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104TH CONGRESS
1ST SESSION

H. R. 1234

To amend the Internal Revenue Code of 1986 to provide for reform of the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to enhance health care quality, to contain costs through market incentives and administrative reforms, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 14, 1995

Mr. THOMAS (for himself, Mrs. JOHNSON of Connecticut, Mr. MCCRERY, Mr. ENSIGN, Mr. CRANE, Mr. HOUGHTON, Mr. CASTLE, Mr. HOBSON, Mr. RIGGS, Mr. HORN, Mr. CLINGER, Mr. GREENWOOD, Mr. FRELINGHUYSEN, Mr. LAZIO of New York, Mr. BLUTE, Mr. LONGLEY, Mr. EHLERS, Ms. PRYCE, Mr. BASS, Mr. PORTMAN, Mr. KOLBE, Mrs. FOWLER, Mr. SHAYS, Mr. GOSS, Mr. ENGLISH of Pennsylvania, Mr. CALVERT, Mr. GUTKNECHT, and Mr. PACKARD) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, Economic and Educational Opportunities, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to provide for reform of the health insurance market, to promote the availability and continuity of health coverage, to remove financial barriers to access, to enhance health care quality, to contain costs through market incentives and administrative reforms, 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 ''Basic Health Care Reform Act of 1995''.

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

TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

Subtitle A—Insurance Reform

PART 1—ACCESS TO HEALTH COVERAGE

SEC. 1001. GUARANTEED OFFER BY CARRIERS.

(a) IN GENERAL.—Each carrier that offers health insurance coverage in the small group market in a fair rat-

ing area (as defined in section 1903) shall make available, to each small employer (covered in such market) in such fair rating area—

(1) qualified standard coverage consistent with section 1011(a), and

(2) subject to subsection (b), qualified high-deductible coverage consistent with section 1011(b).

(b) HIGH-DEDUCTIBLE COVERAGE.—

(1) EXCEPTION FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirement of subsection (a)(2) shall not apply with respect to 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.

(2) LIMITATION ON OFFER OF HIGH-DEDUCTIBLE COVERAGE.—Qualified high-deductible coverage may not be made available by a carrier to a small

employer with respect to an employee unless the carrier also makes available qualified standard coverage that has identical benefits (other than the amount of the deductible) and the employee demonstrates to the carrier that the employee has available assets (as defined by the Secretary) equal to at least the deductible amount established under section 1011(b)(2) applicable to the high-deductible coverage. A carrier may not make available to an employee health coverage (other than coverage for supplemental benefits) the actuarial value of which is less than the actuarial value of qualified high-deductible coverage, unless the employee has available assets (as defined by the Secretary) equal to at least the deductible amount of the coverage offered.

(3) OPTION TO OFFER MEDISAVE COVERAGE.—The offer of high-deductible coverage under subsection (a)(2) may be accompanied by the contribution by an employer to a medical savings account (in accordance with section 7705 of the Internal Revenue Code of 1986).

(c) COVERAGE OF ENTIRE RATING AREA.—

(1) IN GENERAL.—With respect to each fair rating area for which a carrier offers health insurance coverage, the carrier shall provide for coverage

of benefits for items and services furnished throughout the fair rating area.

(2) SPECIAL RULE FOR CARRIERS OFFERING COVERAGE IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier that offers qualified health insurance coverage in the small employer market in a portion of a State that is located in an interstate metropolitan statistical area, the carrier may not provide such coverage with respect to an employer in such metropolitan statistical area unless the carrier also offers such coverage in other portions of the area located in other States.

(3) SPECIAL RULE FOR COVERAGE THROUGH MANAGED CARE ARRANGEMENT.—In the case of coverage offered by a carrier or under a group health plan to the extent that it provides benefits through a managed care arrangement in a fair rating area, this subsection shall not be construed as requiring the establishment of facilities throughout the area, if the facilities are located consistent with section 1002(b)(1).

(d) FAMILY COVERAGE OPTION.—The offer of coverage under this section with respect to an employee shall include the option of coverage of family members of the employee.

(e) LIMITATION ON CARRIERS.—A carrier may not require an employer under a group health plan to impose through a waiting period for health coverage under a plan or similarly require a limitation or condition on health coverage or benefits based on—

(1) the health status of an individual,

(2) claims experience of an individual,

(3) receipt of health care by an individual,

(4) medical history of an individual, or

(5) receipt of public subsidies by an individual.

SEC. 1002. GUARANTEED ISSUE BY CARRIERS.

(a) IN GENERAL.—Subject to subsections (b) and (c) and section 1003, each carrier that offers health insurance coverage in the small group market in a fair rating area—

(1) must accept every small employer in the area that applies for such coverage during an enrollment period provided under section 1005; and

(2) must accept for enrollment under such coverage every qualifying individual (and family member of such an individual) who applies for enrollment during an enrollment period provided under section 1005 and may not place any restriction on the eligibility of an individual to enroll so long as such individual is a qualifying individual.

(b) SPECIAL RULES FOR MANAGED CARE ARRANGEMENTS.—In the case of coverage offered by a carrier or under a group health plan that provides benefits through a managed care arrangement in a fair rating area, the carrier or plan—

(1) need not establish facilities for the delivery of health care services throughout the area so long as such facilities are located in a manner that does not discriminate on the basis of health status of individuals residing in proximity to such facilities, and

(2) may deny such coverage in a fair rating area to employers if the organization demonstrates to the applicable regulatory authority that—

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

(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.

Coverage may be denied under paragraph (2) only if the denial is applied during a consecutive period of at least 180 days.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In addition to the authority provided under subsection (b)(2), in the case of coverage offered by any carrier, the carrier may deny coverage to a small employer if the carrier demonstrates to the applicable regulatory authority that—

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

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

Coverage may be denied under this subsection only if the denial is applied during a consecutive period of at least 180 days.

SEC. 1003. GUARANTEED RENEWAL.

(a) LIMITATION ON TERMINATION BY CARRIERS.—A carrier may not deny, cancel, or refuse to renew health coverage of an eligible employer within a type of coverage option described in section 1903(15) except—

(1) on the basis of nonpayment of premiums,

(2) on the basis of fraud or misrepresentation, or

(3) subject to subsection (b), in a fair rating area because the carrier is ceasing to provide any

health insurance coverage in the small group market within such type of coverage option in the area.

(b) LIMITATIONS ON MARKET EXIT BY CARRIERS.—

(1) NOTICE, ETC.—Subsection (a)(3) shall not apply to a carrier ceasing to provide health insurance coverage unless—

(A) such termination of coverage takes effect at the end of a contract year, and

(B) the carrier provides notice of such termination to employers and individuals covered at least 30 days before the date of an annual open enrollment period established with respect to the employer or individual under section 1005.

(2) LIMITATION ON REENTRY IN SMALL GROUP MARKET.—If a carrier ceases to offer or provide health insurance coverage in an area with respect to the small group market for a type of coverage option, the insurer may not offer health insurance coverage in the area in such market within such type of coverage option until 5 years after the date of the termination.

