I

104TH CONGRESS
1ST SESSION

H. R. 2071

To promote cost containment and reform in health care.

IN THE HOUSE OF REPRESENTATIVES

JULY 19, 1995

Mr. PETERSON of Florida (for himself, Mr. MORAN, Mr. DOOLEY, Mr. CLEMENT, Mr. POSHARD, Mr. STENHOLM, Mr. MARTINEZ, Mr. GIBBONS, Mrs. MEEK of Florida, and Mr. COLEMAN) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, 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 promote cost containment and reform in health care.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Improvement 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—GUARANTEED ACCESS TO HEALTH COVERAGE

SEC. 1001. GUARANTEED OFFER BY CARRIERS.

(a) IN GENERAL.—Each carrier that offers health insurance coverage in the individual/small group market in a fair rating area (as defined in section 1903) shall make available, to each qualifying individual (as defined in sec-

tion 1904(3)) or small employer (covered in such market) in such fair rating area—

(1) qualified standard coverage consistent with section 1102, and

(2) subject to subsection (b), qualified high-deductible coverage consistent with section 1103.

(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 qualifying individual (or 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 individual or employee demonstrates to the carrier that the individual or employee has available assets (as defined by the Secretary) equal to at least the deductible amount established under section 1104(b)(1) applicable to the high-deductible coverage. A carrier may not make available to an individual 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 individual 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 individual/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 individual or 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 individual shall

include the option of coverage of family members of the individual.

(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,

(5) receipt of public subsidies by an individual, or

(6) lack of evidence of insurability of an individual.

(f) CONSTRUCTION FOR MEWAS.—Nothing in this section shall be construed as requiring a multiple employer welfare arrangement that provides health coverage other than through a carrier to meet the requirements of this section.

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 individual/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 or individuals 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 and individuals 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 or individual 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 and individuals 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.

(d) TREATMENT OF CERTAIN MEWAS.—Subsection (a) shall not apply to a carrier if the only coverage offered by the carrier in the individual/small group market is through one or more multiple employer welfare arrangements. In the case of coverage offered by a carrier in the individual/small group market through a multiple employer welfare arrangement and to which the previous sentence does not apply, the requirements of subsection (a) shall apply to the carrier and not to the arrangement.

SEC. 1003. GUARANTEED RENEWAL.

(a) LIMITATION ON TERMINATION BY CARRIERS.—A carrier may not deny, cancel, or refuse to renew health coverage of a qualifying individual or eligible employer within a type of coverage option described in section 1903(14) 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 individual/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 INDIVIDUAL/SMALL GROUP MARKET.—If a carrier ceases to offer or provide health insurance coverage in an area with respect to the individual/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 AND MULTIPLE EMPLOYER HEALTH.—A multiemployer plan and a multiple employer health plan may not cancel coverage

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

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer, 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 6-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 6 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 purchasing organization under subtitle A of title V)

in the individual/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) INDIVIDUALS ELIGIBLE FOR SUBSIDIES.—There shall be an individual open enrollment period with respect to an individual at the time the individual first becomes eligible for any premium assistance under part A of title XXI of the Social Security Act, during the 60-day period beginning on the first date the individual meets eligibility criteria within any 12-month period.

(3) COURT ORDERS.—If a court has ordered that coverage be provided for a spouse or child of an employee or individual under health coverage of the employee or individual, there shall be an open enrollment period during the 30-day period beginning on the date of issuance of the court order.

(4) 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 purchasing organization under subtitle A of title V) in the individual/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.—

(A) CARRIERS IN INDIVIDUAL/SMALL GROUP MARKET.—Such annual open enrollment periods with respect to carriers in the individual/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 enroll-

ment 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 respect 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, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXII of the Public Health Service Act.

(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)(3), (b)(4), 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. 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(11)(A)) shall comply with the applicable requirements of this section.

(b) CONSUMER DISCLOSURE.—

(1) IN GENERAL.—The group health plan, or carrier providing health insurance coverage, that provides for health care shall assure that, before an individual is enrolled with the plan or carrier, the individual is provided with information about the arrangements between the entity providing for the managed care arrangement and health care providers for the provision of covered benefits, including the following:

(A) EMERGENCY SERVICES.—Arrangements for access to emergency care services inside and outside the provider network (including designated trauma centers), including any requirements for prior authorization.

(B) SPECIALIZED TREATMENT.—Arrangements for access to specialized treatment providers (such as centers of excellence).

(C) CHOICE OF PERSONAL PHYSICIAN.—Ability of enrollees to choose (and change the selection of) a personal physician from among available participating physicians and change that selection as appropriate.

(D) ESSENTIAL COMMUNITY PROVIDERS.—Arrangements for access to essential community providers, including disproportionate share hospitals, sole community hospitals, medicare-dependent, small rural hospitals, Federally qualified health centers, rural health clinics, local health departments, and children's hospitals.

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

(A) to provide specialty care,

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

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

(c) PROVIDER DISCLOSURE AND DUE PROCESS RELATING TO PROVIDER NETWORKS.—

(1) DISCLOSURE.—The entity providing for a managed care arrangement under which health coverage shall provide that before entering into a contract with health care providers with respect to the entity's provider network, the provider is given information concerning the terms and conditions of the provider's involvement with the network, including the following:

(A) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—Information concerning the 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.

(B) REVIEW PROCESS.—Information concerning the process under which a provider may request a review of the entity's decision to terminate or refuse to renew the provider's participation agreement.

(2) WRITTEN NOTICE OF DENIALS.—The entity providing for the managed care arrangement shall provide written notice to the provider of any denial of an application to participate in the provider network.

(3) TERMINATION PROCESS.—

(A) IN GENERAL.—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 any standards described in paragraph (1)(A).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 30 days prior to the

effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(d) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier or group health plan may not require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

(e) PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.—

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

(A) 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;

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

(C) 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;

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

(E) 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, except as provided in subsection 1011(d), from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

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

(2) DEFINITIONS.—In this subsection:

(A) 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(11)(A)) that meets the applicable requirements of this section.

(B) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or in-

dividual which provides, sells, or leases health care services as part of a provider network (as defined in section 1903(11)(B)).

SEC. 1012. REPORT ON UTILIZATION REVIEW STANDARDS.

(a) STUDY.—The Secretary shall provide for a study on the feasibility and appropriateness of—

(1) establishing standards for utilization review programs, and

(2) prohibiting group health plans and carriers providing health insurance coverage from denying coverage of or payment for items and services on the basis of a utilization review program unless the program meets such standards.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study under subsection (a). The Secretary shall include the report recommendations regarding the application of standards for utilization review programs to group health plans and carriers providing health insurance coverage.

(c) PREEMPTION.—For provision preempting State laws relating to utilization review, see section 6103.

SEC. 1013. 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 an eligible 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 1103 of the Health Care Improvement 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 re-

ceiving 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 ben-

eficiary 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 DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary 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 benefit 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 ac-

count 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.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any amount paid for insurance.

''(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 Health Care Improvement 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 individual/small group market (including the premium rate for coverage for a small employer through a multiple employer welfare arrangement that is fully-insured) 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(14)) 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 individual/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 5005.

(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 purchasing 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 established by carriers for multiple employer welfare arrangements that are fully-in-

sured or for fully-insured coverage offered with respect to individuals and small employers in the individual/small group market. Such premium rates shall apply based on the fair rating area in which the covered individual or employee resides to reflect the population in the individual/small group market.

SEC. 1022. COORDINATION WITH PREMIUM ASSISTANCE CERTIFICATE PROGRAM.

Each carrier or group health plan providing qualified health coverage shall accept and apply (as a reduction against premiums otherwise imposed) any premium certificate issued under a State premium assistance program under part A of title XXI of the Social Security Act.

SEC. 1023. 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 individual/

small group market and coverage under multiple employer welfare arrangements that are fully insured (without regard to whether such an arrangement is offered through an association) 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 January 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 eligible employees of small employers) or qualifying individuals must disclose to such prospective enrollees, to brokers, and to health plan purchasing 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 individuals or employers coverage the actuarial value of which is more than the actuarial value for high-deductible coverage but less than such value for standard coverage, the carrier must disclose to such employers or individuals detailed information on how the coverage offered compares to any standard and high-deductible coverage offered by the carrier to such individuals and 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 1301.

(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 individual/small group market (including multiple employer health plans that are fully insured, without regard to whether such an arrangement or plan is offered through an association) shall provide to the State such information as the State may require in order to carry out section 1023 (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), in-

sofar as such requirements would apply to the carrier or plan if the carrier or plan were an eligible organization.

Subtitle B—Benefits

SEC. 1101. QUALIFIED HEALTH COVERAGE.

In this Act, the term ''qualified health coverage'' means health coverage that—

(1) provides—

(A) standard coverage consistent with section 1102(a); or

(B) high-deductible coverage consistent with section 1103; and

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

SEC. 1102. STANDARD COVERAGE.

(a) IN GENERAL.—Health insurance coverage is considered to provide standard coverage consistent with this subsection and for preventive benefits under subsection (b)(4) if—

(1) benefits under such coverage are provided within at least each of the required categories of benefits described in paragraph (1) of subsection (b) and consistent with such subsection;

(2) the actuarial value of the benefits meets the requirements of subsection (c); and

(3) the benefits comply with the minimum requirements specified in subsection (d).

(b) REQUIRED CATEGORIES OF COVERED BENEFITS.—

(1) IN GENERAL.—The categories of covered benefits described in this paragraph are the types of benefits specified in each of subparagraphs (A), (B), (C), (D), (E), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees).

(2) COVERAGE OF TREATMENTS IN APPROVED RESEARCH TRIALS.—

(A) IN GENERAL.—Coverage of the routine medical costs (as defined in subparagraph (B)) associated with the delivery of treatments shall be considered to be medically appropriate if the treatment is part of an approved research trial (as defined in subparagraph (C)).

(B) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term ''routine medical costs'' means the cost of health services required to provide treatment according to the design of the trial, except those costs normally

paid for by other funding sources (as defined by the Secretary). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

(C) APPROVED RESEARCH TRIAL DEFINED.—In subparagraph (A), the term ''approved research trial'' means a trial—

(i) conducted for the primary purpose of determining the safety, effectiveness, efficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(ii) approved by the Secretary.

A trial is deemed to be approved under clause (ii) if it is approved by the National Institutes of Health, the Food and Drug Administration (through an investigational new drug exemption), the Department of Veterans Affairs, or by a qualified nongovernmental research entity (as identified in guidelines issued by one or more of the National Institutes of Health).

(3) COVERAGE OF OFF-LABEL USE.—An off-label use for a drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act shall be covered if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

(4) PREVENTIVE BENEFITS.—The following are preventive benefits that shall be covered without any deductibles, copayment, coinsurance, or other cost-sharing:

(A) NEWBORN, WELL-BABY AND WELL-CHILD CARE.—Newborn care, well-baby care, and well-child care for individuals under 19 years of age, including routine physical examinations, routine immunizations, and routine tests, as specified by the Secretary based on the schedule recommended by the American Academy of Pediatricians.

(B) MAMMOGRAMS.—Routine screening mammograms (including their interpretation), limited to 1 mammogram for a woman who is at least 35 (but less than 40) years of age, 1

mammogram every 2 years for a woman who is at least 40 (but less than 50) years of age, and 1 mammogram every year for a woman who is at least 50 years of age.

(C) SCREENING PAP SMEARS AND PELVIC EXAMS.—Screening pap smears and pelvic exams for women over 17 years of age, limited to 1 each year.

(D) COLORECTAL SCREENING.—Colorectal screening for individuals over 18 years of age at high risk, consisting of 1 fecal occult blood screening test every year, 1 screening sigmoidoscopy every 5 years, and 1 screening colonoscopy every 4 years.

(E) SCREENING TUBERCULIN TESTS.—Screening tuberculin tests annually for individuals at risk of contracting tuberculosis.

(F) PRENATAL CARE.—Prenatal care.

(G) ADULT IMMUNIZATIONS.—Routine immunizations for an individual over 17 years of age (including booster immunizations against tetanus and diphtheria, but limited to 1 such immunization every 10 years).

(H) PROSTATE CANCER SCREENING.—Routine cancer screening for a man who is at

least 40 years of age through a prostate specific antigen test, limited to 1 test each year.

(c) STANDARD ACTUARIAL VALUE.—

(1) IN GENERAL.—The actuarial value of the benefits under standard coverage in a fair rating area meets the requirements of this subsection if such value is equivalent to the standard actuarial value described in paragraph (2) for the area. The actuarial value of benefits under standard coverage shall be determined using the adjustment under paragraph (3) for a standardized population and set of standardized utilization and cost factors.

(2) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this paragraph for coverage in a geographic area is the actuarial value of benchmark coverage during 1994 in such area. Such actuarial value shall be determined using the adjustment under paragraph (3) for a standardized population and set of standardized utilization and cost factors and updated annually in accordance with section 1104(a).

(3) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this paragraph—

(A) for a standardized population shall be made by not taking into account individuals 65 years of age or older, employees of the United States Postal Service, retirees, and annuitants; and

(B)(i) except as provided in clause (ii), for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under subparagraph (A)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors, and

(ii) in the case of a group health plan operating in more than one geographic area, the ratio described in clause (i) shall be determined in accordance with regulations promulgated by the Secretary.

At the election of a group health plan under subparagraph (B)(ii), the ratio under such subparagraph shall be 1.

(d) MINIMUM REQUIREMENTS WITHIN A CATEGORY.—Benefits offered in any standard coverage within any category of benefits shall be not less than the narrow-

est scope and shortest duration of benefits within that category in any of the approved health benefits plans offered under chapter 89 of title 5, United States Code (relating to Federal Employees Health Benefits Program) in 1994. Benefits offered in the standard plan within the category of preventive services shall not require payment of cost-sharing for covered items and services.

(e) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section (or section 1103) may be construed to require the coverage of any specific procedure or treatment or class of service in health coverage under this Act or through regulation.

(f) CONSTRUCTION.—Nothing in this section (or section 1103) shall be construed as requiring coverage to include benefits for items and services that are not medically necessary or appropriate.

SEC. 1103. HIGH-DEDUCTIBLE COVERAGE.

