

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2071

To promote cost containment and reform in health care.

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## 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.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Health Care Improvement Act of 1995”.

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

Sec. 1. Short title; table of contents.

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.
- Sec. 1002. Guaranteed issue by carriers.
- Sec. 1003. Guaranteed renewal.
- Sec. 1004. Restricting preexisting condition exclusions.
- Sec. 1005. Enrollment periods.

PART 2—PROVISION OF BENEFITS

- Sec. 1011. Standards for managed care arrangements.
- Sec. 1012. Utilization review.
- Sec. 1013. Medical savings accounts.

PART 3—FAIR RATING PRACTICES

- Sec. 1021. Use of fair rating practices.
- Sec. 1022. Coordination with premium assistance certificate program.
- Sec. 1023. Establishment of risk adjustment mechanisms.

PART 4—CONSUMER PROTECTIONS

- Sec. 1031. Requirement for provision of information.
- Sec. 1032. Prohibition of improper incentives.
- Sec. 1033. Written policies and procedures respecting advance directives.

Subtitle B—Benefits

- Sec. 1101. Qualified health coverage.
- Sec. 1102. Standard coverage.
- Sec. 1103. High-deductible coverage.
- Sec. 1104. Actuarial valuation of benefits.
- Sec. 1105. Limitation on offering supplemental benefits.
- Sec. 1106. Family coverage option; supplemental coverage.
- Sec. 1107. Level playing field for providers.

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

- Sec. 1201. Establishment of standards.
- Sec. 1202. Application of standards to carriers through States.
- Sec. 1203. Application to group health plans.
- Sec. 1204. Enforcement.
- Sec. 1205. Limitation on self insurance for small employers.

Subtitle D—Definitions; General Provisions

- Sec. 1901. General definitions.
- Sec. 1902. Definitions relating to employment.
- Sec. 1903. Definitions relating to health coverage, plans, and carriers.
- Sec. 1904. Definitions relating to residence and immigration status.
- Sec. 1905. Effective dates.

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.
- Sec. 2002. Deduction for health insurance costs of individuals who are not self-employed.
- Sec. 2003. Restrictions on health benefits provided through cafeteria plans and flexible spending arrangements.

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.

“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.
- “Sec. 2102. Eligibility.
- “Sec. 2103. Premium and cost-sharing assistance.
- “Sec. 2104. Eligibility determinations.
- “Sec. 2105. End-of-year reconciliation for premium assistance.
- “Sec. 2106. Payments to States.
- “Sec. 2107. Federal title XXI matching percentage.

“PART B—STATE SUPPLEMENTAL ACUTE CARE BENEFITS PROGRAMS

- “Sec. 2121. Establishment of State supplemental acute care benefits programs.
- “Sec. 2122. Eligibility.
- “Sec. 2123. Scope and provision of benefits; benefits administration.
- “Sec. 2124. Payments to States.

“PART C—GENERAL PROVISIONS

- “Sec. 2141. Nature of payment obligation.
- “Sec. 2142. Audits.
- “Sec. 2143. Demonstration project authority.
- “Sec. 2144. Definitions and determinations of income.
- 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.
- Sec. 2103. Operation of program as State plan requirement under medicaid.
- Sec. 2104. Application of miscellaneous provisions.

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.
- Sec. 3002. Technical assistance grants for networks.

- Sec. 3003. Development grants for networks.
- Sec. 3004. Definitions.

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.
- Sec. 3012. Modification in criteria for designation as health professional shortage area.
- Sec. 3013. Other provisions regarding National Health Service Corps.

PART 3—ASSISTANCE FOR INSTITUTIONAL PROVIDERS

**Subpart A—Emergency Medical Systems**

- Sec. 3021. Emergency medical services.
- Sec. 3022. Grants to States regarding aircraft for transporting rural victims of medical emergencies.

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

- Sec. 3031. State and consortium demonstration projects.
- Sec. 3032. Goals for projects.
- Sec. 3033. Definitions.

**Subpart C—Medicare Demonstration Regarding Consortia of  
Hospitals**

- Sec. 3041. Medicare demonstration regarding consortia of hospitals.