(c) RULE FOR MULTIEMPLOYER PLANS.—A multiemployer plan may not cancel coverage or deny renewal

of coverage under such a plan or arrangement with respect to an employer other than—

(1) for nonpayment of contributions,

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

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

SEC. 1004. RESTRICTING PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Except as provided in this section, a carrier or group health plan providing health coverage may not exclude health coverage with respect to services related to treatment of a condition based on the fact that the condition of an individual existed before the effective date of coverage of the individual.

(b) LIMITED 12-MONTH EXCLUSION PERMITTED.—

(1) IN GENERAL.—Subject to paragraph (2) and subsections (c) through (e), a carrier or group health plan providing health coverage may exclude health coverage with respect to services related to treatment of a condition of an individual based on the fact that the condition existed before the effective date of coverage of the individual only if the period of the exclusion does not exceed 12 months beginning on the date of coverage.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier or group health plan providing health coverage shall provide that if a covered individual is in a period of continuous coverage (as defined in subparagraph (C)) as of a date upon which coverage is initiated or reinitiated, any period of exclusion of coverage with respect to a preexisting condition (as defined in subparagraph (B)) for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) PREEXISTING CONDITION DEFINED.—In this paragraph, the term ''preexisting condition'' means, with respect to health coverage, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(C) PERIOD OF CONTINUOUS COVERAGE.—In this part, the term ''period of continuous coverage'' means the period beginning on the date an individual has health coverage (or coverage under a public plan providing medical benefits) and ends on the date the individual

does not have such coverage for a continuous period of more than 3 months (or 6 months in the case of an individual who loses coverage due to involuntary termination of employment, other than by reason of an employee's gross misconduct).

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—Any exclusion of coverage under subsection (b)(1) shall not apply if the exclusion relates to pregnancy.

(d) EXCLUSION NOT APPLICABLE TO NEWBORNS AND ADOPTED CHILDREN.—

(1) NEWBORNS.—Any exclusion of coverage under subsection (b)(1) shall not apply to a child who is covered at the time of birth and remains in a period of continuous coverage after such time.

(2) ADOPTED CHILDREN.—Any exclusion of coverage under subsection (b)(1) shall not apply (beginning on the date of adoption) to an adopted child who is covered at the time of adoption and remains in a period of continuous coverage after such time.

(e) EXCLUSION NOT APPLICABLE TO INDIVIDUALS ENROLLED OR ENROLLING DURING CERTAIN OPEN ENROLLMENT PERIODS.—

(1) INDIVIDUALS ENROLLING DURING PERIOD.—In the case of an individual who enrolls and

obtains coverage during an open enrollment period described in section 1005(b), any exclusion of coverage under subsection (b)(1) shall not apply so long as the individual remains in a period of continuous coverage.

(2) INDIVIDUALS ENROLLED AT BEGINNING OF PERIOD.—In the case of an individual who has health coverage as of the first day of the initial open enrollment period described in section 1005(b)(1), any exclusion of coverage under subsection (b)(1) shall not apply as of such date and so long as the individual is in a period of continuous coverage.

(f) 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 provisions of this part so long as such exclusion is applied consistent with the provisions of this part.

SEC. 1005. ENROLLMENT PERIODS.

(a) IN GENERAL.—Each carrier and each group health plan providing health coverage (and each health plan choice organization under subtitle B) in the small

group market shall permit qualifying individuals and eligible employers to obtain health coverage from the carrier or group health plan during each enrollment period provided under this section.

(b) OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS WAIVED.—

(1) INITIAL PERIOD.—There shall be an initial open enrollment period, with respect to individuals and employees who are residents of a State, during the 60-day period beginning on January 1, 1997.

(2) ENROLLMENT OF NEWBORNS AND NEWLY ADOPTED CHILDREN.—There shall be an open enrollment period with respect to a newborn child and a newly adopted child during the 30-day period beginning on the date of the birth or adoption of a child, if family coverage is available as of such date.

(c) ANNUAL OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS MAY APPLY.—

(1) IN GENERAL.—Each carrier and each group health plan providing health coverage (and each health plan choice organization under subtitle B) in the small group market shall provide for at least one annual open enrollment period (of not less than 30 days) each year. Such period shall be in addition to

the open enrollment periods described in subsection (b).

(2) COORDINATION.—Such annual open enrollment periods with respect to carriers in the small group market are subject to coordination by States.

(d) OTHER OPEN ENROLLMENT PERIODS FOR WHICH PREEXISTING CONDITION EXCLUSIONS MAY APPLY.—

(1) TERMINATION OF RESIDENCE AREA.—For each qualifying individual, at the time the individual terminates residence in the service area of coverage provided by a carrier to the individual, there shall be an open enrollment period (of not less than 30 days) during which the individual may enroll in health coverage.

(2) FAMILY OR EMPLOYMENT CHANGES.—In the case of a qualifying individual who—

(A) through divorce or death of a family member experiences a change in family composition, or

(B) experiences a change in employment status (including a significant change in the terms and conditions of employment or the terms and conditions of employment of a spouse),

there shall be an open enrollment period (of at least 30 days) in which the individual is permitted to change the individual or family basis of coverage or the health coverage in which the individual is enrolled. The circumstances under which such enrollment periods are required and the duration of such periods shall be specified by the Secretary.

(3) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—In the case of a qualifying individual who—

(A) had health coverage at the time of an individual's enrollment period,

(B) stated at the time of such period that having other health coverage was the reason for declining enrollment, and

(C) lost the other health coverage as a result of the termination of the coverage, termination or reduction of employment, or other reason, except termination at the option of the individual,

there shall be an open enrollment period during the 30-day period beginning on the date of termination of the other coverage.

(4) ENROLLMENT AT TIME OF MARRIAGE.—There shall be an open enrollment period with re-

spect to the spouse of an individual (including children of the spouse) during the 30-day period beginning on the date of the marriage, if family coverage is available as of such date.

(5) NO EFFECT ON COBRA CONTINUATION BENEFITS.—Nothing in this subsection shall be construed as affecting rights of individuals to continuation coverage under section 4980B of the Internal Revenue Code of 1986 or under similar provisions of law.

(e) PERIOD OF COVERAGE.—

(1) IN GENERAL.—In the case of a qualifying individual who enrolls under health coverage during an open enrollment period under this section, coverage shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the Secretary shall specify, consistent with this subsection.

(2) COVERAGE OF FAMILY MEMBERS.—In the case of an open enrollment period described in subsection (b)(2), (b)(3), or (d)(4), the Secretary shall provide for coverage of family members to begin as soon as possible on or after the date of the event that gives rise to the special enrollment period (or,

in the case of birth or adoption, as of the date of birth or adoption).

PART 2—PROVISION OF BENEFITS

SEC. 1011. GENERAL COVERAGE REQUIREMENTS.

(a) STANDARD COVERAGE.—For purposes of this title, health insurance coverage is considered to provide standard coverage consistent with this subsection if benefits under such coverage meet standards promulgated under section 1041 to carry out this subsection. In promulgating such standards to carry out this section, the NAIC and the Secretary shall take into account the following:

(1) CLASSES OF BENEFITS.—The classes of benefits (such as inpatient and outpatient hospital services and physicians services) typically included in health plans under the Federal Employees Health Benefits Program.

(2) ACTUARIAL VALUE.—The actuarial value of benefits included in benchmark coverage for the areas involved (adjusted to take into account a standardized population and standardized utilization and cost factors).