Health insurance coverage is considered to provide high-deductible coverage consistent with this section if—

(1) benefits under such coverage comply with—

(A) the requirements described in section 1102(b) (relating to required categories of covered benefits), and

(B) the requirements described in section 1102(d) (relating to minimum requirements within a category);

(2) the deductible amount is the amount established under section 1104(b)(1);

(3) benefits under the coverage in any year (other than preventive benefits described in section 1102(b)(4)) 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 consistent with section 1102(c)) is equivalent to 80 percent of the actuarial value established under such section for standard coverage.

SEC. 1104. ACTUARIAL VALUATION OF BENEFITS.

(a) IN GENERAL.—The Secretary, in consultation with the NAIC and the American Academy of Actuaries, shall establish (and may from time to time modify) procedures by which health insurance benefits are valued for purposes of this subtitle.

(b) DEDUCTIBLE; MODEL BENEFIT PACKAGES.—The Secretary, in consultation with the NAIC and the American Academy of Actuaries, shall establish—

(1) the deductible amount for high-deductible coverage for the purposes of section 1103(2) such that the actuarial value of high-deductible coverage described in section 1103 is 20 percent less than the actuarial value of standard coverage described in section 1102(a); and

(2) model benefit packages that may be treated, for purposes of this title, as meeting the requirements for standard or high-deductible coverage under sections 1102(a) and 1103, respectively, and which shall include model cost sharing arrangements for fee-for-service options, managed care options, and point-of-service options.

SEC. 1105. LIMITATION ON OFFERING 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.

SEC. 1106. FAMILY COVERAGE OPTION; SUPPLEMENTAL COVERAGE.

(a) FAMILY COVERAGE OPTION.—Each carrier and group health plan that offers health insurance coverage shall provide for an option under which children under 26 years of age (without regard to whether they are full-time students or disabled) will be treated (with respect to family coverage) as family members. The carrier or plan may impose an additional premium for such option.

(b) CONSTRUCTION.—Nothing in this title shall be construed as limiting the benefits that may be offered as part of a group health plan or health insurance coverage.

SEC. 1107. LEVEL PLAYING FIELD FOR PROVIDERS.

(a) IN GENERAL.—Nothing in this subtitle may be construed to require or prohibit the use of a particular

class of provider, among the providers that are legally authorized to provide such treatment.

(b) COVERAGE OF CERTAIN OTHER PROVIDERS.—

(1) IN GENERAL.—For purposes of this subtitle, benefits under standard coverage shall include the following:

(A) Coverage provided at an individual's home by a Christian Science practitioner or Christian Science nurse.

(B) Coverage provided in a Christian Science Sanitorium (as defined in section 1861(y) of the Social Security Act), including coverage provided by a Christian Science practitioner.

(2) QUALIFICATIONS OF PROVIDERS.—A Christian Science practitioner or Christian Science nurse is qualified for purposes of paragraph (1) if the practitioner or nurse is listed as such a practitioner or nurse by the First Church of Christ, Scientist, in Boston, Massachusetts.

Subtitle C—Standards and Certification; Enforcement; Preemption; General Provisions

SEC. 1201. 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 requirements, 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. 1202. 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 1201 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 1201.

(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 1201, 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. 1203. APPLICATION TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), sections 1201 and 1202 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 1201 or 1202 to—

(1) a State or the Secretary of Health and Human Services is deemed a reference to the Secretary of Labor, and

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

SEC. 1204. ENFORCEMENT.

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

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of this title insofar as they relate to group health plans or employers shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to paragraph (1), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY EXCISE TAX FOR CARRIERS.—

(1) 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 TO COMPLY WITH HEALTH INSURANCE STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a carrier to comply with the requirements applicable to the carrier under parts 1 through 4 of subtitle A and subtitle B of title I of the Health Care Improvement 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.

''(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 knew, or exercising reasonable diligence would have known, that such failure existed.

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

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'carrier' have the respective meanings given such terms in section 1903 of the Health Care Improvement Act of 1995.''

(2) 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 to comply with health insurance standards.''

SEC. 1205. LIMITATION ON SELF INSURANCE FOR SMALL EMPLOYERS.

A single employer plan (as defined in section 3(40)(B) of the Employee Retirement Income Security Act of 1974) may not offer health coverage other than through a carrier unless the plan has at least 100 eligible employees.

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 1202(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) 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.

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

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

(3) 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.

(4) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 100 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 1994.

(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'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance coverage under paragraph (7)(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 insurance coverage which meets specified standards and under which health services are offered to be provided on a prepaid, at-risk basis primarily through a defined set of providers.

(9) HEALTH PLAN PURCHASING ORGANIZATION.—The term ''health plan purchasing organization'' means an organization established under subtitle A of title VI.

(10) INDIVIDUAL/SMALL GROUP MARKET.—The term ''individual/small group market'' means the insurance market offered—

(A) 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, and

(B) 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.

(11) 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).

(12) 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.

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

(14) 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.

(15) QUALIFIED HEALTH COVERAGE.—The term ''qualified health coverage'' has the meaning given such term in section 1101.

(16) STANDARD COVERAGE.—The term ''standard coverage'' means coverage provided consistent with section 1102(a).

(17) 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—REMOVAL OF FINANCIAL BARRIERS TO ACCESS

Subtitle A—Tax Deductibility for Individuals and Self-Employed

SEC. 2001. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''the applicable percentage''.

(b) DEDUCTION MADE PERMANENT; APPLICABLE PERCENTAGE.—Paragraph (6) of section 162(l) of such Code is amended to read as follows:

''(6) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

''In the case of taxable years beginning in calendar year:	**The applicable percentage is:**
1996, 1997, or 1998	30 percent
1999	50 percent
2000 or thereafter	100 percent.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 2002. DEDUCTION FOR HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

''(a) IN GENERAL.—In the case of an individual who is not a self-employed individual (as defined in section 401(c)(1)), there shall be allowed as a deduction an amount equal to 25 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) COORDINATION WITH DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—The amount which would (but for this paragraph) be allowed as a deduction under subsection (a) for the taxable year shall be reduced (but not below zero) by the amount (if any) allowed as a deduction under section 162(l) for such taxable year.

''(c) OTHER COVERAGE.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized

health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer.

''(d) COORDINATION WITH MEDICAL DEDUCTION, ETC..—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).''

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by adding at the end the following new paragraph:

''(16) HEALTH INSURANCE COSTS.—The deduction allowed by section 220.''

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 220. Health insurance costs of individuals who are not self-employed.
''Sec. 221. Cross reference.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 2003. RESTRICTIONS ON HEALTH BENEFITS PROVIDED THROUGH CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) INCLUSION OF CERTAIN BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—Gross income of an employee shall include such employer-provided coverage which is provided through a flexible spending or similar arrangement if any amount of deductible, copayment, coinsurance, or similar cost-sharing may be paid for or reimbursed under such arrangement.''

(b) CAFETERIA PLANS.—Subsection (f) of section 125 of such Code (defining qualified benefits) is amended by adding at the end thereof the following new sentence: ''Such term shall not include any benefits or coverage under an accident or health plan if any amount of deductible, copayment, coinsurance, or similar cost-sharing

under such a plan, or more than 20 percent of any premium (or comparable amount in the case of a plan not provided through insurance) for such a plan, may be paid for or reimbursed under the cafeteria plan.''

(c) EMPLOYMENT TAX TREATMENT.—

(1) SOCIAL SECURITY TAX.—

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

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (21) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) of such Code is amended by adding at the end thereof the following new sentence: ''Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'com-

pensation' any amount which is required to be included in gross income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by inserting after paragraph (16) the following new sentence:

''Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

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

''Nothing in the preceding provisions of this subsection shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b).''

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

(e) TRANSFERS FROM FLEXIBLE SPENDING ARRANGEMENTS TO MEDICAL SAVINGS ACCOUNTS PERMITTED DURING 1997.—A flexible spending arrangement for health shall not cease to be treated as such an arrangement, and no amount shall be includible in the gross income of the employee, solely because amounts not paid out as reimbursements under such arrangement during 1996 are contributed to a medical savings account (as defined

in section 7705 of the Internal Revenue Code of 1986) of such employee if such contributions are made before April 1, 1997, and such employee is an eligible employee (as defined in such section) at the time of the contributions.

Subtitle B—Premium and Cost-Sharing Subsidy Program and Supplemental Benefits Program for Low-Income Individuals

SEC. 2101. STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS AND SUPPLEMENTAL BENEFITS PROGRAMS.

(a) REQUIREMENTS FOR PROGRAMS.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE ACUTE CARE BENEFITS PROGRAMS FOR LOW-INCOME INDIVIDUALS

''PART A—STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS

''SEC. 2101. ESTABLISHMENT OF STATE PROGRAMS.

''(a) IN GENERAL.—As a requirement under section 1902(a)(63), effective January 1, 1998, each State shall establish and maintain a premium and cost-sharing subsidy program (in this title referred to as a 'State subsidy program') that provides for—

''(1) premium assistance described in section 2103 to premium assistance eligible individuals described in section 2102(a) in accordance with this part,

''(2) cost-sharing assistance described in section 2103 to cost-sharing assistance eligible individuals described in section 2102(b) in accordance with this part, and

''(3) State maintenance-of-effort payments in accordance with section 2107.

''(b) AVAILABILITY OF FUNDS.—Each State with a State subsidy program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1998, to payment under section 2106.

''(c) APPROVAL OF STATE PROGRAMS.—The Secretary may not approve a State subsidy program unless the State has submitted a detailed description that specifies the form and manner in which it will carry out the program and the Secretary finds that the program meets the requirements of this part.

''(d) DESIGNATION OF STATE AGENCY.—A State shall designate an appropriate State agency to administer the State subsidy program. Such agency shall be the same agency as the agency designated to administer the State supplemental medical benefits program under part B.

"SEC. 2102. ELIGIBILITY.

''(a) ASSISTANCE.—

''(1) PREMIUM ASSISTANCE.—Each premium assistance eligible individual (as defined in subsection (b)) is entitled to premium assistance under section 2103(a)(1).

''(2) COST-SHARING ASSISTANCE.—Each cost-sharing assistance eligible individual (as defined in subsection (c)) is entitled to cost-sharing assistance described in section 2103(a)(2).

''(b) PREMIUM ASSISTANCE ELIGIBLE INDIVIDUAL DEFINED.—

''(1) IN GENERAL.—In this title, subject to the succeeding provisions of this section, the term 'premium assistance eligible individual' means an individual who has been determined under section 2104 to have family modified adjusted income below 100 percent of the applicable poverty line (as defined in section 2144(2)).

''(2) SPECIAL RULE FOR CHILDREN AND PREGNANT WOMEN.—In this title, subject to the succeeding provisions of this section, the term 'premium assistance eligible individual' includes an individual who is a child under 19 years of age or a pregnant woman and who has been determined under section

2104 to have family modified adjusted income below 185 percent of the applicable poverty line.

''(c) COST-SHARING ASSISTANCE ELIGIBLE INDIVIDUAL DEFINED.—In this title, subject to the succeeding provisions of this section, the term 'cost-sharing assistance eligible individual' means an individual who has been determined under section 2104 to have family modified adjusted income below 100 percent of the applicable poverty line.

''(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In this title—

''(1) IN GENERAL.—The terms 'premium assistance eligible individual' and 'cost-sharing assistance eligible individual' do not include, with respect to a month, any of the following individuals:

''(A) MEDICARE BENEFICIARY.—An individual who is entitled to benefits under part A or B of title XVIII for the month.

''(B) INMATES.—An individual who as of the first day of the month is an inmate of a public institution (except as a patient of a medical institution).

''(C) CERTAIN ALIENS.—An alien who is not lawfully admitted for permanent residence or not otherwise permanently residing in the

United States under color of law (as defined in paragraph (2)).

''(D) NONRESIDENTS.—An individual who is not residing in any State.

''(2) 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:

''(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 under 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 has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period 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.

''(e) PROTECTION OF CURRENT BENEFICIARIES.—

''(1) IN GENERAL.—In this title, the term 'premium assistance eligible individual' also includes, with respect to a State as of December 31, 1997, an individual described in paragraph (2) whose eligibility for premium assistance has not terminated under paragraph (3).

''(2) CURRENT BENEFICIARIES DESCRIBED.—An individual described in this paragraph is an individual who—

''(A) is not excluded under subsection (d),

''(B) is enrolled to receive medical assistance under the State plan under title XIX (and for which Federal financial participation was available) as of December 31, 1997, and

''(C) would remain enrolled to receive such assistance under the State plan under title XIX but for amendments made by the Health Care Improvement Act of 1995.

''(3) LIMITATION.—An individual is a premium assistance eligible individual pursuant to this subsection only until the earlier of—

''(A) June 30, 1998, or

''(B) the first date after December 31, 1997, on which the individual's eligibility for medical assistance under the State plan under title XIX would have been terminated if the amendments made by the Health Care Improvement Act of 1995 had not been enacted.

"SEC. 2103. PREMIUM AND COST-SHARING ASSISTANCE.

''(a) IN GENERAL.—

''(1) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—The premium assistance under a State subsidy program shall be in the form of a premium assistance certificate that is in the amount computed under sub-

section (b) and that may be applied toward qualifying coverage (as defined in subparagraph (B)). A carrier or group health plan providing such coverage that is tendered such a certificate with respect to an individual shall reduce the amount of the premium by the amount of the certificate, except as provided in subsection (c)(1)(C).

''(B) QUALIFYING COVERAGE DEFINED.—For purposes of this part—

''(i) IN GENERAL.—Except as provided in clause (ii), the term 'qualifying coverage' means standard coverage described in section 1102 of the Health Care Improvement Act of 1995.

''(ii) OPTIONAL USE OF HIGH-DEDUCTIBLE COVERAGE.—At the election of a premium assistance eligible individual, the term 'qualifying coverage' includes high-deductible coverage described in section 1103 of the Health Care Improvement Act of 1995 with respect to an individual, but only if the individual—

''(I) is not described in section 2102(a)(2) and has been determined

under section 2104 to have family modified adjusted income not less than 100 percent of the applicable poverty line, and

''(II) demonstrates to the satisfaction of the State that the individual meets the requirements of section 1101(b)(2) of the Health Care Improvement Act of 1995 (relating to requirement for available assets).