Subtitle B—Public Health Grants

- Sec. 3101. Grants to States for public health programs.
- Sec. 3102. Scholarship and loan repayment programs regarding service in public health positions.

Subtitle C—Academic Health Centers

- Sec. 3201. Study of payments for medical education at sites other than hospitals.
- Sec. 3202. Study of funding needs of health professions schools.

TITLE IV—MALPRACTICE REFORM

Subtitle A—Findings; Purpose; Definitions

- Sec. 4001. Findings; purpose.
- Sec. 4002. Definitions.

Subtitle B—Uniform Standards for Malpractice Claims

- Sec. 4101. Applicability.
- Sec. 4102. Requirement for initial resolution of action through alternative dispute resolution.
- Sec. 4103. Procedural requirements for filing of actions.
- Sec. 4104. Treatment of noneconomic and punitive damages.
- Sec. 4105. Periodic payments for future losses.

- Sec. 4106. Uniform statute of limitations.
- Sec. 4107. Special provision for certain obstetric services.
- Sec. 4108. Uniform standard for determining liability in actions based on negligence.
- Sec. 4109. Jurisdiction of Federal courts.
- Sec. 4110. Preemption.

Subtitle C—Requirements for State Alternative Dispute Resolution Systems  
(ADR)

- Sec. 4201. Basic requirements.
- Sec. 4202. Certification of State systems; applicability of alternative Federal system.
- Sec. 4203. Grants to States.
- Sec. 4204. Reports on implementation and effectiveness of alternative dispute resolution systems.

Subtitle D—Grants to States for Development of Practice Guidelines

- Sec. 4301. Grants to States.

TITLE V—MARKET INCENTIVES TO CONTAINING COSTS

Subtitle A—Administrative Simplification

- Sec. 5000. Purpose.
- Sec. 5001. Definitions.

PART 1—STANDARDS FOR DATA ELEMENTS AND TRANSACTIONS

- Sec. 5011. General requirements on Secretary.
- Sec. 5012. Standards for data elements of health information.
- Sec. 5013. Information transaction standards.
- Sec. 5014. Health information network privacy standards.
- Sec. 5015. Timetables for adoption of standards.

PART 2—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND  
INFORMATION

- Sec. 5021. Standard transactions and information.
- Sec. 5022. Accessing health information for authorized purposes.
- Sec. 5023. Ensuring availability of information.
- Sec. 5024. Timetables for compliance with requirements.

PART 3—MISCELLANEOUS PROVISIONS

- Sec. 5031. Standards and certification for health information network services.
- Sec. 5032. Imposition of additional requirements.
- Sec. 5033. Effect on State law.

Subtitle B—Antitrust

- Sec. 5101. Publication of antitrust guidelines on activities of health plans.
- Sec. 5102. Issuance of health care certificates of public advantage.
- Sec. 5103. Study of impact on competition.

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.
- Sec. 6002. Expansion and revision of medicare select policies.
- Sec. 6003. Including notice of available health maintenance organizations in annual notice to beneficiaries.
- Sec. 6004. Legislative proposal on enrolling medicare beneficiaries in qualified health plans.
- Sec. 6005. Optional interim enrollment of medicare beneficiaries in private health plans.

PART 2—IMPROVED PROGRAM EFFICIENCY

- Sec. 6011. Improved efficiency through consolidation of administration of parts A and B.

PART 3—NOTICE OF ADVANCE DIRECTIVE RIGHTS

- Sec. 6021. Providing notice of rights regarding medical care to individuals entering medicare.

Subtitle B—Savings

- Sec. 6101. Reduction in conversion factor for physician fee schedule for non-primary care services.
- Sec. 6102. Reduction in hospital outpatient services through establishment of prospective payment system.
- Sec. 6103. Increase in medicare part B premium for individuals with high income.
- Sec. 6104. Phased-in elimination of medicare hospital disproportionate share adjustment payments.
- Sec. 6105. Imposition of coinsurance on laboratory services.

