervision of or in collaboration with a doctor of medicine or osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located, or by an individual qualified to direct, supervise, or perform examinations and procedures under State laws or such standards as the Secretary may establish; and

''(ii) the patient is available for clinical observation; and

''(iii) prompt results are needed to evaluate, diagnose, and treat the patient or to avoid additional burdens on the patient that could result from not performing the test.

''(4) DEFINITION.—As used in this section, the term 'simple laboratory examinations and procedures' includes dipstick tests for total and allergen-specific IgE; microscopic examination of nasal smears (for cells and bacteria); mono spot tests; testing for theophylline using the Accu-Level method; microscopic urinalysis; vaginal wet mount; KOH prep, scabies prep; rapid strep antigen; nonautomated qualitative and quantitative semen analysis; pin worm; prostate smears; synovial fluid

analysis for inflammation and infection; post coital test; fern test; occult blood; Gram stain; qualitative drug screen; pulse oximetry; hemoglobin (by hand-held hemoglobinometer); ASO, CRP, RF, and mono screen; sickle cell screen; white blood cell count by manual chamber count; peripheral blood smears; sputum eosinophil; urine culture colony; urine sensitivities; microscopic examination of hair morphology; molluscum smear; fungal cultures, including dermatophyte test medium; Tzank smear; Darkfield examination; agglutination pregnancy test; urethral gram stains, and centrifigal hematology, including white blood cell count, hematocrit, differential, and platelet count.''.

SEC. 2703. AMENDMENT RELATED TO STUDY.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Centers for Disease Control and Prevention, shall use existing appropriations to conduct the study required by section 4 of the Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. 263a note). The Secretary shall report the results of such study to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Com-

mittee on Labor and Human Resources of the Senate not later than May 1, 1996.

(b) SUNSET.—If the results of the study described in subsection (a) are not reported to the committees of Congress by May 1, 1996, section 353 of the Public Health Service Act shall not be in effect after May 1, 1996.

SEC. 2704. AMENDMENTS RELATED TO THE CLINICAL LABORATORY IMPROVEMENT ADVISORY COMMITTEE.

The Secretary of Health and Human Services shall revise the membership of the Clinical Laboratory Improvement Advisory Committee established by the Secretary in regulations to implement section 353 of the Public Health Service Act (subpart T of part 493 of title 42 Code of Federal Regulations) to contain, in the membership which does not include ex-officio members or officers or employees of the Federal Government, a number of practicing physicians which is proportionate to the number of physician laboratories regulated under such section 353. For purposes of this section, the term ''practicing physician'' means a licensed doctor of medicine or osteopathy who spends at least 80 percent of the physician's professional time in direct patient care and who directs an in-office clinical laboratory for the physician's patients.

Subtitle I—Miscellaneous Provisions

SEC. 2801. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term ''agency'' means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term ''health benefits plan'' means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term ''health-benefits coverage'' means coverage under a health benefits plan;

(4) an individual shall be considered to be an ''annuitant of an agency'' if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term ''Office'' means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a ''pay-as-you-go'' basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

SEC. 2802. INELIGIBILITY OF ALIENS FOR SSI AND MEDICAID.

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsections (b) and (c), no alien shall be eligible for any program referred to in subsection (d).

(b) EXCEPTIONS.—

(1) REFUGEE EXCEPTION.—Subsection (a) shall not apply to an alien admitted to the United States as a refugee under section 207 of the Immi-

gration and Nationality Act until 6 years after the date of such alien's arrival into the United States.

(2) AGED EXCEPTION.—Subsection (a) shall not apply to an alien who—

(A) has been lawfully admitted to the United States for permanent residence;

(B) is over 75 years of age; and

(C) has resided in the United States for at least 5 years.

(3) CURRENT RESIDENT EXCEPTION.—Subsection (a) shall not apply to the eligibility of an alien for a program referred to in subsection (d) until 1 year after the date of the enactment of this Act if, on such date of enactment, the alien is residing in the United States and is eligible for the program.

(c) PROGRAMS FOR WHICH ALIENS MAY BE ELIGIBLE.—The limitation under subsection (a) shall not apply to medical assistance with respect to emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act).