''(2) COST-SHARING ASSISTANCE.—The cost-sharing assistance under a State subsidy program shall be in the form of a cost-sharing assistance certificate (or other means) that may be applied with respect to standard coverage. A carrier providing health insurance coverage or a group health plan that is tendered such a certificate with respect to an individual shall reduce the cost-sharing otherwise imposed with respect to health coverage to amounts that are nominal (as specified by the State, consistent with the regulations established to carry out section 1916(a)(3)) and shall not impose any cost-sharing in the case of preventive benefits described in section 1102(b)(4) of the Health Care Improvement Act of 1995.

''(3) CONSOLIDATED AND ELECTRONIC CERTIFICATES.—Nothing in this section shall be construed as preventing a State from—

''(A) in the case of an individual who is both a premium assistance eligible individual and a cost-sharing assistance eligible individual, from consolidating the premium and cost-sharing certificates of the individual, and

''(B) providing premium and cost-sharing assistance certificates through electronic or other means.

''(b) AMOUNT OF PREMIUM ASSISTANCE.—

''(1) AMOUNT OF ASSISTANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the amount of premium assistance under this subsection for a month for an individual is the lesser of—

''(i) the premium assistance reference amount determined under paragraph (2), or

''(ii) the amount of the monthly premium for the qualifying coverage provided to the individual.

''(B) TAKING INTO ACCOUNT EMPLOYER CONTRIBUTIONS.—If an employer is making a

contribution for the health coverage of a premium assistance eligible individual, the amount of the premium assistance under this subsection for a month shall not exceed the amount by which the premium amount described in subparagraph (A)(ii) exceeds the amount of the employer contribution.

''(2) PREMIUM ASSISTANCE REFERENCE AMOUNT DETERMINED.—

''(A) IN GENERAL.—Subject to paragraph (4), the premium assistance reference amount determined under this paragraph is an amount equal to 1/12 of the weighted average annual premium (determined in accordance with subparagraph (B)) for the individual's family class of enrollment for qualified standard health coverage offered in the fair rating area (as defined in section 1903 of the Health Care Improvement Act of 1995) in the individual/small group market in which the individual resides.

''(B) DETERMINATION OF WEIGHTED AVERAGE ANNUAL PREMIUM.—For purposes of subparagraph (A), the weighted average annual premium for a family class of enrollment for qualified standard health coverage shall be

based on the number of families (or individuals in the case of the individual class of enrollment) so covered in the class and area involved.

''(C) FAMILY CLASS OF ENROLLMENT.—In this paragraph, the term 'family class of enrollment' means a class of enrollment described in section 1021(a)(3) of the Health Care Improvement Act of 1995.

''(c) PAYMENTS OF ASSISTANCE.—

''(1) PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—The State issuing a premium assistance certificate shall, upon tender to the State of such certificate by the carrier or group health plan providing qualifying coverage, pay the carrier or plan the amount of the certificate.

''(B) TIMING OF PAYMENTS.—Payments under this paragraph shall commence in the first month during which the individual obtains qualifying coverage and is determined under section 2104 to be a premium assistance eligible individual.

''(C) TREATMENT OF SURPLUSES AND DEFICITS.—

''(i) DEFICIT.—If the premium for coverage is greater than the amount of the premium assistance for an individual, the individual is responsible for payment of any difference.

''(ii) SURPLUS.—If the premium for coverage is less than the amount of the premium assistance for an individual, the difference shall not be paid to the individual or the carrier or plan but shall revert to the Federal Government.

''(2) COST-SHARING ASSISTANCE.

''(A) IN GENERAL.—The State issuing a cost-sharing assistance certificate shall, upon presentation to the State of evidence of such certificate by the carrier or group health plan providing coverage and evidence of cost-sharing amounts otherwise incurred for which a reduction in cost-sharing is available under the certificate, pay the carrier or plan the amount of the reduction in cost-sharing in relation to standard coverage.

''(B) TIMING OF PAYMENTS.—Payments under this paragraph shall be provided at the time an individual has obtained qualified stand-

ard health coverage, is determined under section 2104 to be a cost-sharing assistance eligible individual, and has incurred health care expenses of the type for which a cost-sharing reduction is available under subparagraph (A).

''(3) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium or cost-sharing assistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"SEC. 2104. ELIGIBILITY DETERMINATIONS.

''(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State subsidy programs with respect to determining eligibility for premium and cost-sharing assistance, including requirements with respect to—

''(1) application procedures;

''(2) information verification procedures;

''(3) timeliness of eligibility determinations;

''(4) procedures for applicants to appeal adverse decisions; and

''(5) any other matters determined appropriate by the Secretary.

''(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

''(1) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person.

''(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c)(2).

''(3) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance widely, including to employers, health plan purchasing organizations, brokers for health coverage, and appropriate public agencies.

''(4) CONVENIENT LOCATION TO SUBMIT APPLICATIONS.—A State program shall provide convenient locations for premium and cost-sharing assistance eligible individuals to apply for premium and cost-sharing assistance.

''(5) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family in-

comes, including changes in employment status of family members, and changes in eligibility status described in section 2002(c) during the year. The State shall revise the amount of any premium and cost-sharing assistance based on such a revised application.

''(6) AFDC AND SSI APPLICANTS.—A State program shall include a procedure under which individuals applying for benefits under part A of title IV or title XVI shall have an opportunity to apply for assistance under this part in connection with such application.

''(7) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this part. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(c) ADMINISTRATION OF STATE PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this part which ensure that such programs are operated in a uniform manner with respect to application procedures, data standards, and such other adminis-

trative activities as the Secretary determines to be necessary.

''(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

''(A) be simple in form and understandable to the average individual;

''(B) require the provision of information necessary to make a determination as to whether an individual is a premium or cost-sharing assistance eligible individual including a declaration of estimated family income by the individual; and

''(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(3) OUTREACH ACTIVITIES.—A State operating a program under this part shall conduct such outreach activities as the Secretary determines appropriate.

''(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM AND COST-SHARING ASSISTANCE.—A determination by a State that an individual is a premium or cost-sharing assistance eligible individual shall be effective for the cal-

endar year for which such determination is made unless a revised application submitted under subsection (b)(5) indicates that an individual is no longer eligible for premium or cost-sharing assistance.

''(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

''(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this part shall be liable to the Federal Government for the amount any premium and cost-sharing assistance received by an individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium and cost-sharing assistance provided on the basis of a misrepresentation.

''(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under paragraph (1) and submit 50 percent of such amount to the Secretary in a timely manner.

"SEC. 2105. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under this part from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

''(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received assistance under this part from such State in any month during the year.

''(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

''(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium assistance that should have been provided under this part with respect to the individual for the year involved.

''(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the excess amount shall be treated as an underpayment of a tax imposed by chapter 1 of the Internal Revenue Code of 1986.

''(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the amount of the difference shall be treated as an overpayment of tax imposed by such chapter, or in the event the taxpayer involved is entitled to a refund of such a tax, subject to the provisions of section 6402(d) of such Code.

''(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this part, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

''(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this section in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium assistance provided in such year shall be considered an excess amount

under subsection (b)(2) and such individual shall not be eligible for premium assistance under this part until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

''(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 2104(e) for a misrepresentation of material fact described in such section.

''(f) NO RECONCILIATION FOR COST-SHARING ASSISTANCE.—No reconciliation statement is required under this section with respect to cost-sharing assistance.

"**SEC. 2106. PAYMENTS TO STATES.**

''(a) PAYMENTS FOR PREMIUM AND COST-SHARING ASSISTANCE.—Subject to subsection (b), the Secretary shall provide for payment to each State operating a State subsidy program in an amount equal to the sum of—

''(1) the Federal title XXI matching percentage (specified under section 2107(a)) of the amount expended by the State under the program during the quarter for premium assistance on behalf of premium assistance eligible individuals and for cost-

sharing assistance on behalf of cost-sharing assistance eligible individuals; plus

''(2) 50 percent of the amounts expended by the State during the quarter as found necessary by the Secretary for the proper and efficient administration of such program in the State.

''(b) LIMITATION ON PAYMENTS.—

''(1) IN GENERAL.—The total amount of payments that may be made to a State under subsection (a)(1) for all quarters in a calendar year may not exceed the lesser of—

''(A) subject to paragraph (3), the product of—

''(i) the per capita core benefit Federal payment limit applicable to the calendar year under subsection (c), and

''(ii) the average monthly number of premium assistance eligible individuals in the State in the year; or

''(B) 110 percent of the total amount that would otherwise have been paid to the State under title XIX in the year with respect to medical assistance described in section 1903(i)(16).

''(2) ESTIMATIONS AND ADJUSTMENTS.—The Secretary shall—

''(A) establish a process for estimating the limit established under this subsection for a year at the beginning of the year and adjusting such amount during such year; and

''(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

''(3) ADJUSTMENT FOR CERTAIN STATES.—In the case of a State in a year in which the product described in paragraph (1)(A) (as adjusted under this paragraph) exceeds the amount described in paragraph (1)(B), the amount described in paragraph (1)(A) shall be increased by a proportion equal to the ratio of—

''(A) the total amount of the reductions in payment made by the application of paragraph (1)(B) in the year, to

''(B) the total of the limitations in payment for all such States in the year under paragraph (1)(A), determined without regard to any adjustment under this paragraph.

''(c) PER CAPITA CORE BENEFIT FEDERAL PAYMENT LIMIT DEFINED.—

''(1) IN GENERAL.—For purposes of subsection (b)(1)(A), the 'per capita core benefit Federal payment limit' for a State for a year is equal to the base per capita core Federal payments (described in paragraph (2)) increased by the FEHBP State rolling increase percentage (as defined in subsection (d)(2)) for each year after 1995 and up to the year involved.

''(2) BASE PER CAPITA CORE FEDERAL PAYMENTS.—For purposes of paragraph (1), the 'base per capita core Federal payments' described in this paragraph, for a State, is—

''(A) the baseline Federal medicaid core benefit expenditures (as defined in paragraph (3)) for the State, divided by

''(B) the number of AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries (as described in section 1931(a)(2)) enrolled in the State plan under title XIX in 1995, as determined under paragraph (4).

''(3) DETERMINATION OF BASELINE FEDERAL MEDICAID CORE PAYMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (2)(A), the 'baseline Federal medicaid core payments' for a State is the amount of

Federal payments made under section 1903(a)(1) with respect to medical assistance furnished for core benefits (as defined in section 1931(b)(1)) for AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries for all calendar quarters in 1995.

''(B) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying subparagraph (A), payments attributable to section 1923 shall not be counted in the amount of payments.

''(C) TREATMENT OF DISALLOWANCES.—The amount determined under this paragraph shall take into account amounts (or an estimate of amounts) disallowed under title XIX.

''(4) APPLICATION TO PARTICULAR ITEMS AND SERVICES.—For purposes of this subsection, in determining the per capita core benefit expenditure limit for a category of items and services (within core benefits) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries) that were attributable to items and services included in the core

benefits (taking into account any limitation on amount, duration, or scope of items and services included in such benefits).

''(5) DETERMINATION OF NUMBER OF RECIPIENTS AND BENEFICIARIES.—For purposes of paragraph (2)(B), the number of AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries for a State for 1995 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients or beneficiaries for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

''(d) FEHBP NATIONAL AND STATE ROLLING INCREASE PERCENTAGES.—

''(1) NATIONAL INCREASE PERCENTAGE.—For purposes of this title, the term 'FEHBP national rolling increase percentage' means, for a year, the 5-year weighted average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the 5-year period ending with the previous year.

''(2) STATE INCREASE PERCENTAGE.—For purposes of this title, the term 'FEHBP State rolling increase percentage' means, for a year with respect to a State, the 5-year weighted average of the annual percentage increase in the premiums for health plans offered in the State under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the 5-year period ending with the previous year.

''(3) DETERMINATION.—The increase percentages under paragraphs (1) and (2) shall be determined by the Secretary, in consultation with the Director of Office of Personnel Management, based on the best information available. Such increases shall be adjusted—

''(A) to take into account the age distribution in the Federal workforce (not taking into account individuals 65 years of age or older, employees of the United States Postal Service, retirees, and annuitants) relative to the age distribution in the population of AFDC recipients and non-cash medicaid beneficiaries, and

''(B) to disregard any changes due to changes in the benefit package under the Fed-

eral Employees Health Benefits Program after 1994.

"SEC. 2107. FEDERAL TITLE XXI MATCHING PERCENTAGE.

''(a) COMPUTATION.—

''(1) IN GENERAL.—In this title, except as provided in subsections (c) and (e), the term 'Federal title XXI matching percentage' means, for each of the 50 States, 100 percent reduced by the product of the applicable percentage (as defined in paragraph (2)) and the ratio of—

''(A) the total taxable resources ratio (as defined in paragraph (3)) of the State, to—

''(B) the population in poverty ratio (as defined in paragraph (4)) of the State.

''(2) APPLICABLE PERCENTAGE.—For purposes of this section, the term 'applicable percentage' means a percentage estimated by the Secretary with the advice of the General Accounting Office that, if it were substituted for the Federal medical assistance percentage for purposes of title XIX with respect to core benefits, would have resulted in an amount of aggregate payments under section 1903(a) for calendar years 1994 through 1998 equal to the amount of aggregate payments that would have been made under such section for quarters in

such years if such percentage had not been so substituted. The applicable percentage estimated by the Secretary under the previous sentence shall apply with respect to quarters beginning on or after January 1, 1998.

''(3) TOTAL TABLE RESOURCES RATIO DEFINED.—For purposes of this section, the term 'total taxable resources ratio' means—

''(A) an amount equal to the most recent 3-year average of the total taxable resources of the State, as determined by the Secretary of the Treasury, divided by

''(B) an amount equal to the sum of the 3-year averages determined under subparagraph (A) for each of the 50 States.

''(4) POPULATION IN POVERTY RATIO DEFINED.—For purposes of this section, the term 'population in poverty ratio' means—

''(A) an amount equal to the 3-year-average of the number of individuals in the State whose family income is below 100 percent of the income official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section

673(2) of the Omnibus Budget Reconciliation Act of 1981), divided by

''(B) an amount equal to the sum of the averages determined under subparagraph (A) for the 50 States.

''(b) RULE FOR TERRITORIES AND THE DISTRICT OF COLUMBIA.—The Federal title XXI matching percentage—

''(1) for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 40 percent, and

''(2) for the District of Columbia shall be 50 percent.