1 **TITLE I—ASSURING AVAILABIL-**  
 2 **ITY AND CONTINUITY OF**  
 3 **HEALTH COVERAGE**

4 **Subtitle A—Insurance Reform**

5 **PART 1—GUARANTEED ACCESS TO HEALTH**  
 6 **COVERAGE**

7 **SEC. 1001. GUARANTEED OFFER BY CARRIERS.**

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

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

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

5 (2) subject to subsection (b), qualified high-de-  
6 ductible coverage consistent with section 1103.

7 (b) HIGH-DEDUCTIBLE COVERAGE.—

8 (1) EXCEPTION FOR HEALTH MAINTENANCE  
9 ORGANIZATIONS.—The requirement of subsection  
10 (a)(2) shall not apply with respect to health insur-  
11 ance coverage that—

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

16 (B) is not provided by such an organiza-  
17 tion but is provided by an organization recog-  
18 nized under State law as a health maintenance  
19 organization or managed care organization or a  
20 similar organization regulated under State law  
21 for solvency.

22 (2) LIMITATION ON OFFER OF HIGH-DEDUCT-  
23 IBLE COVERAGE.—Qualified high-deductible coverage  
24 may not be made available by a carrier to a qualify-  
25 ing individual (or to a small employer with respect

1 to an employee) unless the carrier also makes avail-  
2 able qualified standard coverage that has identical  
3 benefits (other than the amount of the deductible)  
4 and the individual or employee demonstrates to the  
5 carrier that the individual or employee has available  
6 assets (as defined by the Secretary) equal to at least  
7 the deductible amount established under section  
8 1104(b)(1) applicable to the high-deductible cov-  
9 erage. A carrier may not make available to an indi-  
10 vidual health coverage (other than coverage for sup-  
11 plemental benefits) the actuarial value of which is  
12 less than the actuarial value of qualified high-de-  
13 ductible coverage, unless the individual has available  
14 assets (as defined by the Secretary) equal to at least  
15 the deductible amount of the coverage offered.

16 (3) OPTION TO OFFER MEDISAVE COVERAGE.—  
17 The offer of high-deductible coverage under sub-  
18 section (a)(2) may be accompanied by the contribu-  
19 tion by an employer to a medical savings account (in  
20 accordance with section 7705 of the Internal Reve-  
21 nue Code of 1986).

22 (c) COVERAGE OF ENTIRE RATING AREA.—

23 (1) IN GENERAL.—With respect to each fair  
24 rating area for which a carrier offers health insur-  
25 ance coverage, the carrier shall provide for coverage



1 of benefits for items and services furnished through-  
2 out the fair rating area.

3 (2) SPECIAL RULE FOR CARRIERS OFFERING  
4 COVERAGE IN MULTI-STATE METROPOLITAN STATIS-  
5 TICAL AREAS.—In the case of a carrier that offers  
6 qualified health insurance coverage in the individual/  
7 small employer market in a portion of a State that  
8 is located in an interstate metropolitan statistical  
9 area, the carrier may not provide such coverage with  
10 respect to an individual or employer in such metro-  
11 politan statistical area unless the carrier also offers  
12 such coverage in other portions of the area located  
13 in other States.

14 (3) SPECIAL RULE FOR COVERAGE THROUGH  
15 MANAGED CARE ARRANGEMENT.—In the case of cov-  
16 erage offered by a carrier or under a group health  
17 plan to the extent that it provides benefits through  
18 a managed care arrangement in a fair rating area,  
19 this subsection shall not be construed as requiring  
20 the establishment of facilities throughout the area, if  
21 the facilities are located consistent with section  
22 1002(b)(1).

23 (d) FAMILY COVERAGE OPTION.—The offer of cov-  
24 erage under this section with respect to an individual shall

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

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

8 (1) the health status of an individual,

9 (2) claims experience of an individual,

10 (3) receipt of health care by an individual,

11 (4) medical history of an individual,

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

13 or

14 (6) lack of evidence of insurability of an individ-  
15 ual.