(3) PREVENTIVE BENEFITS.—The need to cover cost-effective preventive benefits (such as well-baby

and well-child care and childhood immunizations) without inappropriate cost sharing.

(b) HIGH-DEDUCTIBLE COVERAGE.—For purposes of this title, health insurance coverage is considered to provide high-deductible coverage consistent with this subsection if—

(1) benefits include the same type of benefits as provided for under standard coverage under subsection (a);

(2) the deductible amount is within a range of amounts established under such standards so that the actuarial value of high-deductible coverage is at least 20 percent (but not more than 40 percent) less than the actuarial value of standard coverage;

(3) benefits under the coverage in any year (other than preventive benefits as provided under the standards) are covered only to the extent expenses incurred for items and services included in the coverage for the year exceed the deductible amount specified in paragraph (2); and

(4) the actuarial value of the coverage (as determined under rules established under such standards) is equivalent to a percentage (specified in such standards and not less than 60 percent and not

more than 80 percent) of an actuarial value for standard coverage.

(c) RULES REGARDING OFFERING OF SUPPLEMENTAL BENEFITS.—A carrier or group health plan offering qualified health coverage may offer coverage of items and services only in addition to the qualified standard coverage offered (whether in the form of coverage of additional items and services or a reduction in cost sharing) and only if—

(1) such supplemental coverage is offered and priced separately from the standard coverage offered and is only made available to individuals who obtain qualified standard coverage through the carrier or plan;

(2) the purchase of the qualified health coverage is not conditioned upon the purchase of such supplemental coverage; and

(3) in the case of supplemental coverage that consists of a reduction in the cost-sharing otherwise applicable, the premium for the supplemental coverage takes into account any expected increase in utilization of items and services included in the qualified health coverage resulting from obtaining the supplemental coverage.

(d) MODEL BENEFIT PACKAGES.—The standards established to carry out this section may provide for model benefit packages that will be considered to meet applicable requirements for standard coverage or high-deductible coverage, and which shall include model cost sharing arrangements for fee-for-service options, managed care options, and point-of-service options.

(e) FLEXIBILITY IN BENEFITS.—Nothing in this section (or section 1103) may be construed—

(1) to require the coverage of any specific procedure or treatment or class of service in health coverage under this Act or through regulation;

(2) as requiring coverage to include benefits for items and services that are not medically necessary or appropriate;

(3) as limiting the benefits that may be offered as part of a group health plan or health insurance coverage; and

(4) to require or prohibit the use of a particular class of provider, among the providers that are legally authorized to provide such treatment.

SEC. 1012. STANDARDS FOR MANAGED CARE ARRANGEMENTS.

(a) APPLICATION OF REQUIREMENTS.—Each group health plan, and each carrier providing health insurance

coverage, that provides for health care through a managed care arrangement (as defined in section 1903(12)(A)) shall comply with the applicable requirements of this section.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) ACCESS TO CARE.—The entity providing for a managed care arrangement with respect to health coverage shall enter into such agreements with health care providers (including primary and specialty providers) 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 manner that assures the continuity of the provision of such items and services.

(2) ACCESS TO SPECIALIZED TREATMENT.—The entity providing for a managed care arrangement under health coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise.

(3) CHOICE OF PERSONAL PHYSICIAN.—The entity providing for a managed care arrangement under health coverage shall permit each enrollee to choose a personal physician from among available participating physicians and change that selection as appropriate.

(c) PROVISION OF EMERGENCY CARE SERVICES.—The entity providing for a managed care arrangement under health coverage must cover medically necessary emergency care services provided to covered individuals 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.

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

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—The entity providing for a managed care arrangement under health coverage shall establish standards (including criteria for quality, efficiency, credentialing, and services) to be used by the entity for contracting with health care providers

with respect to the entity's provider network. Such standards shall be established in consultation with providers who are members of the network.

(2) TERMINATION PROCESS.—The entity may not terminate or refuse to renew a participation agreement with a provider in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or 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).

(3) REVIEW PROCESS.—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.

(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 or an entity providing for a managed care arrangement.

SEC. 1013. UTILIZATION REVIEW.

(a) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for uti-

lization 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.

(b) REQUIRING REVIEW TO MEET STANDARDS.—A group health plan or carrier 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.

(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, including upon request a review conducted by the med-

ical director of the carrier or plan or a physician designated by the carrier or plan;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on 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 1103.

SEC. 1014. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Chapter 79 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

''(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

''(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

''(A) it is in cash, and

''(B) such individual is a qualifying employee for the period for which such contribution is made.

''(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

''(3) No part of the trust funds will be invested in life insurance contracts.

''(4) The interest of an individual in the balance of the account is nonforfeitable.

''(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible employee' means any employee who has high-deductible coverage (as defined in section 1011(b) of the Basic Health Care Reform Act of 1995) offered by the employer.

''(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if, for any month during such year, it is reasonably expected that such employee—

''(A) will have adjusted gross income that is less than 100 percent of the income official poverty line (as determined by the Director of the Office of Management and Budget) for a family of the size involved; or

''(B) is an AFDC recipient or SSI recipient.

''(3) DEFINITIONS.—For purposes of paragraph (2)—

''(A) AFDC RECIPIENT.—The term 'AFDC recipient' means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

''(B) SSI RECIPIENT.—The term 'SSI recipient' means, for a month, an individual—

''(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

''(ii) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

''(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

''(iv) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

''(c) TAX TREATMENT OF ACCOUNTS.—

''(1) ACCOUNT TAXED AS GRANTOR TRUST.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

''(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such 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, subsection (d) shall be applied as if—

''(i) 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

''(ii) no portion of such distribution were used to pay qualified medical expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or dependents (as defined in section 152) of such beneficiary shall be included in the gross income of such beneficiary

to the extent such amount does not exceed the excess of—

''(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(2), over

''(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

''(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any

taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

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

''(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the ben-

efit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

''(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

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

''(1) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means any amounts paid dur-

ing the taxable year, not compensated for by insurance or otherwise, for medical care (as defined in section 213(d)) of the taxpayer, his spouse, or a dependent (as defined in section 152).

''(B) LONG-TERM CARE INSURANCE.—Such term includes premiums paid during the taxable year for any long-term care insurance contract for the benefit of the individual or such individual's spouse.

''(C) LONG-TERM CARE INSURANCE CONTRACT.—For purposes of subparagraph (B), the term 'long-term care insurance contract' means any insurance contract issued if—

''(i) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage (as defined under regulations prescribed by the Secretary),

''(ii) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

''(iii) 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,

''(iv) such contract is guaranteed renewable,

''(v) such contract does not have any cash surrender value, and

''(vi) 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) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

''(f) 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)), insurance company (as defined in section 816), 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 (a).

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.

''(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary 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 such regulations.''

(b) INCOME AND EMPLOYMENT TAX TREATMENT OF EMPLOYER CONTRIBUTIONS.—

(1) EMPLOYER PAYMENTS EXCLUDED FROM GROSS INCOME.—The text of section 106 of such Code is amended to read as follows:

''Gross income of an employee does not include—

''(1) employer-provided coverage under an accident or health plan, and

''(2) employer contributions to any medical savings account (as defined in section 7705) of an eligible employee, but only to the extent that the amount contributed does not exceed the excess of premium for standard coverage over the premium for high-deductible coverage (as such terms are defined in section 1903 of the Basic Health Care Reform Act of 1995).''