''(c) LIMITATION FOR STATES.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subsections (b) and (e), the Federal title XXI matching percentage shall in no case be less than 50 percent or greater than 75 percent.

''(2) TREATMENT OF INDIAN FACILITIES.—The Federal title XXI matching percentage shall be 100 percent with respect to amounts expended for premium assistance or cost-sharing assistance or for supplemental acute care benefits with respect to services which are received through an Indian Health Service facility whether operated by the In-

dian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(d) 3 PERCENT BONUS FOR PROMOTING PURCHASING MECHANISMS.—Except in the case described in subsection (c) or in subsection (e), in the case of a State that has established and is operating a system of health plan purchasing organizations or other mechanism that—

''(1) promotes pooling of risk and competition among carriers offering qualified health coverage to residents of the State (including premium subsidy eligible individuals), and

''(2) provides information to such consumers about their health plan options,

the Federal title XXI matching percentage otherwise computed (without regard to this subsection) shall be increased by 3 percentage points.

''PART B—STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS

''SEC. 2121. ESTABLISHMENT OF STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS.

''(a) IN GENERAL.—Each State shall establish a State supplemental acute care benefits program (each in this part referred to as a 'State supplemental acute care

benefits program') that provides supplemental acute care benefits for supplemental benefit eligible individuals.

''(b) AVAILABILITY OF FUNDS.—Each State with a State supplemental acute care benefits program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1998, to payment under section 2124.

''(c) APPROVAL OF STATE PROGRAMS; PROGRAM DESCRIPTIONS.—The Secretary may not approve a State supplemental acute care benefits program unless the State has submitted a detailed description of the form and manner in which it will carry out the program (consistent with the applicable requirements of this part) and the Secretary finds that the program meets such applicable requirements.

"**SEC. 2122. ELIGIBILITY.**

''(a) IN GENERAL.—In this part, the term 'supplemental benefit eligible individual' means an individual who, as of the time of provision of supplemental acute care benefits, is a premium assistance eligible individual (as defined in section 2102(a)).

''(b) CONSTRUCTION.—Nothing in this part shall be construed to create an entitlement for any specific supplemental benefit eligible individual.

"SEC. 2123. SCOPE AND PROVISION OF BENEFITS; BENEFITS ADMINISTRATION.

''(a) IN GENERAL.—The supplemental acute care benefits that may be made available under a State supplemental acute care benefits program may include supplemental acute care benefits (as defined in section 1931(a)(2)(F)).

''(b) COVERAGE OF BENEFITS.—Each State supplemental acute care benefits program—

''(1) shall establish methods and standards to select the types, and the amount, duration, and scope, of supplemental acute care benefits included in the program and to assure access to, and the quality of, services included in such benefits;

''(2) in providing benefits for supplemental benefit eligible individuals—

''(A) may vary the supplemental acute care benefits provided among reasonable classes of such individuals, and

''(B) may take into account the individual needs of individuals; and

''(3) shall coordinate the provision of such benefits with other health insurance coverage and health benefit programs in a manner that avoids duplication of benefits.

''(c) PAYMENT METHODS.—Benefits under a program may be made available in the form of direct provision of services, reimbursement of providers, prepayment to providers or health plans on a capitation basis, reimbursement of supplemental benefit eligible individuals for expenses incurred for supplemental acute care benefits, or a combination of these methods.

''(d) ADMINISTRATION.—

''(1) STATE AGENCY.—Each State supplemental acute care benefits program shall designate any appropriate State agency to administer the program.

''(2) COORDINATION.—The State supplemental acute care benefits program shall specify how the program—

''(A) will be coordinated with the State medicaid plan, titles V and XX, part A of this title, and any other Federal or State programs that provide services or assistance targeted to supplemental benefit eligible individuals, and

''(B) will be coordinated with qualified health coverage.

''(e) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—Each State supplemental acute care benefits program shall furnish to the Secretary—

''(1) such reports, and cooperate with such audits, as the Secretary determines are needed concerning the State's administration of the program under this part, including the processing of any claims under the program, and

''(2) such data and information as the Secretary may require in order to carry out the Secretary's responsibilities.

"SEC. 2124. PAYMENTS TO STATES.

''(a) IN GENERAL.—Subject to subsection (b), the Secretary shall provide for payment to each State operating an approved State supplemental acute care benefits program for a quarter in an amount equal to the sum of—

''(1) the Federal title XXI matching percentage (specified under section 2107(a)) of the amount expended by the State under the program during the quarter for supplemental acute care benefits for supplemental benefit eligible individuals; and

''(2) 50 percent of the amounts expended by the State during the quarter as found necessary by the Secretary for the proper and efficient administration of such program in the State.

''(b) LIMITATION ON PAYMENTS FOR SUPPLEMENTAL ACUTE CARE BENEFITS.—

''(1) IN GENERAL.—The total amount of payments that may be made to a State under subsection (a)(1) for all quarters in a calendar year may not exceed the product of—

''(A) the per capita supplemental acute care benefit Federal payment limit applicable to the calendar year under subsection (c), and

''(B) the average monthly number of supplemental benefit eligible individuals in the State in the year.

''(2) ESTIMATIONS AND ADJUSTMENTS.—The Secretary shall—

''(A) establish a process for estimating the limit established under this subsection for a year at the beginning of the year and adjusting such amount during such year; and

''(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

''(c) PER CAPITA SUPPLEMENTAL ACUTE CARE BENEFIT FEDERAL PAYMENT LIMIT DEFINED.—

''(1) IN GENERAL.—For purposes of subsection (b)(1)(A), the 'per capita supplemental acute care benefit Federal payment limit' for a State for a year is equal to the base per capita supplemental acute

care Federal payments (described in paragraph (2)) increased by the FEHBP national rolling increase percentage (as defined in section 2106(d)(1)) for each year after 1995 and up to the year involved.

''(2) BASE PER CAPITA SUPPLEMENTAL ACUTE CARE FEDERAL PAYMENTS.—For purposes of paragraph (1), the 'base per capita supplemental acute care Federal payments' described in this paragraph, for a State, is—

''(A) the baseline Federal medicaid supplemental acute care benefit expenditures (as defined in paragraph (3)) for the State, divided by

''(B) the number of AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries (as described in section 1931(a)(2)) enrolled in the State plan under title XIX in 1995, as determined under paragraph (4).

''(3) DETERMINATION OF BASELINE FEDERAL MEDICAID SUPPLEMENTAL ACUTE CARE PAYMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (2)(A), the 'baseline Federal medicaid supplemental acute care payments' for a State is the amount of Federal payments made under

section 1903(a)(1) with respect to medical assistance furnished for supplemental acute care benefits (as defined in section 1931(b)(2)) for AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries for all calendar quarters in 1995.

''(B) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying subparagraph (A), payments attributable to section 1923 shall not be counted in the amount of payments.

''(C) TREATMENT OF DISALLOWANCES.—The amount determined under this paragraph shall take into account amounts (or an estimate of amounts) disallowed under title XIX.

''(4) APPLICATION TO PARTICULAR ITEMS AND SERVICES.—For purposes of this subsection, in determining the per capita supplemental medical benefit expenditure limit for a category of items and services (within the supplemental acute care benefits) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries) that were attributable to items

and services included in the supplemental acute care benefits (taking into account any limitation on amount, duration, or scope of items and services included in such benefits).

''(5) DETERMINATION OF NUMBER OF RECIPIENTS AND BENEFICIARIES.—For purposes of paragraph (2)(B), the number of AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries for a State for 1995 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients or beneficiaries for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

''(d) SUPPLEMENTAL ACUTE CARE BENEFIT INCREASE FACTOR DESCRIBED.—For purposes of subsection (b)(1)(C), the 'supplemental medical benefit increase factor' for a year for a State is equal to the FEHBP national rolling increase factor (as defined in section 2107(c)(1)) for the year.

''(e) FUNDING.—Payments to States under this section shall be made by the Secretary at such time and in such form as provided in regulations promulgated by the

Secretary, based on the form and manner in which payments are made under section 1903.

''PART C—GENERAL PROVISIONS

"SEC. 2141. NATURE OF PAYMENT OBLIGATION.

''Sections 2106 and 2124 constitute budget authority in advance of appropriations Acts, and represent the obligation of the Federal Government to provide payments to States under such sections in accordance with the applicable provisions of this title.

"SEC. 2142. AUDITS.

''The Secretary shall conduct regular audits of the activities under the State programs conducted under this title.

"SEC. 2143. DEMONSTRATION PROJECT AUTHORITY.

''(a) IN GENERAL.—In the case of any experimental, pilot, or demonstration project which in the judgment of the Secretary is likely to assist in promoting the objectives of this title in a State or States, the Secretary may waive compliance with any of the requirements of this title to the extent and for the period the Secretary finds necessary to enable the Secretary to carry out the project.

''(b) RESTRICTION.—The Secretary may authorize a waiver under subsection (a) only if the Secretary determines that under the waiver—

''(1) all individuals who would be premium assistance eligible individuals remain eligible for premium assistance,

''(2) benefits under part A are not reduced below the level of benefits otherwise provided, and

''(3) the amount of payments made by the Federal Government do not exceed the amount of payments otherwise provided.

"SEC. 2144. DEFINITIONS AND DETERMINATIONS OF INCOME.

''For purposes of this title:

''(1) DETERMINATIONS OF INCOME.—

''(A) FAMILY INCOME.—The term 'family income' means, with respect to an individual who—

''(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

''(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the

other individual's spouse, and dependents of the other individual.

''(B) DEPENDENT.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

''(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

''(D) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 162(l), 220, 911, 931, and 933 of such Code, and

''(ii) increased by—

''(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax,

''(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code,

''(III) the amount of aid to families with dependent children received during the taxable year under part A of title IV to the extent not included in gross income under such Code, and

''(IV) the amount of any supplemental security income benefits provided under title XVI.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

''(E) ELECTION WITH RESPECT TO INCOME DETERMINATION.—As elected by a family at the time of submission of an application for a premium or cost-sharing assistance under this part, family income shall be determined either—

''(i) by multiplying by a factor of 4 the individual's family income for the 3-

month period immediately preceding the month in which the application is made, or

''(ii) based upon estimated income for the entire year in which the application is submitted.

''(2) APPLICABLE POVERTY LINE.—The term 'applicable poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

''(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

''(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

''(3) PREGNANT WOMAN.—The term 'pregnant woman' includes a woman during the 60-day period beginning on the last day of the pregnancy.

''(4) PREMIUM.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.''.

SEC. 2102. DIVISION OF MEDICAID BENEFITS INTO CORE BENEFITS AND SUPPLEMENTAL BENEFITS FOR AFDC, SSI, AND NON-CASH BENEFICIARIES; LIMITATION ON FEDERAL FINANCIAL PARTICIPATION FOR CORE AND SUPPLEMENTAL BENEFITS.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''MEDICAID REFORM RULES FOR BENEFITS FOR ACUTE MEDICAL AND SUPPLEMENTAL SERVICES FOR AFDC RECIPIENTS, SSI RECIPIENTS, AND NON-CASH MEDICAID BENEFICIARIES

''SEC. 1931. (a) APPLICATION OF SECTION.—

''(1) IN GENERAL.—This section applies with respect to medical assistance for acute medical services (as defined in paragraph (2)) under State plans under this title for calendar quarters beginning on or after January 1, 1998, provided to AFDC recipients, SSI recipients, and non-cash medicaid categorical beneficiaries. To the extent this section applies, it supersedes any contrary provision of this title or of other applicable law.

''(2) DEFINITIONS.—In this section:

''(A) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means items and services described in section 1905(a) other than the following:

''(i) Nursing facility services (as defined in section 1905(f)).

''(ii) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

''(iii) Personal care services (as described in section 1905(a)(24)).

''(iv) Private duty nursing services (as referred to in section 1905(a)(8)).

''(v) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

''(vi) Home and community care furnished to functionally disabled elderly individuals under section 1929.

''(vii) Community supported living arrangements services under section 1930.

''(viii) Case-management services (as described in section 1915(g)(2)).

''(ix) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous clause.

''(x) Hospice care.

''(B) 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 for the month.

''(C) CORE BENEFITS.—The term 'core benefits' means benefits with respect to acute medical services which the Secretary identifies under subsection (b)(1) as typically included in the services covered under benchmark coverage (as defined in section 1903(1) of the Health Care Improvement Act of 1995).

''(D) NON-CASH MEDICAID BENEFICIARY.—The term 'non-cash medicaid beneficiary' means an individual described in section

1902(a)(10)(A) who is not an AFDC recipient or a SSI recipient.

''(E) 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 for the month,

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

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

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

''(F) SUPPLEMENTAL ACUTE CARE BENEFITS.—The term 'supplemental acute care benefits' means benefits for acute medical services which are not—

''(i) core benefits, and

''(ii) benefits for items or services described in clauses (i) through (x) of subparagraph (A).

''(b) DIVISION OF ACUTE MEDICAL SERVICE BENEFITS INTO CORE BENEFITS AND SUPPLEMENTAL ACUTE CARE BENEFITS.—The Secretary shall divide the class of benefits for acute medical services into the following benefit groups:

''(1) CORE BENEFITS.—A group of benefits consisting of core benefits (as defined in subsection (a)(2)(C)).

''(2) SUPPLEMENTAL ACUTE CARE BENEFITS.—A group of benefits consisting of supplemental acute care benefits (as defined in subsection (a)(2)(F)).

''(c) LIMITATION ON AMOUNT OF FEDERAL FINANCIAL PARTICIPATION FOR BENEFITS FOR ACUTE MEDICAL SERVICES FOR AFDC RECIPIENTS, SSI RECIPIENTS, AND NON-CASH MEDICAID BENEFICIARIES.—With respect to expenditures for medical assistance for acute medical services benefits for AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries who are not entitled to benefits under part A of title XVIII in a State for quarters in a calendar year after 1998—

''(1) no such Federal financial participation shall be payable under section 1903(a)(1), and

''(2) such a recipient or beneficiary is not entitled to receive any medical assistance for such benefits under the State plan under this title.

''(d) ELIMINATION OF ENTITLEMENT FOR SUPPLEMENTAL ACUTE CARE BENEFITS.—With respect to medical assistance for supplemental acute care benefits for AFDC recipients and non-cash medicaid beneficiaries who are not entitled to benefits under part A of title XVIII in a State for quarters in 1998 or any succeeding year—

''(1) no Federal financial participation shall be payable under section 1903(a)(1),

''(2) the State may receive payments for such supplemental acute care benefits under part B of title XXI, and

''(3) such a recipient or beneficiary is not entitled to receive any medical assistance for such benefits under the State plan under this title.''.