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

21 **SEC. 1002. GUARANTEED ISSUE BY CARRIERS.**

22 (a) IN GENERAL.—Subject to subsections (b) and (c)  
23 and section 1003, each carrier that offers health insurance  
24 coverage in the individual/small group market in a fair rat-  
25 ing area—

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

4           (2) must accept for enrollment under such cov-  
5           erage every qualifying individual (and family mem-  
6           ber of such an individual) who applies for enrollment  
7           during an enrollment period provided under section  
8           1005 and may not place any restriction on the eligi-  
9           bility of an individual to enroll so long as such indi-  
10          vidual is a qualifying individual.

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

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

21               (2) may deny such coverage in a fair rating  
22               area to employers or individuals if the organization  
23               demonstrates to the applicable regulatory authority  
24               that—

1 (A) it will not have the capacity to deliver  
2 services adequately to enrollees of any addi-  
3 tional groups or additional enrollees because of  
4 its obligations to existing group contract hold-  
5 ers and enrollees, and

6 (B) it is applying this paragraph uniformly  
7 to all employers and individuals without regard  
8 to the health status, claims experience, or dura-  
9 tion of coverage of those employers and their  
10 employees.

11 Coverage may be denied under paragraph (2) only if the  
12 denial is applied during a consecutive period of at least  
13 180 days.

14 (c) SPECIAL RULE FOR FINANCIAL CAPACITY LIM-  
15 ITS.—In addition to the authority provided under sub-  
16 section (b)(2), in the case of coverage offered by any car-  
17 rier, the carrier may deny coverage to a small employer  
18 or individual if the carrier demonstrates to the applicable  
19 regulatory authority that—

20 (1) it does not have the financial reserves nec-  
21 essary to underwrite additional coverage, and

22 (2) it is applying this subsection uniformly to  
23 all employers and individuals without regard to the  
24 health status, claims experience, or duration of cov-  
25 erage of those employers and their employees.

1 Coverage may be denied under this subsection only if the  
2 denial is applied during a consecutive period of at least  
3 180 days.

4 (d) TREATMENT OF CERTAIN MEWAs.—Subsection  
5 (a) shall not apply to a carrier if the only coverage offered  
6 by the carrier in the individual/small group market is  
7 through one or more multiple employer welfare arrange-  
8 ments. In the case of coverage offered by a carrier in the  
9 individual/small group market through a multiple em-  
10 ployer welfare arrangement and to which the previous sen-  
11 tence does not apply, the requirements of subsection (a)  
12 shall apply to the carrier and not to the arrangement.

13 **SEC. 1003. GUARANTEED RENEWAL.**

14 (a) LIMITATION ON TERMINATION BY CARRIERS.—  
15 A carrier may not deny, cancel, or refuse to renew health  
16 coverage of a qualifying individual or eligible employer  
17 within a type of coverage option described in section  
18 1903(14) except—

19 (1) on the basis of nonpayment of premiums,

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

21 or

22 (3) subject to subsection (b), in a fair rating  
23 area because the carrier is ceasing to provide any  
24 health insurance coverage in the individual/small

1 group market within such type of coverage option in  
2 the area.

3 (b) LIMITATIONS ON MARKET EXIT BY CARRIERS.—

4 (1) NOTICE, ETC.—Subsection (a)(3) shall not  
5 apply to a carrier ceasing to provide health insur-  
6 ance coverage unless—

7 (A) such termination of coverage takes ef-  
8 fect at the end of a contract year, and

9 (B) the carrier provides notice of such ter-  
10 mination to employers and individuals covered  
11 at least 30 days before the date of an annual  
12 open enrollment period established with respect  
13 to the employer or individual under section  
14 1005.

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

23 (c) RULE FOR MULTIEMPLOYER PLANS AND MUL-  
24 TIPLE EMPLOYER HEALTH.—A multiemployer plan and  
25 a multiple employer health plan may not cancel coverage

1 or deny renewal of coverage under such a plan with re-  
2 spect to an employer other than—

3 (1) for nonpayment of contributions,

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

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

8 **SEC. 1004. RESTRICTING PREEXISTING CONDITION EXCLU-**  
9 **SIONS.**

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

16 (b) LIMITED 6-MONTH EXCLUSION PERMITTED.—

17 (1) IN GENERAL.—Subject to paragraph (2)  
18 and subsections (c) through (e), a carrier or group  
19 health plan providing health coverage may exclude  
20 health coverage with respect to services related to  
21 treatment of a condition of an individual based on  
22 the fact that the condition existed before the effec-  
23 tive date of coverage of the individual only if the pe-  
24 riod of the exclusion does not exceed 6 months be-  
25 ginning on the date of coverage.