(2) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(A) SOCIAL SECURITY TAXES.—

(i) 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting ''; or'', and by inserting after paragraph (19) the following new paragraph:

''(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2) of the Internal Revenue Code of 1986.''

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(C) 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(D) 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) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2).''

(c) TECHNICAL AMENDMENTS.—

(1) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

(A) 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 7705) 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 medical savings account by reason of the application of section 7705(c)(2)(A) to such account.'', and

(B) by inserting ''or a medical savings account described in section 7705'' in subsection (e)(1) after ''described in section 408(a)''.

(2) 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—

(A) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(B) by adding at the end of subsection (a) the following: ''The person required by section

7705(g) 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.''

(3) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 79 of such Code is amended by adding at the end the following:

''Sec. 7705. Medical savings accounts.''

(B) 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.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

PART 3—FAIR RATING PRACTICES

SEC. 1021. USE OF FAIR RATING PRACTICES.

(a) USE OF FAIR RATING PRACTICES.—The premium rate established by a carrier for health insurance coverage in the small group market may not vary except by the following:

(1) AGE.—By age, based on classes of age established by the Secretary, in consultation with the NAIC, consistent with subsection (b).

(2) GEOGRAPHIC AREA.—By geographic area, as identified by a State consistent with subsection (c).

(3) FAMILY CLASS.—By family class, based on the following 4 classes of family coverage: individual, individual with one or more children, married couple without a child, and married couple with one or more children.

(4) BENEFIT DESIGN.—By benefit design of coverage, including by type of coverage, such as standard coverage and high-deductible coverage, and by type of coverage option (described in section 1903(15)) with respect to standard coverage.

(5) ADMINISTRATIVE CATEGORIES.—By permitted expense category, based on differences in expenses among such categories, consistent with subsection (d).

The premiums shall be established for the different benefit designs (including standard coverage and high-deductible coverage) based on the actuarial value of the coverage for the population of the small group market in the fair rating

area, without regard to the distribution of such population among the types of coverage or type of coverage options.

(b) LIMITATION ON VARIATION BY AGE.—

(1) IN GENERAL.—Any variation in premium rates by age under subsection (a)(1) for age classes of individuals under 65 years of age may not result in the ratio of the highest age rate to the lowest age rate exceeding the limiting ratio described in paragraph (2).

(2) LIMITING RATIO.—For purposes of paragraph (1), the limiting ratio described in this paragraph is—

(A) 4-to-1, for premiums for months in 1997,

(B) 3.67-to-1, for premiums for months in 1998,

(C) 3.33-to-1, for premiums for months in 1999, and

(D) 3-to-1, for premiums for months in 2000 and any succeeding year.

(3) SEPARATE AGE CLASSES FOR INDIVIDUALS 65 YEARS OF AGE OR OLDER.—The Secretary shall establish one or more separate age classes for individuals 65 years of age or older.

(4) PREEMPTION.—For preemption of State laws relating to establishment of premium rates, see section 1204.

(c) GEOGRAPHIC AREA VARIATIONS.—For purposes of subsection (a)(2), a State—

(1) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area,

(2) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered, and

(3) may, upon agreement with one or more adjacent States, identify multi-state geographic areas consistent with paragraphs (1) and (2).

(d) ADMINISTRATIVE VARIATIONS.—

(1) EXPENSE CATEGORIES.—Expense categories shall be established under subsection (a)(5) by a carrier in a manner that only reflects differences based on marketing, commissions, and similar expenses. Such categories shall take into account health plan choice organizations.

(2) LIMITATION ON VARIATIONS.—The variation provided among expense categories under subsection (a)(5) may not result in a premium for the

highest expense category exceeding 120 percent of the premium for the lowest expense category.

(e) PREMIUM RATING IN GROUP HEALTH PLANS.—The premium rate established under a group health plan for health insurance coverage may not vary within a benefit design except by the factors described in subsection (a) and subject to the limitation specified in subsection (b).

(f) ACTUARIAL CERTIFICATION.—Each carrier that offers health insurance coverage 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 carrier and methods used by the carrier in establishing premium rates for applicable health insurance coverage—

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

(2) the rating methods are actuarially sound.

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

(g) CONSTRUCTION.—The provisions of this section shall apply to premium rates based on the fair rating area

in which the covered individual or employee resides to reflect the population in the small group market.

SEC. 1022. ESTABLISHMENT OF RISK ADJUSTMENT MECHANISMS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) DEVELOPMENT OF MODELS.—

(A) IN GENERAL.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act and in consultation with the American Academy of Actuaries, a model risk adjustment system composed of one or more risk adjustment mechanisms under which premiums applicable to health insurance coverage in the small group market would be adjusted to take into account such factors as may be appropriate to predict the future need and the efficient use of services by covered individuals in the market. Such factors may include the age, gender, geographic residence, health status, or other demographic characteristics of individuals enrolled in such plans and shall include consideration of enrollment of a disproportionate share of individuals who enroll during the initial open enrollment period under section 1005(b)(1).

(B) PROMULGATION AS PROPOSED RULE.—If the NAIC develops such model within such period, the Secretary shall publish the model as a proposed rule under section 553 of title 5, United States Code. If the NAIC has not developed such model within such period, the Secretary shall publish (not later than 60 days after the end of such period) a proposed rule that specifies a proposed model that provides for effective risk adjustment mechanisms.

(2) RULE MAKING PROCESS.—The Secretary shall provide for a period (described in section 553(c) of title 5, United States Code) of not less than 30 days for public comment on a proposed rule published under paragraph (1)(B). The Secretary shall publish a final rule, by not later than July 1, 1996, that specifies risk adjustment mechanisms that the Secretary finds are effective for purposes of carrying out this section. Such rule shall include models developed by the NAIC if the Secretary finds that such models provide for effective risk adjustment mechanisms.

(3) MODIFICATION.—The Secretary, at the request of the NAIC or otherwise, may by regulation

modify the model risk adjustment system established under this subsection.

(b) IMPLEMENTATION OF RISK ADJUSTMENT SYSTEM.—Each State shall establish and maintain a risk adjustment system that conforms with the model established under this section by not later than January 1, 1997. A State may establish and maintain such a system jointly with one or more other States.

PART 4—CONSUMER PROTECTIONS

SEC. 1031. REQUIREMENT FOR PROVISION OF INFORMATION.

(a) CARRIERS.—

(1) IN GENERAL.—Each carrier that offers health insurance coverage to small employers (or qualifying employees of small employers) must disclose to such prospective enrollees, to brokers, and to health plan choice organizations the information that the Secretary may specify relating to the performance of the carrier in providing such coverage and relating to differences between the coverage provided and the most similar model benefit package established under section 1104(b)(2). If a carrier offers to employers coverage the actuarial value of which is more than the actuarial value for high-deductible coverage but less than such value for stand-

ard coverage, the carrier must disclose to such employers detailed information on how the coverage offered compares to any standard and high-deductible coverage offered by the carrier to such employers.