(b) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following:

''(16) in accordance with section 1931, with respect to amounts expended for medical assistance for core benefits for AFDC recipients, SSI recipients, and non-cash medicaid beneficiaries who are not entitled to benefits under part A of title XVIII for calendar quarters beginning on or after January 1, 1998.''.

SEC. 2103. OPERATION OF PROGRAM AS STATE PLAN REQUIREMENT UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

(3) by inserting after paragraph (62) the following new paragraph:

''(63) provide for a State program furnishing premium subsidies for low-income individuals in accordance with part A of title XXI.''.

(b) EFFECTIVE DATE.—The requirement of section 1902(a)(63) of the Social Security Act (as added by subsection (a)) shall apply to Federal financial participation for calendar quarters beginning on or after January 1, 1998.

SEC. 2104. APPLICATION OF MISCELLANEOUS PROVISIONS.

(a) APPLICATION OF SAVE PROVISIONS.—Section 1137(b) of the Social Security Act (42 U.S.C. 1320b–7(b)) is amended—

(1) by striking ''and'' at the end of paragraph (4),

(2) by striking the period at the end of paragraph (5) and inserting ''; and'', and

(3) by adding at the end the following:

''(6) a State subsidy program under part A of title XXI.''.

(b) DISCLOSURE OF CERTAIN INFORMATION.

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH PREMIUM ASSISTANCE CERTIFICATE PROGRAM.—The Secretary shall, upon written request from a State, disclose to officials of

the State return information for purposes of determining or verifying whether any individual is entitled to a premium assistance certificate under part A of title XXI of the Social Security Act and the amount thereof. Return information disclosed under this paragraph may be used by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification.''.

(2) CONFORMING CHANGE.—Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (14)'' each place it appears and inserting ''(14) or (15)''.

(c) APPLICATION OF DEFINITION OF STATE.—Section 1001(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended by striking ''title XX'' and inserting ''titles XX and XXI''.

(d) CONSTRUCTION.—Nothing in this title shall be construed as preventing the Secretary of Health and Human Services from continuing in effect waivers (in effect as of the date of the enactment of this Act) of requirements under title XIX of the Social Security Act.

TITLE III—ACCESS IMPROVEMENTS

Subtitle A—Improved Access in Rural Areas

PART 1—GRANTS TO ENCOURAGE COMMUNITY RURAL HEALTH NETWORKS

SEC. 3001. ASSISTANCE FOR DEVELOPMENT OF ACCESS PLANS FOR CHRONICALLY UNDERSERVED AREAS.

(a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IMPLEMENT ACTION PLANS TO INCREASE ACCESS.—

(1) IN GENERAL.—The Secretary shall provide grants (in amounts determined in accordance with paragraph (3)) over a 3-year period to an eligible State for the development of plans to increase access to health care services during such period for residents of areas in the State that are designated as chronically underserved areas in accordance with subsection (b).

(2) ELIGIBILITY REQUIREMENTS.—A State is eligible to receive grants under this section if the State submits to the Secretary (at such time and in such form as the Secretary may require) assurances that the State has developed (or is in the process of developing) a plan to increase the access of residents

of a chronically underserved area to health care services that meets the requirements of subsection (c), together with such other information and assurances as the Secretary may require.

(3) AMOUNT OF ASSISTANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount of assistance provided to a State under this subsection with respect to any plan during a 3-year period shall be equal to—

(i) for the first year of the period, an amount equal to 100 percent of the amounts expended by the State during the year to implement the plan described in paragraph (1) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(ii) for the second year of the period, an amount equal to 50 percent of the amounts expended by the State during the year to implement the plan; and

(iii) for the third year of the period, an amount equal to 33 percent of the amounts expended by the State during the year to implement the plan.

(B) AGGREGATE PER PLAN LIMIT.—The amount of assistance provided to a State under this subsection with respect to any plan may not exceed $100,000 during any year of the 3-year period for which the State receives assistance.

(b) DESIGNATION OF AREAS.—

(1) DESIGNATION BY GOVERNOR.—In accordance with the guidelines developed under paragraph (2), the Governor of a State may designate an area in the State as a chronically underserved area for purposes of this section upon the request of a local official of the area or upon the Governor's initiative.

(2) GUIDELINES FOR DESIGNATION.—

(A) DEVELOPMENT BY SECRETARY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop guidelines for the designation of areas as chronically underserved areas under this section.

(B) FACTORS CONSIDERED IN DEVELOPMENT OF GUIDELINES.—In developing guidelines under paragraph (1), the Secretary shall consider the following factors:

(i) Whether the area (or a significant portion of the area)—

(I) is designated as a health professional shortage area (under section 332(a) of the Public Health Service Act), or meets the criteria for designation as such an area; or

(II) was previously designated as such an area or previously met such criteria for an extended period prior to the designation of the area under this section (in accordance with criteria established by the Secretary).

(ii) The availability and adequacy of health care providers and facilities for residents of the area.

(iii) The extent to which the availability of assistance under other Federal and State programs has failed to alleviate the lack of access to health care services for residents of the area.

(iv) The percentage of residents of the area whose income is at or below the poverty level.

(v) The percentage of residents of the area who are age 65 or older.

(vi) The existence of cultural or geographic barriers to access to health care services in the area, including weather conditions.

(3) REVIEW BY SECRETARY.—No designation under paragraph (1) shall take effect under this section unless the Secretary—

(A) has been notified of the proposed designation; and

(B) has not, within 60 days after the date of receipt of the notice, disapproved the designation.

(4) PERIOD OF DESIGNATION.—A designation under this section shall be effective during a period specified by the Governor of not longer than 3 years. The Governor may extend the designation for additional 3-year periods, except that a State may not receive assistance under subsection (a)(3) for amounts expended during any such additional periods.

(c) REQUIREMENTS FOR STATE ACCESS PLANS.—A State plan to increase the access of residents of chronically underserved areas to health care services meets the requirements of this section if the Secretary finds that the plan was developed with the participation of health care

providers and facilities and residents of the area that is the subject of the plan, together with such other requirements as the Secretary may impose.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for assistance under this section $10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under subsection (b)(2).

SEC. 3002. TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall make funds available under this section to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in subsection (b) seeking to establish or enhance a community rural health network in an underserved rural area.

(b) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The following entities are eligible to receive funds for technical assistance under this section:

(1) An entity receiving a grant under section 3003.

(2) A State or unit of local government.

(3) An entity providing health care services (including health professional education services) in the area involved.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used—

(A) for planning a community health network and the submission of the plan for the network to the Secretary under section 3003(c) (subject to the limitation described in paragraph (2));

(B) to provide assistance in conducting community-based needs and prioritization, identifying existing regional health resources, and developing networks, utilizing existing local providers and facilities where appropriate;

(C) to provide advice on obtaining the proper balance of primary and secondary facilities for the population served by the network;

(D) to provide assistance in coordinating arrangements for tertiary care;

(E) to provide assistance in recruitment and retention of health care professionals;

(F) to provide assistance in coordinating the delivery of emergency services with the pro-

vision of other health care services in the area served by the network;

(G) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(H) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(2) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1) may not exceed $50,000 and may not be available for a period of time exceeding 1 year.

(d) USE OF RURAL HEALTH OFFICES.—In carrying out this section with respect to entities in rural areas, the Secretary shall make funds available through—

(1) not more than 10 regional centers acting as clearinghouses for the distribution of such funds; and

(2) State Offices of Rural Health, or any combination of such centers and Offices.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each

of fiscal years 1996 and 1997 and $30,000,000 for each of fiscal years 1998 through 2000 to carry out this section. Amounts appropriated under this section shall be available until expended.

SEC. 3003. DEVELOPMENT GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall provide financial assistance to eligible entities in order to provide for the development and implementation of community rural health networks.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—An entity is eligible to receive financial assistance under this section only if the entity—

(A) is (i) based in a rural area or (ii) is described in paragraph (2), (3), or (4) of section 3002(b),

(B) is undertaking to develop and implement a community rural health network in an underserved rural area (or underserved rural areas) with the active participation of at least 3 health care providers or facilities in the area, and

(C) has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(2) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this section shall be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members located in adjoining States from qualifying for such assistance.

(3) PERMITTING ENTITIES NOT RECEIVING FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE FUNDING FOR IMPLEMENTATION.—An entity that is eligible to receive financial assistance under this section may receive assistance to carry out activities described in subsection (c)(1)(B) notwithstanding that the entity does not receive assistance to carry out activities described in subsection (c)(1)(A).

(c) USE OF FUNDS.—

(1) IN GENERAL.—Financial assistance made available to eligible entities under this section may be used only—

(A) for the development of a community health network and the submission of the plan for the network to the Secretary; and

(B) after the Secretary approves the plan for the network, for activities to implement the network, including (but not limited to)—

(i) establishing information systems, including telecommunications,

(ii) recruiting health care providers,

(iii) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(iv) establishing and operating a community health advisor program described in paragraph (2).

(2) COMMUNITY HEALTH ADVISOR PROGRAM.—

(A) PROGRAM DESCRIBED.—In paragraph (1), a ''community health advisor program'' is a program under which community health advisors carry out the following activities:

(i) Collaborating efforts with health care providers and related entities to facilitate the provision of health services and health-related social services.

(ii) Providing public education on health promotion and disease prevention and efforts to facilitate the use of available health services and health-related social services.

(iii) Providing health-related counseling.

(iv) Making referrals for available health services and health-related social services.

(v) Improving the ability of individuals to use health services and health-related social services under Federal, State, and local programs through assisting individuals in establishing eligibility under the programs.

(vi) Providing outreach services to inform the community of the availability of the services provided under the program.

(B) COMMUNITY HEALTH ADVISOR DEFINED.—In subparagraph (A), the term ''community health advisor'' means, with respect to a community health advisor program, an individual—

(i) who has demonstrated the capacity to carry out one or more of the activities carried out under the program; and

(ii) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(3) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this section may not be used for any of the following:

(A) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

(B) For construction or remodeling of health care facilities.

(4) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1)(A) may not exceed $50,000 and may not be made available for a period of time exceeding 1 year.

(d) APPLICATION.—

(1) IN GENERAL.—No financial assistance shall be provided under this section to an entity unless the entity has submitted to the Secretary, in a time

and manner specified by the Secretary, and had approved by the Secretary an application.

(2) INFORMATION TO BE INCLUDED.—Each such application shall include—

(A) a description of the community rural health network, including service area and capacity, and

(B) a description of how the proposed network will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 1996 and 1997, $120,000,000 for fiscal year 1998, $130,000,000 for fiscal year 1999, $140,000,000 for fiscal year 2000, $150,000,000 for fiscal year 2001, $160,000,000 for fiscal year 2002, $170,000,000 for fiscal year 2003, and $180,000,000 for fiscal year 2004, to carry out this section. Amounts appropriated under this section shall be available until expended.

(2) INTEGRATION OF OTHER AUTHORIZATIONS.—In order to provide for the authorization of appropriations under paragraph (1), notwithstanding any other provision of law, no funds are authorized

to be appropriated to carry out the following programs in fiscal years after fiscal year 1996:

(A) The rural health transition grant program (under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987).

(B) The rural health outreach program (for which appropriations were annually provided under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Acts).

(3) ANNUAL LIMIT ON ASSISTANCE TO GRANTEE.—The amount of financial assistance provided to an entity under this section during a year may not exceed $250,000.

SEC. 3004. DEFINITIONS.

For purposes of this part:

(1) COMMUNITY RURAL HEALTH NETWORK.—The term ''community rural health network'' means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(A) is located in an underserved rural area;

(B) furnishes health care services to individuals residing in the area; and

(C) is governed by a board of directors selected by participating health care providers and residents of the area.

(2) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

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

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

(5) UNDERSERVED RURAL AREA.—The term ''underserved rural area'' means a rural area designated—

(A) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(B) as a chronically underserved area under section 3001.

PART 2—INCENTIVES FOR HEALTH PROFESSIONALS TO PRACTICE IN RURAL AREAS THROUGH THE NATIONAL HEALTH SERVICE CORPS PROGRAM

SEC. 3011. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(c) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal

Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.
''Sec. 138. Cross-references to other Acts.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

SEC. 3012. MODIFICATION IN CRITERIA FOR DESIGNATION AS HEALTH PROFESSIONAL SHORTAGE AREA.

(a) RELEVANCE OF TRAVEL TIMES WITHIN FRONTIER AREAS.—Section 332(a) of the Public Health Service Act (42 U.S.C. 245e(a)) is amended by adding at the end the following new paragraph:

''(4) With respect to meeting the criteria under paragraph (1)(A) for an area to be designated as a health professional shortage area, the Secretary shall, in the case of a frontier area, make the determination of whether the frontier area is a rational area for the delivery of health services without regard to—

''(A) the travel time between population centers in the frontier area; or

''(B) the travel time to contiguous area resources in the frontier area.''.

(b) REGULATIONS DEFINING HEALTH PROFESSIONAL SHORTAGE AREAS.—Within 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations that define health professional shortage areas for purposes of title III of the Public Health Service Act.

(c) AGENCY RECOMMENDATIONS FOR IMPROVEMENTS.—Not later than July 1, 1996, the Secretary of Health and Human Services shall submit to the Congress a report specifying the recommendations of the Secretary for improving the manner of determining the extent to which a geographic area has a need for assignments of members of the National Health Service Corps, and for equitably allocating such assignments among the geographic areas with a need for such assignments.

(d) EFFECTIVE DATE.—This section shall take effect on October 1, 1995, or upon the date of the enactment of this Act, whichever occurs later.

SEC. 3013. OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.

(a) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(A) by striking ''and'' after ''1991,''; and

(B) by striking ''through 2000.'' and inserting ''through 2004.''.

(2) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP PROGRAM.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

''(C) Of the amounts appropriated under paragraph (1) for fiscal year 1995 and subsequent fiscal years, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 20 percent.''.