(d) PROGRAMS FOR WHICH ALIENS ARE INELIGIBLE.—The programs referred to in this subsection are the following:

(1) The program of medical assistance under title XIX of the Social Security Act, except emergency services as provided in subsection (c).

(2) The supplemental security income program under title XVI of the Social Security Act.

(e) NOTIFICATION OF ALIENS.—Any Federal agency that administers a program referred to in subsection (d) shall, directly or through the States, notify each alien receiving benefits under the program whose eligibility for the program is or will be terminated by reason of this section.

SEC. 2803. LIMITATION ON SSI BENEFITS FOR DRUG AND ALCOHOL ADDICTS.

(a) IN GENERAL.—

(1) LIMITATION DESCRIBED.—Section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a)) is amended by adding at the end the following:

''(5)(A) The Secretary shall identify all recipients of benefits under this title by reason of disability whose disability is a result of addiction to illegal drugs.

''(B) The Secretary shall periodically, on a random basis, test each recipient identified under subparagraph (A) to determine whether the recipient is using illegal drugs.

''(C)(i) Notwithstanding any other provision of this title, any individual who is determined under subpara-

graph (B) to be using illegal drugs, or who refuses to submit to testing as provided for under subparagraph (B), shall not be eligible for benefits under this title for a period of at least 1 year.

''(ii) The period of ineligibility under clause (i) shall terminate (after the last day of such 1-year period) if the individual has 2 tests (at least 2 months apart and not paid for through Federal funds) which establish that the recipient is not using illegal drugs.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to quarters beginning after the expiration of the 6-month period that begins on the date of the enactment of this Act.

(b) REPRESENTATIVE PAYEE REFORMS.—

(1) AUTHORITY OF GOVERNMENT AGENCIES TO BECOME PAID REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following: ''The term 'qualified organization' also includes any government agency that meets the requirements of items (aa) and (bb) of subclause (II).''.

(2) MAXIMUM FEE PAYABLE TO REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(i) of such Act (42 U.S.C. 1383(a)(2)(D)(i)) is amended by striking

''the lesser of—'' and all that follows and inserting ''10 percent of the monthly benefit involved.''.

TITLE III—LONG-TERM CARE

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Subtitle A—Tax Treatment of Long-term Care Insurance

SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this part, a long-term care insurance contract shall be treated as an accident or health insurance contract.

''(b) LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

''(A) the only insurance protection provided under such contract is coverage of quali-

fied long-term care services and benefits incidental to such coverage,

''(B) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

''(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(D) such contract is guaranteed renewable,

''(E) such contract does not have any cash surrender value, and

''(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other

periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(C) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual in a qualified facility, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

''(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

''(i) which is licensed under State law, or

''(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

''(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

''(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

''(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy con-

tinuation coverage requirements of group health plans) applies.

''(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

''(1) IN GENERAL.—In the case of a calendar year after 1994, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1993.''

(b) RESERVES.—Clause (iii) of section 807(d)(3)(A) is amended by inserting ''(other than a long-term care insurance contract within the meaning of section 818A)'' after ''contract''.

(c) CLERICAL AMENDMENT.—The table of sections for such subpart E is amended by inserting after the item relating to section 818 the following new item:

''Sec. 818A. Treatment of long-term care insurance or plans.''

SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE; INCLUSION OF EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking ''and'' at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting '', and'', and by inserting after paragraph (4) the following new paragraph:

''(6) benefits under a long-term care insurance contract (as defined in section 818A(b)).''

(b) INCLUSION OF EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end thereof the following sentence: ''The preceding sentence shall not apply to any plan providing coverage for long-term care services.''

SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of

subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 818A(c)), or''.

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2)(A) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

''In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

''In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each dollar amount contained in paragraph (1) shall be increased by the

medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1991.''

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 3004. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1994.

Subtitle B—Establishment of Federal Standards for Long-term Care Insurance

SEC. 3101. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

''TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

''PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

''SEC. 2701. STANDARDS.