(2) MARKETING MATERIAL.—Each carrier that provides any health insurance coverage 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 1041.

(b) GROUP HEALTH PLANS.—Each group health plan that provides health coverage must disclose to enrollees and potential enrollees information, similar to the information described in subsection (a), relating to performance of the plan in providing such coverage and relating to differences between the coverage provided and the most similar model benefit package established under section 1104(b)(2).

(c) INFORMATION RELATING TO RISK ADJUSTMENT.—Each carrier or group health plan providing coverage in the small group market shall provide to the State such information as the State may require in order to

carry out section 1022 (relating to risk adjustment mechanisms).

SEC. 1032. PROHIBITION OF IMPROPER INCENTIVES.

(a) LIMITATION ON FINANCIAL INCENTIVES.—No carrier that provides 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) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of health insurance coverage because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No carrier 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. 1033. WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES.

A carrier and a group health plan offering health coverage shall meet the requirements of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respecting advance directives), insofar as such requirements would apply to the carrier or plan if the carrier or plan were an eligible organization.

PART 5—STANDARDS AND CERTIFICATION; ENFORCEMENT; PREEMPTION; GENERAL PROVISIONS

SEC. 1041. ESTABLISHMENT OF STANDARDS.

(a) ROLE OF NAIC.—

(1) IN GENERAL.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to the requirements of this subtitle as applicable to carriers and health insurance coverage.

(2) REVIEW OF STANDARDS.—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 re-

quirements, such standards shall serve as the standards under this subtitle, with such amendments as the Secretary deems necessary.

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

SEC. 1042. APPLICATION OF STANDARDS TO CARRIERS THROUGH STATES.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on steps the State is taking to implement and enforce the standards established under section 1041 with respect to carriers and health insurance coverage offered or renewed not later than such deadline.

(2) DEADLINE FOR REPORT.—The deadline under this paragraph is 1 year after the date the standards are established under section 1041.

(b) FEDERAL ROLE.—

(1) NOTICE OF DEFICIENCY.—If the Secretary determines that a State has failed to submit a report by the deadline specified under subsection (a)(2) or finds that the State has not implemented and provided adequate enforcement of the standards established under section 1041, 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.

(2) IMPLEMENTATION OF ALTERNATIVE.—

(A) IN GENERAL.—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.

(B) EFFECTIVE PERIOD.—Such implementation and enforcement shall take effect with respect to carriers, and health insurance coverage offered or renewed, on or after 3 months after the date of the Secretary's finding under subparagraph (A), and until the date the Secretary finds that such a failure has been corrected.

SEC. 1043. APPLICATION TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), sections 1041 and 1042 shall apply to group health plans providing health coverage in the same manner as they apply to carriers providing health insurance coverage.

(b) SUBSTITUTION OF REFERENCES.—For purposes of subsection (a), any reference in section 1041 or 1042 to—

(1) a State is deemed a reference to the Secretary, and

(2) a carrier or health insurance coverage is deemed a reference to a group health plan and health coverage, respectively.

SEC. 1044. ENFORCEMENT.

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

"SEC. 4980C. FAILURE OF CARRIER OR GROUP HEALTH PLANS TO COMPLY WITH STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a carrier or group health plan to comply with the requirements applicable to the carrier or group health plan under parts 1 through

4 of subtitle A of title I of the Basic Health Care Reform Act of 1995.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a carrier 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 a carrier.

''(b) AMOUNT OF TAX.—

''(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 a carrier 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 TAX.—The tax imposed by this section shall be paid by the carrier or administrator of the group health plan (as the case may be).

''(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 carrier or administrator of the group health plan 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', 'group health plan', and 'carrier' have the respective meanings given such terms in section 1903 of the Basic Health Care Reform Act of 1995.''

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

''Sec. 4980C. Failure of carrier or group health plans to comply with standards.''

SEC. 1045. LIMITATION ON SELF INSURANCE FOR CERTAIN EMPLOYER PLANS.

(a) IN GENERAL.—An employer plan (other than a multiemployer plan, as defined in section 414(f) of the Internal Revenue Code of 1986) may not offer health coverage other than through a carrier unless the plan has at least 50 qualifying employees.

(b) EXCEPTION.—Subsection (a) shall not apply to an employer plan that offers health coverage through a multiple employer welfare arrangement if the arrangement covers at least 1,000 qualifying employees and meets solvency standards established by the State.

PART 6—MARKETPLACE FOR INDIVIDUALS

SEC. 1051. APPLICATION OF SIMILAR REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (b), the provisions of this subtitle shall apply to carriers offering health insurance coverage to qualifying individuals in the individual market (as defined in section 1903(11)) in the same manner as such provisions apply to carriers offering health insurance coverage to employers. For purposes of this subsection, any reference to an employee or a qualifying employee is deemed a reference to such an individual.

(b) EXCEPTION FOR RISK ADJUSTMENT.—Section 1022 (relating to risk adjustment systems) shall be ap-

plied under this part in a manner that is separate from its application under part 3.

Subtitle B—Facilitating Establishment of Health Plan Choice Organizations (HPCOs)

SEC. 1101. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Health plan choice organizations (each in this part referred to as a ''choice organization'') may be established in accordance with this part. Each choice organization shall be chartered under State law and operated as a not-for-profit corporation. A carrier may not form, underwrite, or possess a majority vote of a choice organization, but may administer such an organization.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each choice organization 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 organization in accordance with paragraph (3). Such Board shall be composed as follows:

(A) In the case of a choice organization offering coverage in the small group market, the Board shall be composed of small employers (or representatives of small employers) and qualify-

ing employees of small employers (or representatives of such employees) in the area in which the organization operates.

(B) In the case of a choice organization offering coverage in the individual market, the Board shall be composed of qualifying individuals in the area in which the organization operates.

(C) In the case of a choice organization offering coverage in both the small group market and the individual market, the Board shall be composed of individuals described in subparagraph (A) and individuals described in subparagraph (B).

(2) MEMBERSHIP.—For each market for which a choice organization offers coverage, the choice organization shall accept all small employers, qualifying employees, and qualifying individuals who are in the market within the area served by the organization as members if such employers, employees, or individuals request such membership.

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

(c) DUTIES OF CHOICE ORGANIZATIONS.—

(1) IN GENERAL.—Subject to paragraph (2), each choice organization shall—

(A) market health insurance coverage in the small group market, the individual market, or in both the small group market and the individual market throughout the entire area served by the organization;

(B) enter into agreements under section 1102 with carriers offering qualified health coverage under this subtitle;

(C) provide information and enter into agreements under section 1103;

(D) enroll individuals with carriers offering qualified health coverage, only in accordance with section 1104;

(E) disseminate quality information under section 4002; and

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

(2) LIMITATION ON ACTIVITIES.—A choice organization 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 carriers (and health coverage provided by carriers) with the requirements of subtitle A;

(C) assume financial risk in relation to any such carrier; 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) IN GENERAL.—A choice organization need not serve geographic areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established under section 1021 for fair rating areas.

(B) SERVICE OF ENTIRE METROPOLITAN STATISTICAL AREA.—If a choice organization serves a part of a metropolitan statistical area the organization shall serve the entire area.