(b) INCREASE IN NUMBER OF MENTAL HEALTH PROFESSIONALS IN SHORTAGE AREAS.—

(1) IN GENERAL.—Section 338H(b) of the Public Health Service Act (42 U.S.C. 254q(b)) is amended by adding at the end the following paragraph:

''(3) MENTAL HEALTH PROFESSIONALS.—In providing contracts under this subpart for scholar-

ships and loan repayments, the Secretary shall ensure that an appropriate number of mental health professionals is assigned under section 333 for health professional shortage areas.''.

(2) APPLICABILITY.—With respect to contracts for scholarships and loan repayments under subpart III of part D of title III of the Public Health Service Act, the amendment made by subsection (a) applies with respect to contracts entered into on or after October 1, 1995.

PART 3—ASSISTANCE FOR INSTITUTIONAL PROVIDERS

Subpart A—Emergency Medical Systems

SEC. 3021. EMERGENCY MEDICAL SERVICES.

(a) HEADINGS.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in the heading for the title, by striking ''**TRAUMA CARE**'' and inserting ''**EMERGENCY MEDICAL AND TRAUMA CARE SERVICES**''; and

(2) in the heading for part A, by striking ''General'' and all that follows and inserting ''General Authorities and Duties''.

(b) STATE OFFICES OF EMERGENCY MEDICAL SERVICES; DEMONSTRATION PROGRAM REGARDING TELE-

COMMUNICATIONS.—Part A of title XII of the Public Health Service Act (42 U.S.C. 300d et seq.), as amended by section 601(b) of Public Law 103-183 (107 Stat. 2238), is amended—

(1) by redesignating sections 1202 and 1203 as sections 1203 and 1204, respectively;

(2) by inserting after section 1201 the following section:

"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

''(a) PROGRAM OF GRANTS.—The Secretary may make grants to States for the purpose of improving the availability and quality of emergency medical services through the operation of State offices of emergency medical services.

''(b) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

''(A) for the first fiscal year of payments under the grant, is not less than $1 for each $3 of Federal funds provided in the grant;

''(B) for any second fiscal year of such payments, is not less than $1 for each $1 of Federal funds provided in the grant; and

''(C) for any third fiscal year of such payments, is not less than $3 for each $1 of Federal funds provided in the grant.

''(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

''(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

''(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

''(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

''(c) CERTAIN REQUIRED ACTIVITIES.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

''(1) coordinating the activities carried out in the State that relate to emergency medical services;

''(2) activities regarding the matters described in paragraphs (1) through (4) section 1201(a); and

''(3) identifying Federal and State programs regarding emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

''(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will

be provided with an annual budget of not less than $50,000.

''(e) CERTAIN USES OF FUNDS.—

''(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

''(A) if research with respect to emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

''(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

''(2) ESTABLISHMENT OF OFFICE.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

''(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

''(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless

an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''; and

(3) in section 1204 (as redesignated by paragraph (1) of this subsection)—

(A) by redesignating subsection (c) as subsection (d); and

(B) by inserting after subsection (b) the following new subsection:

''(c) DEMONSTRATION PROGRAM REGARDING TELECOMMUNICATIONS.—

''(1) LINKAGES FOR RURAL FACILITIES.—Projects under subsection (a)(1) shall include demonstration projects to establish telecommunications between rural medical facilities and medical facilities that have expertise or equipment that can be utilized by the rural facilities through the telecommunications.

''(2) MODES OF COMMUNICATION.—The Secretary shall ensure that the telecommunications technologies demonstrated under paragraph (1) include interactive video telecommunications, static video imaging transmitted through the telephone

system, and facsimiles transmitted through such system.''.

(c) FUNDING.—Section 1232 of the Public Health Service Act (42 U.S.C. 300d–32) is amended by striking subsections (a) and (b) and inserting the following:

''(a) EMERGENCY MEDICAL SERVICES GENERALLY.—For the purpose of carrying out section 1201 other than with respect to trauma care, and for the purpose of carrying out section 1204(c), there are authorized to be appropriated $2,000,000 for each of the fiscal years 1997, 1998, and 1999.

''(b) STATE OFFICES.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for each of the fiscal years 1997, 1998, and 1999.''.

SEC. 3022. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

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

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

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhance-

ment of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

''(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

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

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

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

''(C) demonstrate that there is a lack of facilities available and equipped to deliver ad-

vanced levels of medical care in the geographic areas to be served;

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

''(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

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

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

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

the fiscal year for which the grant is received; and

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

''(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

''(I) contain such other information as the Secretary may determine appropriate.

''(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

''(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

''(2) give preference to States with State plans that demonstrate an effective integration of the pro-

posed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

''(d) STATE ADMINISTRATION AND USE OF GRANT.—

''(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

''(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

''(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

''(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

''(f) REPORTS.—

''(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

''(A) a description of the manner in which the grant proceeds were utilized;

''(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

''(C) such other information as the Secretary may require.

''(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

''(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, such sums as may be necessary for each of fiscal years 1997 through 2000.''.

Subpart B—Demonstration Projects to Encourage Primary Care and Rural-Based Graduate Medical Education

SEC. 3031. STATE AND CONSORTIUM DEMONSTRATION PROJECTS.

(a) IN GENERAL.—

(1) PARTICIPATION OF STATES AND CONSORTIA.—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (d)—

(A) to not more than 10 States for the purpose of testing and evaluating mechanisms to meet the goals described in section 3032; and

(B) to not more than 10 health care training consortia for the purpose of testing and evaluating mechanisms to meet such goals.

(2) EXCLUSION OF CONSORTIA IN PARTICIPATING STATES.—A consortia may not receive payments under the demonstration project under paragraph (1)(B) if any of its members is located in a State receiving payments under the project under paragraph (1)(A).

(b) APPLICATIONS.—

(1) IN GENERAL.—Each State and consortium desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require to assure that the State or consortium will meet the goals described in section 3032. In the case of an application of a State, the application shall include—

(A) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(B) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(C) an explanation of a plan for evaluating the impact of the project in the State.

(2) APPROVAL OF APPLICATIONS.—A State or consortium that submits an application under paragraph (1) may begin a demonstration project under this subsection—

(A) upon approval of such application by the Secretary; or

(B) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

(3) NOTICE AND COMMENT.—A State or consortium shall issue a public notice on the date it submits an application under paragraph (1) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or consortium or the Secretary during the 30-

day period beginning on the date the public notice is issued.

(c) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

(1) REQUIREMENTS FOR STATES.—Each State participating in the demonstration project under this subtitle shall use the payments provided under subsection (d) to test and evaluate either of the following mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice:

(A) USE OF ALTERNATIVE WEIGHTING FACTORS.—

(i) IN GENERAL.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(ii) USE OF PAYMENTS FOR PRIMARY CARE RESIDENTS.—In applying different

weighting factors under clause (i), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(B) PAYMENTS FOR MEDICAL EDUCATION THROUGH CONSORTIUM.—The State may make payments for graduate medical education costs through payments to a health care training consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium) that is established in the State but that is not otherwise participating in the demonstration project.

(2) REQUIREMENTS FOR CONSORTIUM.—

(A) IN GENERAL.—In the case of a consortium participating in the demonstration project under this subtitle, the Secretary shall make payments for graduate medical education costs through a health care training consortium

whose members provide medical residency training (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium).

(B) USE OF PAYMENTS.—

(i) IN GENERAL.—Each consortium receiving payments under subparagraph (A) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use such funds for the operation of the consortium.

(ii) PAYMENTS TO PARTICIPATING PROGRAMS.—The consortium shall ensure that the majority of the payments received under subparagraph (A) are directed to consortium members for primary care residency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the con-

sortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, non-ambulatory training experience.

(d) ALLOCATION OF PORTION OF MEDICARE GME PAYMENTS FOR ACTIVITIES UNDER PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, the following rules apply with respect to each State and each health care training consortium participating in the demonstration project established under this section during a year:

(1) In the case of a State—

(A) the Secretary shall reduce the amount of each payment made to hospitals in the State during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the State an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(2) In the case of a consortium—

(A) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(e) ADDITIONAL GRANT FOR PLANNING AND EVALUATION.—

(1) IN GENERAL.—The Secretary may award grants to States and consortia participating in the demonstration project under this section for the purpose of developing and evaluating such projects. A State or consortia may conduct such an evaluation or contract with a private entity to conduct the evaluation. Each State and consortia desiring to receive a grant under this paragraph shall prepare and submit to the Secretary an application, at such time, in

such manner, and containing such information as the Secretary may require.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for grants under this paragraph for fiscal years 1997 through 2001.

(f) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 5 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(g) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each State or consortium participating in the demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the State or consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subtitle begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium

activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(h) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this subtitle shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

SEC. 3032. GOALS FOR PROJECTS.

The goals referred to in this section for a State or consortium participating in the demonstration project under this subtitle are as follows:

(1) The training of an equal number of physician and non-physician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency training program at sites at which acute care inpatient hospital services are not furnished.

(4) The rotation of residents in approved medical residency training programs among practices that serve residents of rural areas.

(5) The development of a plan under which, after a 5-year transition period, not less than 50 percent of the residents who begin an initial residency period in an approved medical residency training program shall be primary care residents.

SEC. 3033. DEFINITIONS.

In this subpart:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term ''approved medical residency training program'' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term ''health care training consortium'' means a State, regional, or local entity consisting of at least one of each of the following:

(A) A hospital operating an approved medical residency training program at which residents receive training at ambulatory training sites located in rural areas.

(B) A school of medicine or osteopathic medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term ''primary care'' means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term ''resident'' has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

Subpart C—Medicare Demonstration Regarding Consortia of Hospitals

SEC. 3041. MEDICARE DEMONSTRATION REGARDING CONSORTIA OF HOSPITALS.

(a) IN GENERAL.—The Secretary shall establish and conduct not more than 10 demonstration projects to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (c) to participating health care training consortia.

(b) APPLICATIONS.—Each consortium desiring to participate in a demonstration project under this section shall prepare and submit to the Secretary an application

at such time and in such manner as the Secretary may require, and containing—

(1) an explanation of a plan with the goal of training at least 50 percent of all residents participating in approved residency training programs conducted by members of the consortium as primary care residents (as defined in subsection (f)(4)); and

(2) such other information and assurances as the Secretary may require.

(c) PAYMENTS TO PARTICIPANTS.—

(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act—

(A) in the case of a consortium participating in a demonstration project under this subtitle, the Secretary shall make payments under such title for the direct and indirect costs of graduate medical education of members of the consortium to the consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium), except that the amount paid to the consortium shall be based on the designations described in paragraph (2); and

(B) the Secretary may not make any payment under such title to a member of a consor-

tium for the direct and indirect costs of graduate medical education during the period of the consortium's participation in the demonstration project.

(2) DESIGNATION OF RESIDENTS BY CONSORTIUM.—Each consortium participating in a demonstration project shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the amount paid to the consortium under paragraph (1)(A). Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

(3) LIMIT ON PAYMENT.—The amount paid to a consortium under paragraph (1)(A) during a year may not exceed the Secretary's estimate of the sum of the payments that would have been made under title XVIII to each member of the consortium during the year but for the application of this section, determined as if such payments were based on—

(A) the number of full-time-equivalent residents in approved medical residency training programs of the member calculated under section 1886(h)(4) of the Social Security Act dur-

ing the academic year beginning July 1, 1994; and

(B) the ratio of the member's full-time equivalent interns and residents to beds applicable under section 1886(d)(5)(B)(ii) of such Act for discharges occurring during the 12-month cost reporting period beginning or after July 1, 1994.

(d) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 10 years. The Secretary may terminate a project if the Secretary determines that the consortium participating in the project is not in substantial compliance with the terms of the application approved by the Secretary.

(e) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each consortium participating in a demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which such a project is conducted, the Sec-

retary shall submit a report to Congress which evaluates the effectiveness of the consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(f) DEFINITIONS.—In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term ''approved medical residency training program'' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term ''health care training consortium'' means a State, regional, or local entity consisting of at least 2 hospitals operating approved medical residency training programs.

(3) RESIDENT.—The term ''resident'' has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(4) PRIMARY CARE RESIDENT.—The term ''primary care resident'' means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, or obstetrics and gynecology.

Subtitle B—Public Health Grants

SEC. 3101. GRANTS TO STATES FOR PUBLIC HEALTH PROGRAMS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by section 703 of Public Law 103–183 (107 Stat. 2240), is amended by inserting after section 317F the following section:

''GRANTS TO STATES FOR PUBLIC HEALTH PROGRAMS

''SEC. 317G. (a) IN GENERAL.—The Secretary may make grants to States for the following purposes:

''(1) Education and training of public health professionals.

''(2) Prevention and control of poisoning.

''(3) Prevention and control of infectious diseases.

''(4) Laboratory services regarding public health.

''(5) Community and school-based health education.

''(6) Prevention programs regarding public health.

''(7) Community and school-based public-health services.

''(8) Collection and reporting of data regarding public health.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 1998.''.

SEC. 3102. SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REGARDING SERVICE IN PUBLIC HEALTH POSITIONS.

Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended—

(1) by redesignating subparts II and III as subparts III and IV, respectively; and

(2) by inserting after subpart I the following subpart:

''Subpart II—Scholarship and Loan Repayment Programs Regarding Service in Public Health Positions

''SEC. 765A. SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

''(a) SCHOLARSHIP PROGRAM.

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Secretary awards scholarships to individ-

uals described in paragraph (2) for the purpose of assisting the individuals with the costs of attending public and nonprofit private schools of public health (or other public or nonprofit private institutions providing graduate or specialized training in public health).

''(2) ELIGIBLE INDIVIDUALS.—An individual referred to in paragraph (1) is any individual meeting the following conditions:

''(A) The individual is enrolled (or accepted for enrollment) at a school or other institution referred to in paragraph (1) as a full-time or part-time student in a program providing training in a health profession in a field of public health (including the fields of epidemiology, biostatistics, environmental health, health administration and planning, behavioral sciences, maternal and child health, occupational safety, public health nursing, nutrition, and toxicology).

''(B) The individual enters into the contract required pursuant to subsection (c) as a condition of receiving the scholarship (relating to an agreement to provide services in approved

public health positions, as defined in subsection (c).

''(3) ELIGIBLE SCHOOLS.—For fiscal year 1997 and subsequent fiscal years, the Secretary may make an award of a scholarship under paragraph (1) only if the Secretary determines that—

''(A) the school or other institution with respect to which the award is to be provided has coordinated the activities of the school or institution with relevant activities of the Health Resources and Services Administration and the Centers for Disease Control and Prevention; and

''(B) not fewer than 60 percent of the graduates of the school or institution are in public health positions determined by the Secretary to be consistent with the needs of the United States regarding such professionals.