1 (2) CREDITING OF PREVIOUS COVERAGE.—

2 (A) IN GENERAL.—A carrier or group  
3 health plan providing health coverage shall pro-  
4 vide that if a covered individual is in a period  
5 of continuous coverage (as defined in subpara-  
6 graph (C)) as of a date upon which coverage is  
7 initiated or reinitiated, any period of exclusion  
8 of coverage with respect to a preexisting condi-  
9 tion (as defined in subparagraph (B)) for such  
10 services or type of services shall be reduced by  
11 1 month for each month in the period of contin-  
12 uous coverage.

13 (B) PREEXISTING CONDITION DEFINED.—  
14 In this paragraph, the term “preexisting condi-  
15 tion” means, with respect to health coverage, a  
16 condition which has been diagnosed or treated  
17 during the 6-month period ending on the day  
18 before the first date of such coverage (without  
19 regard to any waiting period).

20 (C) PERIOD OF CONTINUOUS COVERAGE.—  
21 In this part, the term “period of continuous  
22 coverage” means the period beginning on the  
23 date an individual has health coverage (or cov-  
24 erage under a public plan providing medical  
25 benefits) and ends on the date the individual



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

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

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

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

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

21 (e) EXCLUSION NOT APPLICABLE TO INDIVIDUALS  
22 ENROLLED OR ENROLLING DURING CERTAIN OPEN EN-  
23 ROLLMENT PERIODS.—

24 (1) INDIVIDUALS ENROLLING DURING PE-  
25 RIOD.—In the case of an individual who enrolls and

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

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

13 (f) APPLICATION OF RULES BY CERTAIN HEALTH  
14 MAINTENANCE ORGANIZATIONS.—A health maintenance  
15 organization that provides health insurance coverage shall  
16 not be considered as failing to meet the requirements of  
17 section 1301 of the Public Health Service Act notwith-  
18 standing that it provides for an exclusion of the coverage  
19 based on a preexisting condition consistent with the provi-  
20 sions of this part so long as such exclusion is applied con-  
21 sistent with the provisions of this part.

22 **SEC. 1005. ENROLLMENT PERIODS.**

23 (a) IN GENERAL.—Each carrier and each group  
24 health plan providing health coverage (and each health  
25 plan purchasing organization under subtitle A of title V)

1 in the individual/small group market shall permit qualify-  
2 ing individuals and eligible employers to obtain health cov-  
3 erage from the carrier or group health plan during each  
4 enrollment period provided under this section.

5 (b) OPEN ENROLLMENT PERIODS FOR WHICH PRE-  
6 EXISTING CONDITION EXCLUSIONS WAIVED.—

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

11 (2) INDIVIDUALS ELIGIBLE FOR SUBSIDIES.—  
12 There shall be an individual open enrollment period  
13 with respect to an individual at the time the individ-  
14 ual first becomes eligible for any premium assistance  
15 under part A of title XXI of the Social Security Act,  
16 during the 60-day period beginning on the first date  
17 the individual meets eligibility criteria within any  
18 12-month period.

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

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

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

10           (1) IN GENERAL.—Each carrier and each group  
11           health plan providing health coverage (and each  
12           health plan purchasing organization under subtitle A  
13           of title V) in the individual/small group market shall  
14           provide for at least one annual open enrollment pe-  
15           riod (of not less than 30 days) each year. Such pe-  
16           riod shall be in addition to the open enrollment peri-  
17           ods described in subsection (b).

18           (2) COORDINATION.—

19           (A) CARRIERS IN INDIVIDUAL/SMALL  
20           GROUP MARKET.—Such annual open enrollment  
21           periods with respect to carriers in the individ-  
22           ual/small group market are subject to coordina-  
23           tion by States.