''(a) APPLICATION OF STANDARDS.—

''(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the 'NAIC')—

''(A) develop specific standards that incorporate the requirements of this title; and

''(B) report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

''(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

''(3) RELATION TO STATE LAW.—Nothing in this title shall be construed as preventing a State from applying standards that provide greater protec-

tion to policyholders of long-term care insurance policies than the standards promulgated under this title, except that such State standards may not be inconsistent or in conflict with any of the requirements of this title.

''(b) DEADLINE FOR APPLICATION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

''(A) the date the State adopts the standards established under subsection (a)(1); or

''(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

''(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

''(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

''(B) having a legislature which is not scheduled to meet within 1 year following the

beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

''(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

''(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

''(2) standards for the enhanced protection of consumers with long-term care insurance;

''(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

''(4) other activities determined appropriate by Congress.

''(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

''(1) three individuals who are representatives of carriers;

''(2) three individuals who are representatives of consumer groups;

''(3) three representatives who are representatives of providers of long-term care services;

''(4) three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and

''(5) the Secretary of Veterans Affairs.

''(e) DUTIES.—The advisory committee established under subsection (d) shall—

''(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

''(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

''(3) recommend appropriate standards for benefits under section 2715(c); and

''(4) perform such other activities as determined appropriate by the Secretary.

''(f) ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

''(1) Subparagraph (C) (relating to staffing and administration).

''(2) Subparagraph (D) (relating to compensation of members).

''(3) Subparagraph (F) (relating to access to information).

''(4) Subparagraph (G) (relating to use of funds).

''(5) Subparagraph (H) (relating to periodic GAO audits).

''(6) Subparagraph (J) (relating to requests for appropriations).

''PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

''(a) IN GENERAL.—

''(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2721)) may be is-

sued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

''(A) the Secretary determines that the State has established a regulatory program that—

''(i) provides for the application and enforcement of the standards established under section 2701(a); and

''(ii) complies with the requirements of subsection (b);

by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

''(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indi-

rectly, shall be deemed the offering for sale of the policy.

''(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

''(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of

subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

''(1) ENFORCEMENT.—The enforcement under the program—

''(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

''(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

''(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

''(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

''(B) responding on a timely basis to such complaints;

''(C) the investigation of—

''(i) those complaints which have a reasonable probability of validity, and

''(ii) such other alleged violations of the standards as the program finds appropriate; and

''(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

''(3) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

''(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

''(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

''(4) PROCESS FOR APPROVAL OF PREMIUMS.—

''(A) IN GENERAL.—Each State regulatory program shall—

''(i) provide for a process for approving or disapproving proposed premium in-

creases or decreases with respect to long-term care insurance policies; and

''(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

''(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

''(i) includes a description of the assumptions that justify the increase;

''(ii) contains such information as may be required under the Standards; and

''(iii) is made available to the public.

''(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide no-

tice to policyholders and certificate holders of any premium change under such group policy.

''(D) EXCEPTION.—Subparagraph (C) shall not apply to—

''(i) group conversion policies;

''(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

''(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

''(5) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, in-

cluding information concerning violations in excess of 30 days.

''(6) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

''(7) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

''(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

''(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

''(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

''(B) for responding on a timely basis to such complaints; and

''(C) for the investigation of—

''(i) those complaints that have a reasonable probability of validity; and

''(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

''(3) HEARINGS.—

''(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

''(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's

imposition of the order shall constitute a final and unappealable order.

''(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

''(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

''(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

''(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing

under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

''(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

''(i) shall require the agent, association or its subsidiary, or a carrier—

''(I) to cease and desist from such violations; and

''(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

''(ii) may require the agent, association or its subsidiary, or a carrier to take

such other remedial action as is appropriate.

''(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

''(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

''(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

''(C) WAIVER BY SECRETARY.—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

''(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

''(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

''(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity

and appropriateness of the final order shall not be subject to review.

''(d) DEMONSTRATION GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary may award grants to States for the establishment of demonstration programs to improve the enforcement within such States of long-term care insurance standards applicable under this title.

''(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State intends to use the amounts provided under the grant.

''(3) MINIMUM AMOUNT OF GRANTS.—The amount of a grant awarded under this subsection shall not be less than $100,000.