''(4) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this subsection or subsection (c), the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an award of a scholarship under paragraph (1) to the same extent and in the

same manner as such provisions apply to an award of a scholarship under section 338A.

''(b) LOAN REPAYMENT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Federal Government enters into agreements to repay all or part of the educational loans of individuals meeting the following conditions:

''(A) The individual involved is a graduate of a school or other institution described in subsection (a)(1).

''(B) The individual meets the applicable legal requirements to provide services as a public health professional (including a professional in any of the fields specified in subsection (a)(2)(A)).

''(C) The individual enters into the contract required pursuant to subsection (c) as a condition of the Federal Government repaying such loans (relating to an agreement to provide services in approved public health positions, as defined in subsection (c)).

''(2) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this subsection or subsection (c), the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an agreement regarding repayment under paragraph (1) to the same extent and in the same manner as such provisions apply to an agreement regarding repayment under section 338B.

''(3) AMOUNT OF REPAYMENTS.—For each year for which an individual contracts to serve in an approved public health position pursuant to paragraph (2), the Secretary may repay not more than $20,000 of the principal and interest of the educational loans of the individual.

''(c) APPROVED PUBLIC HEALTH POSITIONS.—

''(1) POSITION REGARDING POPULATIONS WITH SIGNIFICANT NEED FOR SERVICES.—

''(A) With respect to the programs under this section, the obligated service of a program participant pursuant to subsections (a)(4) and (b)(2) shall be provided through an assignment, to an entity described in paragraph (2), for a position in which the participant provides serv-

ices as a public health professional to a population determined by the Secretary to have a significant unmet need for the services of such a professional.

''(B) For purposes of subsection (a)(4) and (b)(2), the period of obligated service is the following, as applicable to the program participant involved:

''(i) In the case of scholarships under subsection (a) for full-time students, the greater of—

''(I) 1 year for each year for which such a scholarship is provided; or

''(II) 2 years.

''(ii) In the case of scholarships under subsection (a) for part-time students, a period determined by the Secretary on the basis of the number of hours of education or training received under the scholarship, considering the percentage constituted by the ratio of such number to the number of hours for a full-time student in the program involved.

''(iii) In the case of the loan repayments under subsection (b), such period as the Secretary and the participant may agree, except that the period may not be less than 2 years.

''(2) APPROVAL OF ENTITIES FOR ASSIGNMENT OF PROGRAM PARTICIPANTS.—The entities referred to in paragraph (1)(A) are public and nonprofit private entities approved by the Secretary as meeting such requirements for the assignment of a program participant as the Secretary may establish. The entities that the Secretary may so approve include State and local departments of health, public hospitals, community and neighborhood health clinics, migrant health clinics, community-based health-related organizations, certified regional poison control centers, purchasing cooperatives regarding health insurance, and any other public or nonprofit private entity.

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

''(1) The term 'approved public health position', with respect to a program participant, means a position to which the participant is assigned pursuant to paragraph (1).

''(B) The term 'program participant' means an individual who enters into a contract pursuant to subsection (a)(2)(B) or subsection (b)(1)(C).

''(d) CERTAIN CONSIDERATIONS.—

''(1) SPECIAL CONSIDERATION FOR CERTAIN INDIVIDUALS.—In making awards of scholarships under subsection (a) and making repayments under subsection (b), the Secretary shall give special consideration to individuals who are in the armed forces of the United States or who are veterans of the armed forces.

''(2) SCHOOL HEALTH EDUCATION PROGRAMS.—The Secretary shall ensure that the approved public health positions to which the Secretary assigns program participants under this part include positions in programs that provide education on the promotion of health and the prevention of diseases and that are carried out on the premises of public or nonprofit private elementary and secondary schools.

''(e) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may

be necessary for each of the fiscal years 1996 through 1998.

''(2) ALLOCATIONS.—Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall obligate not less than 30 percent for the purpose of providing awards for scholarships under subsection (a) to individuals who have not previously received such scholarships.''.

Subtitle C—Academic Health Centers

SEC. 3201. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities that are not hospitals for the direct and indirect costs of graduate medical education attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

SEC. 3202. STUDY OF FUNDING NEEDS OF HEALTH PROFESSIONS SCHOOLS.

(a) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the funding needs of health professions schools, including schools of medicine and osteopathic medicine, schools of dentistry, and schools of public health.

(b) CONSIDERATION OF CERTAIN COSTS.—In conducting the study under subsection (a), the Secretary shall also consider the following costs regarding the funding needs of health professions schools:

(1) Uncompensated costs incurred in providing health care.

(2) Costs resulting from reduced productivity due to teaching responsibilities.

(3) Increased costs of caring for the health needs of patients with severe medical complications.

(4) Uncompensated costs incurred by faculty, residents, and students in providing consultations for hospitalized patients.

(5) Uncompensated costs incurred in conducting clinical research.

(c) CONSIDERATIONS REGARDING ADDITIONAL FUNDING.—In conducting the study under subsection (a), the Secretary shall determine the following:

(1) Whether the health professions schools involved have a significant need for an increase in the amount of funds available to the schools.

(2) If there is such a need—

(A) recommendations regarding the sources of funds to provide the increase; and

(B) recommendations for a methodology for determining the amount that should be provided to the schools involved.

(d) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Congress a report describing the findings and recommendations made in the study.

TITLE IV—MALPRACTICE REFORM

Subtitle A—Findings; Purpose; Definitions

SEC. 4001. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds that—

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

(2) the Federal Government has a major interest in health care as a direct provider of health care and as a source of payment for health care, and has a demonstrated interest in assessing the quality of care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

(b) PURPOSE.—It is the purpose of this title to—

(1) provide grants to States to develop alternative dispute resolution procedures to attain a more efficient, expeditious, and equitable resolution of health care malpractice disputes;

(2) enhance general knowledge concerning the benefits of different forms of alternative dispute resolution mechanisms; and

(3) establish uniformity and curb excesses in the State-based medical liability systems through Federally-mandated reforms.

SEC. 4002. DEFINITIONS.

As used in this title:

(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 a 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 de-

vice which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for 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.

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

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

Subtitle B—Uniform Standards for Malpractice Claims

SEC. 4101. APPLICABILITY.

Except as provided in section 4110, this subtitle shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 4102. 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 4202(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 4202(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. 4103. PROCEDURAL REQUIREMENTS FOR FILING OF ACTIONS.

(a) CERTIFICATE OF MERIT.—

(1) IN GENERAL.—Each individual who files a medical malpractice liability action shall, not later than 90 days after filing the action—

(A) submit a certificate of merit described in subsection (b); or

(B) post a surety (or equivalent security) bond of $4,000 (or, during the 45-day period that begins on the date the action is filed, a cost bond of $2,000) with the court.

(2) EXTENSION OF DEADLINE.—On the motion of any party to the action or upon a written agreement of the parties filed with the court, the court may extend the deadline specified in paragraph (1) for a period not to exceed 30 days.

(3) DISMISSAL FOR FAILURE TO MEET REQUIREMENT.—If an individual filing a medical malpractice liability action fails to meet the requirements of paragraph (1)—

(A) the court shall dismiss the action without prejudice to the refiling of the action by the individual; and

(B) require the individual to pay any court costs incurred by the defendants as a result of the filing of the action.

(4) WAIVER FOR GOOD CAUSE.—The court may waive the application of paragraph (1) to a plaintiff if the plaintiff shows good cause that such paragraph should not apply.

(5) CERTIFICATE OF MERIT DESCRIBED.—In paragraph (1), a ''certificate of merit'' is, with re-

spect to an individual filing a medical malpractice liability action, an affidavit declaring that the individual (or the individual's attorney) has obtained a written opinion from a medical expert who is knowledgeable of the relevant medical issues involved in the action that the defendant was negligent and the defendant's conduct was a proximate cause of the alleged injury that is the subject of the action.

(b) RESPONSE TO STANDARD INTERROGATORIES AND REQUESTS FOR DOCUMENTS.—

(1) DEADLINE.—Each party to a medical malpractice liability action shall respond to the standard set of interrogatories and requests for production of documents developed pursuant to paragraph (4) as follows:

(A) In the case of a plaintiff, the party shall provide the defendant (or the defendant's attorney) with full and complete responses not later than 45 days after filing the action.

(B) In the case of a defendant, the party shall provide the plaintiff (or the plaintiff's attorney) with full and complete responses not later than 45 days after receiving the plaintiff's responses under subparagraph (A).

(C) In the case of a party who is added to the action after the action is filed, the party shall provide all other parties (or such parties' attorneys) with full and complete responses not later than 45 days after the date of the filing of the pleading by which the party is added to the action.

(2) EXTENSION OF DEADLINE.—On the motion of any party to the action that is supported by good cause, or upon a written agreement of the parties filed with the court, the court shall extend the deadline specified in paragraph (1) for a period not to exceed 30 days.

(3) IMPOSITION OF SANCTIONS FOR FAILURE TO RESPOND.—If a party to a medical malpractice liability action fails to respond to the standard set of interrogatories and requests for production of documents as required under paragraph (1), the party shall be subject to sanctions by the court under any applicable laws, rules, and regulations governing the imposition of sanctions by the court.

(4) DEVELOPMENT OF STANDARD INTERROGATORIES AND REQUESTS.—

(A) APPOINTMENT OF EXPERT PANELS.—The Governor of each State shall appoint a

panel to develop the standard set of interrogatories and requests for production of documents that will be used for purposes of this subsection in the courts of the State. The set shall be comprehensive and designed to expedite the discovery process in the courts. The Attorney General shall appoint a panel to develop such set that will be used for purposes of this subsection in the Federal courts.

(B) COMPOSITION.—Each panel appointed pursuant to subparagraph (A) shall consist of not less than 6 and not more than 12 members, of whom an equal number shall be attorneys who customarily represent plaintiffs in medical malpractice liability actions and attorneys who customarily represent defendants in such actions.

(C) DEADLINES.—Not later than October 1, 1996, each panel appointed pursuant to subparagraph (A) shall complete and publish the standard set of interrogatories and requests for production of documents.

SEC. 4104. 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) 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). The previous sentence shall not apply if the defendant has been found to be liable as a result of gross negligence or fraud.

(d) ALLOCATION OF PUNITIVE DAMAGE AWARDS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—

(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) for the purposes of carrying out the activities described in paragraph (2).

(2) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to paragraph (1) 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;

(B) implementing health care quality assurance programs;

(C) carrying out public education programs to increase awareness of the availability of comparative quality information on accountable health plans;

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

(E) implementing and operating a State alternative dispute resolution system certified by the Secretary under section 4202.

(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 the activities described in paragraph (2).

(e) DEVELOPMENT OF ALTERNATIVE LIMITS ON NONECONOMIC DAMAGES.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary in consultation with the Attorney General shall develop and transmit to Congress alternative limits on the amount of noneconomic damages that may be awarded with respect to medical malpractice liability claims, together with legislative specifications necessary to replace the limit imposed under subsection (a) on the amount of such damages with such alternative limits. The purpose of the development of the limits is to provide certainty and fairness in malpractice awards and to avoid unwarranted disparities

among health care providers and health care professionals who have engaged in similar conduct.

(2) ESTABLISHMENT OF SEPARATE LIMITS FOR CATEGORIES OF INJURIES.—In developing limits under paragraph (1), the Secretary shall establish separate limits for noneconomic damages resulting from each of the following categories of injuries:

(A) Non-physical injuries.

(B) Insignificant physical injuries.

(C) Temporary minor physical injuries.

(D) Temporary major physical injuries.

(E) Permanent minor physical injuries.

(F) Permanent substantial physical injuries.

(G) Permanent major physical injuries.

(H) Permanent grave physical injuries.

(I) Death.

(3) FACTORS CONSIDERED.—In developing limits under paragraph (1) for each of the categories described in paragraph (2), the Secretary shall—

(A) examine the most recent available data on the amount of damages awarded with respect to such claims; and

(B) set specific limits that reasonably compensate most injured parties at the level of

compensation currently provided, excluding those levels of compensation that the Secretary finds unreasonably large.

(4) CONSULTATION.—In developing limits under this subsection, the Secretary shall consult with representatives of each of the following:

(A) Attorneys who represent plaintiffs in medical malpractice liability actions.

(B) Attorneys who represent health care professionals and health care providers in medical malpractice liability actions.

(C) Physicians and other health care professionals and providers.

(D) Individuals who have suffered injury as a result of medical malpractice.

(E) Judges who preside over medical malpractice liability actions.

(F) Medical ethicists.

(G) Health care economists.

(H) Liability insurers.

(5) GUIDANCE TO ENTITIES RESOLVING CLAIMS.—If Congress enacts legislation that imposes the limits developed by the Secretary under this subsection on the amount of noneconomic damages that may be awarded with respect to medical malpractice

liability claims, the Secretary shall prepare and disseminate guidelines to assist courts and other entities resolving such claims in the determination of the particular category of injury specified in paragraph (2) to which a claimant's injury shall be assigned for purposes of applying the appropriate limit on such damages.

SEC. 4105. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on a periodic basis. 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. 4106. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered or the date

on which the alleged injury that is the subject of such claim was discovered or the date on which such injury should reasonably have been discovered, whichever is earlier.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may be initiated after the expiration of the period described in subsection (a) if the claim is initiated before the minor attains 8 years of age.

SEC. 4107. 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. 4108. UNIFORM STANDARD FOR DETERMINING LIABILITY IN ACTIONS BASED ON NEGLIGENCE.

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

(b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—Subsection (a) shall not apply with respect to a medical malpractice action if (in accordance with applicable State law) the theory of liability upon which the action is based is a theory of strict liability.

SEC. 4109. JURISDICTION OF FEDERAL COURTS.

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

SEC. 4110. PREEMPTION.

(a) IN GENERAL.—This subtitle supersedes any State law only to the extent that the State law permits the recovery by a claimant or the assessment against a defendant of a greater amount of damages or establishes a less strict standard of proof for determining whether a defendant has committed malpractice, than the provisions of this subtitle.