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

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

(2) that there be only one choice organization established with respect to any area.

SEC. 1102. AGREEMENTS TO OFFER QUALIFIED HEALTH COVERAGE.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each choice organization for an area shall enter into an agreement under this section—

(A) with each carrier that desires to make available qualified health coverage in the small group market through the choice organization (consistent with any procedures established by the State);

(B) with each carrier that desires to make available qualified health coverage in the individual market through the choice organization (consistent with any procedures established by the State); or

(C) with each carrier described in subparagraph (A) or subparagraph (B).

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the choice organization may terminate an agreement under paragraph (1) if the carrier's license or certification under

State law is terminated or for other good cause shown.

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

(1) IN GENERAL.—Under an agreement under this section between a choice organization and a carrier—

(A) premiums shall be payable, and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the choice organization for the benefit of the carrier.

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

(3) CARRIERS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a choice organization any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the choice organization administrative fee under sec-

tion 1105). Each small employer and qualifying individual who enrolls with a carrier providing qualified health coverage through the choice organization is liable to the carrier for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments for qualified health coverage are made to the choice organization, the choice organization shall forward to the carrier the amount of the premiums.

(2) PAYMENTS.—Payments shall be made by the choice organization 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 qualifying employee or the qualifying individual, as the case may be.

(d) PAYMENT OF COMMISSIONS.—

(1) IN GENERAL.—Subject to paragraph (2), nothing in this part shall be construed to preclude a carrier from paying a commission or other remuneration in connection with the purchase of health care coverage by individuals or groups, consistent with State law.

(2) LIMITATION ON VARIATION.—A carrier may not vary such compensation or remuneration based,

directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals purchasing health care coverage.

SEC. 1103. PROVISION OF INFORMATION.

Each choice organization for an area shall make available to small employers that employ individuals in the area and to qualifying individuals who reside in the area—

(1) information provided to the choice organization by the State or carriers, and

(2) the opportunity to enter into an agreement with the organization for the purchase of qualified health coverage (to the extent that the organization offers coverage in the market through which the employer or individual seeks coverage).

SEC. 1104. ENROLLING INDIVIDUALS FOR QUALIFIED HEALTH COVERAGE THROUGH A CHOICE ORGANIZATION.

A choice organization shall offer, on behalf of each carrier with which an agreement was entered into under section 1102 and in accordance with the enrollment procedures of such carriers and the enrollment periods provided under section 1005, enrollment for the coverage only to individuals in the market through which the organization offers coverage in the area served by the choice organization. Each choice organization shall coordinate annual

open enrollment periods (described in section 1005(c)) of all carriers through which coverage is offered by the organization so that there is one common annual open enrollment period for all such carriers with respect to each individual enrolled for coverage through the organization. Nothing in this section shall preclude a choice organization from having different common annual open enrollment periods for different individuals.

SEC. 1105. RESTRICTION ON CHARGES.

(a) IN GENERAL.—A choice organization may impose an administrative fee with respect to a qualifying employee or qualifying individual enrolled for qualified health coverage offered through the choice organization.

(b) FEE.—A choice organization that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for each such coverage option, is imposed uniformly with respect to all coverage options offered through the organization, and is disclosed explicitly as an addition to the premium.

Subtitle C—Preemption of State Benefit Mandates and Anti-Managed Care Laws

SEC. 1201. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1997, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of health insurance coverage, of any services, category of care, or services of any class or type of provider; or

(2) specifies the individuals to be provided health insurance coverage or the duration of such coverage.

SEC. 1202. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1997—

(1) a State may not prohibit or limit a carrier or group health plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such a carrier or plan from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(4) a State may not prohibit or limit such a carrier or plan from limiting the number of participating providers;

(5) a State may not prohibit or limit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

(6) a State may not prohibit or limit the corporate practice of medicine.

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term ''managed care coverage'' means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in section 1903(12)(A)) that meets the applicable requirements of such section.

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services as part of a provider network (as defined in section 1903(12)(B)).

(c) REFERENCE TO STANDARDS FOR MANAGED CARE ARRANGEMENTS.—For requirements relating to managed care arrangements, see section 1011.

SEC. 1203. PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—Effective January 1, 1997, no State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in subsection (b)).

(b) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term ''utilization review program'' means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(c) EXEMPTION OF LAWS PREVENTING DENIAL OF LIFESAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this subtitle shall be construed to invalidate any State law that has the effect of preventing involuntary denial of life-preserving medical treatment when such denial would cause the involuntary death of the patient pending transfer of the patient to a health care provider willing to provide such treatment.

SEC. 1204. PREEMPTION RELATING TO DIFFERENT INSURANCE STANDARDS.

A State may not establish or enforce standards for health insurance coverage made available in the individual and small group markets that are different from the standards established under this title.

Subtitle D—Definitions; General Provisions

SEC. 1901. GENERAL DEFINITIONS.

For purposes of this Act:

(1) APPLICABLE REGULATORY AUTHORITY.—The term ''applicable regulatory authority'' means, with respect to a carrier operating in a State—

(A) the State insurance commissioner, or

(B) the Secretary, in the case described in section 1042(b)(2).

(2) FAMILY MEMBER.—

(A) IN GENERAL.—Individuals are considered to be members of a family if—

(i) they are married, or

(ii) they have a legal parent-to-child relationship (whether by natural birth or adoption), if the child is—

(I) under 19 years of age,

(II) is under 25 years of age and a full-time student, or

(III) an unmarried dependent regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22.

(B) SPECIAL RULES.—Family members—

(i) include an adopted child and a recognized natural child;

(ii) include a stepchild or foster child with respect to an individual but only if the child lives with the individual in a regular parent-child relationship; and

(iii) include such other children as the Secretary may specify, but shall not include an emancipated minor.

(3) PRISONER.—The term ''prisoner'' means, as specified by the Secretary, an individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

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

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

SEC. 1902. DEFINITIONS RELATING TO EMPLOYMENT.

For purposes of this title:

(1) COUNTABLE EMPLOYEE.—The term ''countable employee'' means, with respect to an employer for a month, any employee other than an employee whose normal work week is less than 10 hours.

(2) EMPLOYEE.—The term ''employee'' means any individual employed by an employer.

(3) EMPLOYER.—The term ''employer'' means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(4) LARGE EMPLOYER.—The term ''large employer'' means an employer that is not a small employer (as defined in paragraph (4)).

(5) MULTIEMPLOYER PLAN.—The term ''multiemployer plan'' has the meaning given such term in section 414(f) of the Internal Revenue Code of 1986.

(6) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—The term ''qualifying employee'' means, with respect to an employer for a month, any employee other than—

(i) a part-time, seasonal, or temporary employee (as defined in subparagraph (B)); or

(ii) an employee who is a child described in section 1901(2)(A)(ii).

(B) PART-TIME, SEASONAL, OR TEMPORARY EMPLOYEE DEFINED.—For purposes of subparagraph (A), the term ''part-time, seasonal, or temporary employee'' means any of the following employees with respect to a month:

(i) CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the first day of such month to be less than 20 hours.

(ii) SEASONAL OR TEMPORARY EMPLOYEES.—Any employee who is not reasonably expected as of the first day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such first day.