''(4) EVALUATION.—A State that receives a grant under this subsection shall comply with such evaluation procedures as the Secretary shall by regulation establish. The Secretary shall utilize such evaluations to conduct an overall evaluation of the results of the demonstration programs established under this section.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $5,000,000 for each of the fiscal years 1996 through 2000.

"SEC. 2712. REGULATION OF SALES PRACTICES.

''(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

''(1) IN GENERAL.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

''(2) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

''(A) TWISTING.—

''(i) IN GENERAL.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

''(ii) POLICY REPLACEMENT FORM.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

''(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

''(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that con-

tact will be made by an insurance agent or insurance company.

''(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

''(b) FINANCIAL STANDARDS.—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

''(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

''(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

''(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

''(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

''(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

''(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

''(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

''(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) without providing to the purchaser or potential purchaser (or representative) an outline of coverage that com-

plies with the standards established under section 2701(a).

''(g) PENALTIES.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation.

''(h) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

''(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

''(2) specify procedures for certifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

''(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

''(b) MAILING OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written request by the policyholder or certificate holder (or representative)—

''(1) provide a written explanation of the reasons for the denial; and

''(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

''(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

''(1) the long-term care insurance policies of the carrier that are in force;

''(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

''(3) the lapse rate, replacement rate, and rescission rates by policy;

''(4) the names of that 10 percent of its agents that—

''(A) have the greatest lapse and replacement rate; and

''(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

''(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

''(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

''(1) IN GENERAL.—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for sell-

ing or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

''(2) SUBSEQUENT YEARS.—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

''(3) LIMITATION.—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

''(4) COMPENSATION DEFINED.—As used in this subsection, the term 'compensation' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

"SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

''(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

''(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

''(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

''(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

''(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conver-

sion of coverage if the policy entitles each individual—

''(A) whose coverage under the group policy would otherwise be terminated for any reason; and

''(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

''(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

''(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any

exclusion for preexisting conditions that would have been covered under the group policy being replaced.

''(c) STANDARDS FOR ISSUANCE.—

''(1) IN GENERAL.—

''(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

''(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

''(2) UPGRADE FOR CURRENT POLICIES.—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

''(d) EFFECT OF INCAPACITATION.—

''(1) IN GENERAL.—

''(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

''(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termi-

nation and shall allow for the collection of past due premium.

''(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

''(A) the period of such nonpayment is in excess of 30 days; and

''(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"**SEC. 2715. BENEFIT STANDARDS.**

''(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

''(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with re-

spect to definitions and terminology used for long-term care services and providers;

''(2) use a uniform format for presenting the outline of coverage under such a policy; and

''(3) provide coverage for at least one standard benefits package (of those developed by the NAIC) that shall include the limitations on the amount of payments per day and the lengths of covered stays for nursing facility and home health care services;

as prescribed under guidelines issued by the NAIC and periodically updated.

''(b) DISCLOSURE.—

''(1) OUTLINE OF COVERAGE.—

''(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

''(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

''(i) A description of the principal benefits and coverage under the policy.

''(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

''(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

''(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

''(v) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

''(vi) Information on national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs, where available.

''(vii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

''(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

''(A) a description of the principal benefits and coverage provided in the policy;

''(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

''(C) a statement that the group master policy determines governing contractual provisions.

''(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life

insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

''(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

''(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

''(C) any exclusions, reductions, and limitations on benefits of long-term care.

''(4) ADDITIONAL INFORMATION.—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

''(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

''(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

''(A) for benefits for a type of services to the need for or receipt of any other services;

''(B) for any benefit on the medical necessity for such benefit;

''(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

''(D) for residential care (if covered under the policy) only—

''(i) to care provided in facilities which provide a higher level of care; or

''(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

''(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

''(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

''(B) may not require benefits for such services to be provided by a nurse or therapist

that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exist, in compliance with qualifications developed by the NAIC;

''(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

''(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

''(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing

uniform language and definitions under section 2715(a)(1)) in the State.