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

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

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

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

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

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

Subtitle C—Requirements for State Alternative Dispute Resolution Systems (ADR)

SEC. 4201. BASIC REQUIREMENTS.

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

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

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

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

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

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

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

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

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

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

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of subtitle B (other than sections 4102 and 4103) 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. 4202. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1996), 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 4201.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1996, 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 4201(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. 4203. GRANTS TO STATES.

(a) IN GENERAL.—The Secretary shall make grants to States for a 2-year period to assist States in implementing and operating alternative dispute resolution systems that meet the requirements of section 4201.

(b) ELIGIBILITY.—A State is eligible to receive a grant under this section if the Secretary has certified the State's alternative dispute resolution system under section 4202(b).

(c) LIMITATION ON AMOUNT OF GRANT.—The amount of funds provided to a State under a grant under this section may not exceed $5,000,000 during the 2-year period of the grant.

SEC. 4204. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this subtitle and the alternative Federal system established under section 4202(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.

Subtitle D—Grants to States for Development of Practice Guidelines

SEC. 4301. GRANTS TO STATES.

(a) IN GENERAL.—The Secretary shall make grants to States for a 2-year period for the development of medical practice guidelines for health care professionals (including mid-level practitioners) that may be applied to resolve medical malpractice liability claims and actions in the State.

(b) ELIGIBILITY.—A State is eligible to receive a grant under this section if the State submits to the Secretary an application at such time, in such form, and containing such information and assurances as the Secretary may require, including assurances that the State will submit such periodic reports on the development and application of the State's medical practice guidelines as the Secretary may require.

(c) NUMBER OF GRANTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall award not less than 10 grants under this section.

(2) EXCEPTION.—Notwithstanding paragraph (1), the Secretary may award less than 10 grants under this section if the Secretary determines that there are an inadequate number of applications submitted that meet the eligibility and approval requirements of this section.

(d) LIMITATION ON AMOUNT OF GRANT.—The amount of funds provided to a State under a grant under this section may not exceed $5,000,000 during the 2-year period of the grant.

TITLE V—MARKET INCENTIVES TO CONTAINING COSTS

Subtitle A—Administrative Simplification

SEC. 5000. PURPOSE.

It is the purpose of this subtitle 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. 5001. DEFINITIONS.

For purposes of this subtitle:

(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 subtitle.

(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 subtitle, 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 or-

ganization'' 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 person (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 informa-

tion'' 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(12)) providing benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974; 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 part 1 that applies to the transaction or data elements.

PART 1—STANDARDS FOR DATA ELEMENTS AND TRANSACTIONS

SEC. 5011. GENERAL REQUIREMENTS ON SECRETARY.

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

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted, developed, or modified by the standard-setting organizations accredited by the American National Standard Institute.

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this part.

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

SEC. 5012. 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 5021.

(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. 5013. 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 5014 relating to the method by which standard data elements of health information may be transmitted electronically, including standards with respect to the format in which such data elements may be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standard adopted by the Secretary under paragraph (1) that relates to coordination of benefits shall provide that a claim for reimbursement for health services furnished shall be tested, by an algorithm specified by the Secretary, against all records of enrollment and eligibility for the individual who received such services that are available to the recipient of the claim through the health information network to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic

transmission and authentication of signatures, compliance with which shall be deemed to satisfy State and Federal statutory requirements for written signatures with respect to transactions described in section 5021 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. 5014. 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. 5015. 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 5012(a) not later than 9 months after the date of the enactment of this Act (except in the case of standards with respect to data elements for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act); and

(2) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL PRIVACY STANDARDS.—The Secretary shall adopt standards relating to the privacy of individually identifiable health information in the health information network under section 5014 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 5013 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 part 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 purchasing organization that is required to comply with part 2.

(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 part 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 purchasing organization to comply with part 2.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or health plan purchasing organization that is required to comply with part 2.

(e) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this part.

Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

PART 2—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

SEC. 5021. STANDARD TRANSACTIONS AND INFORMATION.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the sponsor to the provider or by the provider to the sponsor in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS WITH SPONSORS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with another plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by either sponsor in connection with the trans-

action shall be in the form of standard data elements.

(3) TRANSACTIONS.—The transactions referred to in paragraphs (1) and (2) are the following:

(A) Verification of eligibility for benefits.

(B) Coordination of benefits.

(C) Claim submission.

(D) Claim attachment submission.

(E) Claim status notification.

(F) Claim status verification.

(G) Claim adjudication.

(H) Payment and remittance advice.

(I) Certification or authorization of a referral to a health provider who is not part of a provider network.

(b) USE OF HEALTH INFORMATION NETWORK SERVICES.—A plan sponsor, a health provider, or a health plan purchasing 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 5031 pursuant to which the service undertakes the duties applicable to the sponsor, provider, or organization under the provision.

SEC. 5022. 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 5031 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 part 1; 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 part 1 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 5031; and

(B) requests the information.

SEC. 5023. 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 5031, may comply with the provisions of this part.

SEC. 5024. 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

part 1 with respect to a type of transaction, or data elements for a type of health information, a plan sponsor, health provider, or health plan purchasing organization shall comply with the requirements of this part 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 5012, a plan sponsor, health provider, or health plan purchasing organization shall comply with the requirements of this part using such data elements.

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

(1) IN GENERAL.—If the Secretary adopts a modified standard under section 5015(c), a plan sponsor, health provider, or health plan purchasing 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.

PART 3—MISCELLANEOUS PROVISIONS

SEC. 5031. 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 subtitle 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 5014 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. 5032. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c), after the Secretary has established standards under section 5012 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 part 2, 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 5013 relating to the method by which data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in part 2 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. 5033. 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 subtitle 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 subtitle 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 subtitle 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.

Subtitle B—Antitrust

SEC. 5101. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate 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 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15

U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

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

(2) the term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

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

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

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 5102. 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 activity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

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

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

(B) such reduction in competition is 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 collaborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

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

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

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

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

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 90 days after an eligible health care collaborative activity submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 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 applica-

tion for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

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

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney

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

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

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

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

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws'' has the meaning given it in section 5101(c)(1).

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

(3) The term ''health care collaborative activity'' means an agreement (whether existing or pro-

posed) 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 engagement in any other conduct that is not reasonably required to carry out such agreement.

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

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

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

SEC. 5103. STUDY OF IMPACT ON COMPETITION.

The Attorney General, in consultation with the Chairman of the Federal Trade Commission, annually shall submit to the Congress a report as part of the annual budget oversight proceedings concerning the Antitrust Division of

the Department of Justice. The report shall enable the Congress to determine how enforcement of antitrust laws is affecting the formation of efficient, cost-saving joint ventures and if the certificate of public advantage procedure set forth in section 5102 has resulted in undesirable reduction in competition in the health care marketplace. The report shall include an evaluation of the factors set forth in paragraphs (2)(A) and (2)(B) of section 5102(b).

TITLE VI—MEDICARE

Subtitle A—Increased Beneficiary Choice; Improved Program Efficiency

PART 1—INCREASED BENEFICIARY CHOICE

SEC. 6001. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS UNDER MEDICARE.

(a) USE OF METROPOLITAN STATISTICAL AREAS TO DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) is amended by striking ''in a geographic area served by an eligible organization or in a similar area'' and inserting ''in the metropolitan statistical area (as defined by the Office of Management and Budget) in which the individual resides, or in the entire portion of the State in which the individual resides which is not located in a metropolitan statistical area in the case of an

individual who does not reside in a metropolitan statistical area''.

(b) DETERMINATION OF MODEL ADDITIONAL HEALTH BENEFIT PACKAGES.—Section 1876(g) of such Act (42 U.S.C. 1395mm(g)) is amended by inserting after paragraph (3) the following new paragraph:

''(4) The Secretary shall develop the following model packages of additional health benefits (referred to in paragraph (3)(B)) which an eligible organization may provide (at its option) under paragraph (2):

''(A) Coverage for catastrophic illness (subject to a limit on out-of-pocket expenditures).

''(B) Coverage for prescription drugs.

''(C) Coverage for preventive services.''.

(c) REVISION OF MEMBERSHIP LIMITATION.—Section 1876(f) of such Act (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1), by striking ''one-half'' and inserting ''25 percent''; and

(2) in paragraph (2)(A), by striking ''50 percent'' and inserting ''75 percent''.

(d) ENROLLMENT PERIODS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.—

(1) UNIFORM OPEN ENROLLMENT PERIOD.—Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.

1395mm(c)(3)(A)(i)) is amended by striking ''must have'' and all that follows through ''and including'' and inserting the following: ''shall have open enrollment during an annual uniform open enrollment period established by the Secretary for all eligible organizations, together with''.

(2) OPEN ENROLLMENT FOR CERTAIN DISENROLLED INDIVIDUALS.—Section 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C. 1395mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: ''Each eligible organization with a risk-sharing contract under this section shall have an open enrollment period for individuals residing in the organization's service area who disenroll from another eligible organization with a risk-sharing contract under this section on the grounds that the individual's primary care physician is no longer a member of the organization's provider network or for cause (in accordance with such standards, and as demonstrated through an appeals process that meets such requirements, as the Secretary may establish).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 6002. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as ''OBRA–1990'') is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA–1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition

and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except

in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

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

''(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

''(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such

individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I), and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

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

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall

be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1994 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1994 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

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

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

ary 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6003. INCLUDING NOTICE OF AVAILABLE HEALTH MAINTENANCE ORGANIZATIONS IN ANNUAL NOTICE TO BENEFICIARIES.

Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) by striking ''and'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '', and''; and

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

''(4) with respect to the area in which the individual receiving the notice resides, a description of the eligible organizations under section 1833(a)(1) or section 1876 and the carriers offering a medicare supplemental policy described in section 1882(t)(1) which serve the area in which the individual receiving the notice resides.''.

SEC. 6004. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the voluntary enrollment of medicare beneficiaries in private health insurance plans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a private health insurance plan.

SEC. 6005. OPTIONAL INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN PRIVATE HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a private health insurance plan on behalf of enrolled medicare beneficiaries who choose to enroll in such a plan.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term ''medicare beneficiary'' means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a private health insurance plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act; or

(ii) the monthly premium charged the individual for coverage under the private health insurance plan.

(B) SOURCE OF PAYMENT.—The payment to a private health insurance plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the private plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the plan the difference between the monthly premium charged the individual for coverage under the plan and the amount specified in paragraph (1)(A)(i).

(3) BUDGET-NEUTRALITY.—The total amount of payments made by the Secretary under this sec-

tion with respect to a beneficiary for a year may not exceed the amount of payment that would have been made under title XVIII of the Social Security Act during the year if the beneficiary did not choose to enroll in a private health insurance plan during the year.

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2), as amended by section 6003, is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting '', and''; and

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

''(5) a description of the option provided pursuant to section 6005 of the Health Care Improvement Act of 1995 for payment to be made by the Sec-

retary on the individual's behalf for enrollment in a private health insurance plan.''.

PART 2—IMPROVED PROGRAM EFFICIENCY

SEC. 6011. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) over a 4-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

PART 3—NOTICE OF ADVANCE DIRECTIVE RIGHTS

SEC. 6021. PROVIDING NOTICE OF RIGHTS REGARDING MEDICAL CARE TO INDIVIDUALS ENTERING MEDICARE.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period at the end and inserting '', and''; and

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

''(4) a description of an individual's rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in section 1866(f)(3)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to notices provided under section 1804 of the Social Security Act on or after January 1 of the first year beginning after the date of the enactment of this Act.

Subtitle B—Savings

SEC. 6101. REDUCTION IN CONVERSION FACTOR FOR PHYSICIAN FEE SCHEDULE FOR NON-PRIMARY CARE SERVICES.

Section 1848(d)(3)(A) of the Social Security Act (42 U.S.C. 1395w–4(d)(3)(A)) is amended—

(1) in clause (i), by striking ''through (v)'' and inserting ''through (vi)'';

(2) in clause (vi), by striking ''(iv) and (v)'' and inserting ''(iv), (v), and (vi)'';

(3) by redesignating clause (vi) as clause (vii); and

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

''(vi) ADJUSTMENT IN PERCENTAGE INCREASE FOR YEARS FROM 1998 THROUGH 2001.—In applying clause (i) for services furnished during the period beginning January 1, 1998, and ending December 31, 2001, the percentage increase in the appropriate update index shall be reduced by such percent as the Secretary determines will result in a reduction in aggregate payments for physicians' services under this part during such period of at

least $6,300,000,000 from the amount of aggregate payments for such services that would otherwise have been made during the period.''.

SEC. 6102. REDUCTION IN HOSPITAL OUTPATIENT SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1997, such amount shall be equal to 90 percent of the amount that would otherwise have been determined;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1996, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary

to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1997.

SEC. 6103. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

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

"PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 49B. Medicare part B premium tax.

"SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

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

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

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

''(1) IN GENERAL.—The Medicare part B premium tax for any month is the applicable percentage (as defined in paragraph (2)) of the amount equal to the excess of—

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

''(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) PHASE-IN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by—

''(A) less than $25,000, the applicable percentage under this paragraph is 33 percent;

''(B) at least $25,000, but less than $50,000, the applicable percentage under this paragraph is 66 percent,

''(C) at least $50,000, but less than $75,000, the applicable percentage under this paragraph is 75 percent, or

''(D) at least $75,000, the applicable percentage under this paragraph is 100 percent.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $75,000,

''(B) $100,000 in the case of a joint return, and

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

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

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

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

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

''(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''.

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

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''.

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

SEC. 6104. PHASED-IN ELIMINATION OF MEDICARE HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.

Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting ''and before September 30, 2000,'' after ''1986,'';

(2) in clause (ii), by striking ''The amount of such payment'' and inserting ''Subject to clause (ix), the amount of such payment''; and

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

''(ix) The amount of the additional payment made under this paragraph for a discharge shall be equal to—

''(I) for discharges occurring during fiscal year 1997, 80 percent of the amount otherwise determined for the discharge under clause (ii);

''(II) for discharges occurring during fiscal year 1998, 60 percent of the amount otherwise determined for the discharge under clause (ii);

''(III) for discharges occurring during fiscal year 1999, 40 percent of the amount otherwise determined for the discharge under clause (ii); and

''(IV) for discharges occurring during fiscal year 2000, 20 percent of the amount otherwise determined for the discharge under clause (ii).''.

SEC. 6105. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

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

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1996.

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