(iii) DELAY FOR CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal

work week is reasonably expected as of the first day of such month to be at least 20 hours, but less than 35 hours, and the normal work week of the employee during the preceding 3 months was less than 20 hours.

(7) 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 countable 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.

SEC. 1903. DEFINITIONS RELATING TO HEALTH COVERAGE, PLANS, AND CARRIERS.

Except as otherwise provided, for purposes of this Act:

(1) 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 1995.

(2) CARRIER.—The term ''carrier'' means a licensed insurance company, an entity offering prepaid hospital or medical services, and a health maintenance organization, and includes a similar organization regulated under State law for solvency.

(3) CLASS OF FAMILY COVERAGE.—The term ''class of family coverage'' means the 4 classes described in section 1021(a)(3).

(4) FAIR RATING AREA.—The term ''fair rating area'' means a geographic area identified by a State for purposes of section 1021(a)(2).

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, but does not include any type of coverage excluded from the definition of a health insurance coverage under paragraph (8)(B).

(6) HEALTH COVERAGE.—The term ''health coverage'' means health insurance coverage provided by a carrier or medical care provided under a group health plan.

(7) 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 a carrier.

(B) EXCEPTION.—Such term does not include any of the following (or any combination 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) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as defined in standards established under section 1103, an organization that provides health benefits coverage which meets specified standards and provides (or arranges for the provision of) covered health benefits primarily through a defined set of providers.

(9) HEALTH PLAN CHOICE ORGANIZATION.—The term ''health plan choice organization'' means an organization established under subtitle E.

(10) HIGH DEDUCTIBLE COVERAGE.—The term ''high deductible coverage'' means coverage provided consistent with section 1011(b).

(11) INDIVIDUAL MARKET.—The term ''individual market'' means the insurance market offered to individuals seeking health insurance coverage on behalf of themselves (and their dependents) insofar as no employer is seeking such coverage on behalf of the individual.

(12) MANAGED CARE ARRANGEMENTS.—

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

(13) 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.

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

(15) OPTIONS.—Each of the following is a ''type of coverage option'' in relation to standard coverage:

(A) FEE-FOR-SERVICE OPTION.—Standard coverage is considered to provide a ''fee-for-

service option'' if, regardless of whether covered individuals may receive benefits through a provider network, 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 and payment is made to such a provider whether or not there is a contractual arrangement between the provider and the carrier or plan.

(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 provider network, except in the case of emergency 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.

(16) QUALIFIED HEALTH COVERAGE.—The term ''qualified health coverage'' means health coverage that—

(1) provides standard coverage or high-deductible coverage, and

(2) meets other requirements of subtitle A applicable to the coverage and the carrier or group health plan providing the coverage.

(17) SMALL GROUP MARKET.—The term ''small group market'' means the insurance market offered to small employers seeking health insurance coverage on behalf of their employees (and their dependents), regardless of whether or not such coverage is made available directly or through a multiple employer welfare arrangement, association, or otherwise.

(18) STANDARD COVERAGE.—The term ''standard coverage'' means coverage provided consistent with section 1011(a).

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

SEC. 1904. DEFINITIONS RELATING TO RESIDENCE AND IMMIGRATION STATUS.

Except as otherwise provided, for purposes of this Act:

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term ''alien permanently residing in the United States under color of law'' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following (such status not having changed):

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien whose deportation is suspended pursuant to section 244 of such Act.

(E) An alien who is granted conditional entry pursuant to section 203(a)(7) of such Act as in effect before April 1, 1980.

(F) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(G) An alien who is within a class of aliens lawfully present in the United States pursuant to any other provision of such Act, if (i) the Attorney General determines that the continued presence of such class of aliens serves a humanitarian or other compelling public interest, and (ii) the Secretary determines that such interest would be further served by treating each such alien within such class as a ''legal permanent resident'' for purposes of this Act or who has been granted extended voluntary departure as a member of a nationality group.

(H) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(I) An alien within such other classification of permanent resident aliens as the Secretary may establish by regulation.

(2) LONG-TERM NONIMMIGRANT.—The term ''long-term nonimmigrant'' means a nonimmigrant described in subparagraph (E), (H), (I), (K), (L), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act.

(3) QUALIFYING INDIVIDUAL.—The term ''qualifying individual'' means, an individual who is a resident of the United States, who is not a prisoner, and is—

(A) a citizen or national of the United States;

(B) an alien permanently residing in the United States under color of law (as defined in paragraph (1)); or

(C) a long-term nonimmigrant (as defined in paragraph (2)).

SEC. 1905. EFFECTIVE DATES.

The requirements of this title shall apply with respect to—

(1) group health plans for plan years beginning on or after January 1, 1997, and

(2) carriers (with respect to coverage other than under a group health plan) as of January 1, 1997.

TITLE II—ADMINISTRATIVE SIMPLIFICATION

SEC. 2000. PURPOSE.

It is the purpose of this title 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. 2001. DEFINITIONS.

For purposes of this title:

(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) 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.

(4) 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 title.

(5) 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 title, 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 security organization.

(6) HEALTH INFORMATION SECURITY ORGANIZATION.—The term ''health information security organization'' 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.

(7) 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 per-

son (other than a plan sponsor) furnishing health care items or services.

(8) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' means health information in the health information network—

(A) that identifies an individual who is the subject of the information; or

(B) with respect to which there is a reasonable basis to believe that the information can be used to identify such an individual.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not individually identifiable health information.

(10) PLAN SPONSOR.—The term ''plan sponsor'' means—

(A) a carrier (as defined in section 1903(2)) providing health insurance coverage (as defined in section 1903(7));

(B) a group health plan;

(C) an association or other entity which establishes or maintains a multiple employer welfare arrangement (as defined in section 1903(13)) providing benefits consisting of medi-

cal care described in section 213(d) of the Internal Revenue Code of 1986; and

(D) 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 a carrier.

(11) 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 subtitle A that applies to the transaction or data elements.

Subtitle A—Standards for Data Elements and Transactions

SEC. 2101. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle 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 subtitle.

(c) PROTECTION OF COMMERCIAL INFORMATION.—In adopting standards under this subtitle, the Secretary may not require disclosure of trade secrets and confidential commercial information by any person.

SEC. 2102. 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 2201.

(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. 2103. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards that are consistent with the health information network privacy standards adopted under section 2104 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 subsection (a) 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 2201 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. 2104. HEALTH INFORMATION NETWORK PRIVACY STANDARDS.

The Secretary shall adopt standards respecting the privacy of individually identifiable health information that is in the health information network. Such standards shall include standards concerning at least the following:

(1) The rights of an individual who is the subject of such information.

(2) The procedures to be established for the exercise of such rights.

(3) The uses and disclosures of such information that are authorized or required.

(4) Safeguards for the security of such information and adequate security practices.

SEC. 2105. 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 2102(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 adopt-

ed 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 PRIVACY STANDARDS.—The Secretary shall adopt standards relating to the privacy of individually identifiable health information in the health information network under section 2104 not later than 12 months after the date of the enactment of this Act.

(c) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 2103 not later than 18 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).

(d) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subtitle 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 health plan choice organization that is required to comply with subtitle 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 subtitle 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 sponsor, a health provider, or a health plan choice organization to comply with subtitle 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 con-

verted 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 health plan choice organization that is required to comply with subtitle B.