''(4) PER DIEM POLICIES.—

''(A) DEFINITION.—For purposes of this title, the term 'per diem long-term care insurance policy' means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condition or otherwise exclude benefit payments based on the receipt of any type of nursing facility, home health care or community-based services.

''(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other

cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

''(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

''(1) INITIAL ISSUANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

''(B) 6-MONTH LIMIT.—

''(i) IN GENERAL.—No long-term care insurance policy or certificate issued under this title shall utilize a definition of 'preexisting condition' that is more restrictive than the following: The term 'preexisting condition' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

''(ii) PROHIBITION ON EXCLUSION OF COVERAGE.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

''(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

''(f) ELIGIBILITY FOR BENEFITS.—

''(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

''(A) describe the level of benefits available under the policy; and

''(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

''(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term 'control' means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

''(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

''(4) APPEALS PROCESS.—

''(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the claimant's functional assessment, conducted under paragraph (2).

''(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

''(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

''(i) by an individual who has a direct or indirect significant or controlling inter-

est in, or direct affiliation or relationship with, the issuer of the policy;

''(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

''(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

''(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

''(g) INFLATION PROTECTION.—

''(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not

offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

''(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

''(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

''(i) the existing policy benefit; and

''(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and ex-

tending until the year in which the offer of increase is made.

''(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

''(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

''(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this title:

''(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

''(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such

individual delays purchasing such protection until a future time.

''(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

''(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

''(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2716. NONFORFEITURE.

''(a) IN GENERAL.—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period

(specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

''(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

''SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

''(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or material misrepresentation relating to the issuance of the policy unless notice of such fraud or material misrepresentation is provided within a time period to be determined by the NAIC.

''(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2718. CIVIL MONEY PENALTY.

''(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) provides a commission or compensation in violation of section 2713(e);

''(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

''(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

''(1) fails to make a refund in accordance with section 2713(a);

''(2) fails to transmit a policy in accordance with section 2713(b);

''(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

''(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

''(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

''PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

''(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

''(1) group and individual annuities and life insurance policies, riders or certificates that provide

directly, or that supplement long-term care insurance; and

''(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(b) ISSUANCE.—Long-term care insurance policies may be issued by—

''(1) carriers;

''(2) fraternal benefit societies;

''(3) nonprofit health, hospital, and medical service corporations;

''(4) prepaid health plans;

''(5) health maintenance organizations; or

''(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

''(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health cov-

erage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(d) APPLICATIONS.—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

''Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

''(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

''(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

''(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

''(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

''(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

''PART D—MISCELLANEOUS PROVISIONS

"SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE.

''(a) IN GENERAL.—The Secretary, acting through the Public Health Service, may award grants to States, and national organizations with demonstrated experience in long-term care insurance, for the establishment of programs to provide information, counseling, and assistance

relating to the procurement of adequate and appropriate long-term care insurance.

''(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a State or national organization shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State or organization intends to use the amounts provided under the grant.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated for grants to States under subsection (a), $10,000,000 for each of the fiscal years 1996 through 1998.

''(2) NATIONAL ORGANIZATIONS.—There are authorized to be appropriated for grants to national organizations under subsection (a), $1,000,000 for each of the fiscal years 1996 through 1998.

"SEC. 2732. DEFINITIONS.

''As used in this title:

''(1) AGENT.—The term 'agent' means—

''(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is

licensed or required to be licensed under State law for such purpose; and

''(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2712(f).

''(2) ASSOCIATION.—The term 'association' includes the association and its subsidiaries.

''(3) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).''.

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking

''2701'' each place that such appears and inserting ''2801''.

Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance

SEC. 3201. PROTECTION OF ASSETS THROUGH USE OF QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by sections 1601(a) and 1701(a), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

''SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

''SEC. 1933. (a) IN GENERAL.—Each State plan under this title may provide, subject to subsection (d), that in determining the eligibility of an individual for medical assistance under the plan with respect to such services there shall be disregarded some or all of the individual's assets which are attributable (as determined under subsection (c)(2)) to coverage under a qualified long-term care insurance contract (as defined in subsection (b)).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—In this section, the term 'qualified long-term care insurance contract' means, with respect to a State, a long-term care insurance contract (as defined in section 818A(b) of the Internal Revenue Code of 1986) which—

''(1) provides such protection against the costs of receiving long-term care services as the State may require by law;

''(2) provides that benefits under the contract shall be paid without regard to eligibility for medical assistance under this title; and

''(3) meets such other requirements (such as requirements relating to premiums, disclosure, minimum benefits, rights of conversion, and standards for claims processing) as the State may determine to be appropriate.

''(c) OTHER DEFINITIONS.—In this section:

''(1) LONG-TERM CARE SERVICES.—The term 'long-term care services' means nursing facility services, home health care services, and home and community-based services, and includes such other similar items and services described in section 1905(a) as a State may specify.

''(2) ATTRIBUTION RULES.—An individual's assets are considered to be 'attributable' to a qualified long-term care insurance contract to the extent specified under the State plan. Such a plan shall provide for at least one of the following:

''(A) All assets are considered attributable if the insurance contract provides coverage for at least a specified period of coverage (of not less than 3 years and of not more than 6 years) for long-term care services.

''(B) An amount of assets, up to the dollar limitation on benefits for long-term care services under the contract, is considered attributable to the contract.

''(d) LIMITATION.—In no case shall this section result in (1) the total Federal payments to the State for the quarter under this title (including payments attributable to this section), exceeding (2) the total Federal payments that the Secretary estimates would have been paid under this title to the State for the quarter if the State did not provide for the determination of eligibility in accordance with subsection (a).''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A))

is amended by inserting ''and section 1932'' after ''objectives of this title''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply (except as provided under paragraph (2)) to payments to States under title XIX of the Social Security Act for calendar quarters beginning on or after one year after the date of the enactment of this Act, without regard to whether regulations to implement such amendment are promulgated by such date.

(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the

date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle D—Studies

SEC. 3301. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOMEBOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 3302. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family

member to the extent such expenses exceed 5 percent of adjusted gross income.

SEC. 3303. CASE MANAGEMENT OF CURRENT LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility of encouraging or requiring the use of a single designated public or nonprofit agency (such as an area agency on aging) to coordinate, through case management, the provision of long-term care benefits under current Federal, State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Congress a report on the study conducted under subsection (a) by not later than 1 year after the date of the enactment of this Act. Such report shall include such recommendations regarding changes in legislation to encourage or require the use (described in subsection (a)) of an agency to coordinate long-term care benefits as may be appropriate.

Subtitle E—Volunteer Service Credit Demonstration Projects

SEC. 3401. AMENDMENT TO THE OLDER AMERICANS ACT OF 1965.

(a) IN GENERAL.—Part B of title IV of the Older Americans Act of 1965 (42 U.S.C. 3034–3035r) is amended by adding at the end the following:

"SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRATION PROJECTS.

''(a) REQUIREMENTS.—The Commissioner shall—

''(1) establish and operate (directly, or through the State agency on aging or one or more area agencies on aging) a volunteer service credit demonstration project in all or part of each State;

''(2) establish criteria for selecting individuals to whom volunteer services will be provided under volunteer service credit demonstration projects operated under paragraph (1);

''(3) recruit and train (directly or through State agencies on aging or area agencies on aging) individuals who volunteer to provide services through such projects;

''(4) establish a minimum standard for each service to be provided by volunteers through such projects;

''(5) monitor services provided by volunteers through such projects to ensure that standards established under paragraph (4) are met; and

''(6) maintain (directly or through State agencies on aging or area agencies on aging) with respect to each individual who provides services through a volunteer service credit demonstration project operated under paragraph (1) a separately identifiable account showing the number of hours such individual provided such services.

''(b) DEFINITION.—For purposes of subsection (a), the term 'volunteer service credit demonstration project' means a demonstration project through which homemaker services, respite care for families, adult day care, and educational, transportation, and home-delivery services are provided by—

''(1) volunteer older individuals for the benefit of older individuals or low-income children; or

''(2) volunteer individuals of any age for the benefit of older individuals;

in return for the receipt of similar services under any such demonstration project (that is established under this section) at a time at which such volunteers are older individuals in need of such services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 1995.

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