(e) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subtitle. Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

Subtitle B—Requirements with Respect to Certain Transactions and Information

SEC. 2201. 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 transaction 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 a provider network.

(b) TRANSACTIONS BY CHOICE ORGANIZATIONS.—

(1) IN GENERAL.—If a health plan choice organization 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 organization to the sponsor or by the sponsor to the organization 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 health plan choice organization 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 2301 pursuant to which the service under-

takes the duties applicable to the sponsor, provider, or organization under the provision.

SEC. 2202. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

(a) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

(1) IN GENERAL.—A health information security organization that is certified under section 2301 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 individually identifiable 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 subtitle 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 security organization requires health information consisting of data elements that are subject to a standard under subtitle

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 SECURITY ORGANIZATIONS.—A health information security organization 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 security organization that—

(A) is certified under section 2301; and

(B) requests the information.

SEC. 2203. 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 2301, may comply with the provisions of this subtitle.

SEC. 2304. 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 subtitle A with respect to a type of transaction, or data elements for a type of health information, a plan sponsor, health provider, or health plan choice organization shall comply with the requirements of this subtitle 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 2102, a plan sponsor, health provider, or health plan choice organization shall comply with the requirements of this subtitle using such data elements.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Secretary adopts a modified standard under section 2105(c), a plan sponsor, health provider, or health plan choice organization 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.

Subtitle C—Miscellaneous Provisions

SEC. 2301. 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 standards adopted under part 1 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; and

(4) 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 18 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 title 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 subtitle 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 health information network privacy standard adopted under section 2104 that is applicable to the service, 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. 2302. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c), after the Secretary has established standards under section 2102 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 subtitle 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 2103 relating to the method by which data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subtitle 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 to be imposed.

(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). Subject to paragraph (2), the Secretary may grant such a waiver.

(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.

(e) 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 subsection (d).

SEC. 2303. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as otherwise provided in this section, a provision, requirement, or standard under this subtitle 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 title 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 title 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 title 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.

TITLE III—FRAUD AND ABUSE REFORM: ADVISORY OPINIONS

SEC. 3001. 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. 3002. 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. 3003. EFFECTIVE DATE.

Unless otherwise specified, the amendments made by this title shall be effective upon the enactment of this Act.

TITLE IV—MALPRACTICE REFORM AND ANTITRUST

Subtitle A—Malpractice Reform

PART 1—UNIFORM STANDARDS FOR MALPRACTICE CLAIMS

SEC. 4001. APPLICABILITY.

Except as provided in section 4021, this part shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 4002. 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 4012(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 4022(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A)

may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

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

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

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

(c) 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. 4003. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines from national specialty societies, to be updated annually. In the absence of recommended guidelines from such societies, each State may develop such guidelines based on such criteria as the State considers appropriate (including based on recommended guidelines developed by the Agency for Health Care Policy and Research).

(b) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any medical malpractice liability action arising from the conduct of a health care provider or health care professional, if such conduct was in accordance with a guideline developed by the State in which the conduct occurred and certified by the Secretary under subsection (a), the guideline—

(1) may be introduced by any party to the action (including a health care provider, health care professional, or patient); and

(2) if introduced, shall establish a rebuttable presumption that the conduct was in accordance with the appropriate standard of medical care, which may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

SEC. 4004. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

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

(b) NO AWARD OF PUNITIVE DAMAGES 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.

(c) JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.—The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

(d) USE OF PUNITIVE DAMAGE AWARDS FOR OPERATION OF ADR SYSTEMS IN STATES.—

(1) IN GENERAL.—The total amount of any punitive 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), and shall be used by the State solely to implement and operate the State alternative dispute resolution system certified by the Secretary under section 4022 (except as provided in paragraph (2)).

(2) USE OF REMAINING AMOUNTS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—If the amount of punitive damages paid to a State under paragraph (1) for a year is greater than the State's costs of implementing and operating the

State alternative dispute resolution system during the year, the balance of such punitive damages paid to the State shall be used solely to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

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

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

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for implementing and operating the State alternative dispute resolution system or carrying out the activities described in paragraph (2).

SEC. 4005. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceed $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on

a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 4006. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) 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 4002(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 is less than the amount of damages awarded to the party under the ADR system; 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 greater 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) LIMIT ON ATTORNEYS' 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.

(4) 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.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 4007. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Except as provided in subsection (b), no medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered, but in no event may such a claim be initiated after the expiration of the 4-year period that begins on the date on which the alleged injury that is the subject of such claim occurred.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may not be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject

of such claim was discovered or should reasonably have been discovered, but in no event may such a claim be initiated after the date on which the minor attains 12 years of age.

SEC. 4008. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

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

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

SEC. 4009. JURISDICTION OF FEDERAL COURTS.

Nothing in this part shall be construed to establish any jurisdiction over any medical malpractice liability action in the district courts of the United States on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4010. PREEMPTION.

(a) IN GENERAL.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with such provisions, except that the provisions of this part 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 part, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

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

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

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

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

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

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

PART 2—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

SEC. 4021. 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 1 (other than section 4002) 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. 4022. 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 4021, including the requirement described in section 4004 that punitive damages awarded under the system are paid to the State for the uses described in such section.

(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 4021(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of

the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

SEC. 4023. 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 4022(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 3—DEFINITIONS

SEC. 4031. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term ''alternative dispute resolution system'' means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(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 losses 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 State law or regulation 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 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.

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

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means any claim relating to the provision of (or the failure to provide) health care services or the use of a medical product, without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counterclaim, or contribution claim in a medical malpractice liability action.

(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 Ad-

ministration for marketing as a result of withheld information, misrepresentation, or an illegal payment by the manufacturer of the product.

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

(12) PUNITIVE DAMAGES.—The term ''punitive damages'' means compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

Subtitle B—Antitrust

SEC. 4101. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facili-

tate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 60 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A); and

(2) the term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense in-

curred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

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

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 4102. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such activity, and the parties to such activ-

ity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, and

(B) such reduction in competition is necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the activity is likely—

(i) to maintain or to increase the quality of health care by providing new

services not currently offered in the relevant market,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs, that cannot be achieved by the provision of available services and facilities in the relevant market,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible

for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative activity on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the activity.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care col-

laborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE ACTIVITY.—To be an eligible health care collaborative activity for purposes of this section, a health care collaborative activity shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the activity that the activity will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the activity,

(2) an agreement that the activity will submit to the Attorney General annually a report that describes the operations of the activity and information regarding the impact of the activity on health care and on competition in health care, and

(3) an agreement that the parties to the activity will notify the Attorney General and the Secretary of the termination of the activity not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 90 days after an eligible health care col-

laborative activity submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 90-day period, the Attorney General may extend the time for issuance for good cause.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care collaborative activity with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative activity involved may

commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws'' has the meaning given it in 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.

(2) The term ''certificate'' means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term ''health care collaborative activity'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision and coordination of health care services and that involves substantial integration and financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engage-

ment in any other conduct that is not reasonably required to carry out such agreement.

(4) The term ''health care services'' includes services related to the delivery or administration of health care services.

(5) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(6) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

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