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

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

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

13 (A) through divorce or death of a family  
14 member experiences a change in family com-  
15 position, or

16 (B) experiences a change in employment  
17 status (including a significant change in the  
18 terms and conditions of employment or the  
19 terms and conditions of employment of a  
20 spouse),

21 there shall be an open enrollment period (of at least  
22 30 days) in which the individual is permitted to  
23 change the individual or family basis of coverage or  
24 the health coverage in which the individual is en-  
25 rolled. The circumstances under which such enroll-

1       ment periods are required and the duration of such  
2       periods shall be specified by the Secretary.

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

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

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

11                      (C) lost the other health coverage as a re-  
12      sult of the termination of the coverage, termi-  
13      nation or reduction of employment, or other  
14      reason, except termination at the option of the  
15      individual,

16      there shall be an open enrollment period during the  
17      30-day period beginning on the date of termination  
18      of the other coverage.

19               (4) ENROLLMENT AT TIME OF MARRIAGE.—  
20      There shall be an open enrollment period with re-  
21      spect to the spouse of an individual (including chil-  
22      dren of the spouse) during the 30-day period begin-  
23      ning on the date of the marriage, if family coverage  
24      is available as of such date.

1           (5) NO EFFECT ON COBRA CONTINUATION BEN-  
2           EFITS.—Nothing in this subsection shall be con-  
3           strued as affecting rights of individuals to continu-  
4           ation coverage under section 4980B of the Internal  
5           Revenue Code of 1986, part 6 of subtitle B of title  
6           I of the Employee Retirement Income Security Act  
7           of 1974, or title XXII of the Public Health Service  
8           Act.

9           (e) PERIOD OF COVERAGE.—

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

17           (2) COVERAGE OF FAMILY MEMBERS.—In the  
18           case of an open enrollment period described in sub-  
19           section (b)(3), (b)(4), or (d)(4), the Secretary shall  
20           provide for coverage of family members to begin as  
21           soon as possible on or after the date of the event  
22           that gives rise to the special enrollment period (or,  
23           in the case of birth or adoption, as of the date of  
24           birth or adoption).

1                   **PART 2—PROVISION OF BENEFITS**  
2   **SEC. 1011. STANDARDS FOR MANAGED CARE ARRANGE-**  
3                   **MENTS.**

4           (a) APPLICATION OF REQUIREMENTS.—Each group  
5 health plan, and each carrier providing health insurance  
6 coverage, that provides for health care through a managed  
7 care arrangement (as defined in section 1903(11)(A))  
8 shall comply with the applicable requirements of this sec-  
9 tion.

10          (b) CONSUMER DISCLOSURE.—

11               (1) IN GENERAL.—The group health plan, or  
12 carrier providing health insurance coverage, that  
13 provides for health care shall assure that, before an  
14 individual is enrolled with the plan or carrier, the in-  
15 dividual is provided with information about the ar-  
16 rangements between the entity providing for the  
17 managed care arrangement and health care provid-  
18 ers for the provision of covered benefits, including  
19 the following:

20                   (A) EMERGENCY SERVICES.—Arrange-  
21 ments for access to emergency care services in-  
22 side and outside the provider network (includ-  
23 ing designated trauma centers), including any  
24 requirements for prior authorization.



1 (B) SPECIALIZED TREATMENT.—Arrange-  
2 ments for access to specialized treatment pro-  
3 viders (such as centers of excellence).

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

9 (D) ESSENTIAL COMMUNITY PROVIDERS.—  
10 Arrangements for access to essential community  
11 providers, including disproportionate share hos-  
12 pitals, sole community hospitals, medicare-de-  
13 pendent, small rural hospitals, Federally quali-  
14 fied health centers, rural health clinics, local  
15 health departments, and children’s hospitals.

16 (2) DESIGNATION OF CENTERS OF EXCEL-  
17 LENCE.—The Secretary shall establish a process for  
18 the designation of facilities, including children’s hos-  
19 pitals and other pediatric facilities, as centers of ex-  
20 cellence for purposes of this subsection. A facility  
21 may not be designated unless the facility is deter-  
22 mined—

23 (A) to provide specialty care,

1 (B) to deliver care for complex cases re-  
2 quiring specialized treatment and for individ-  
3 uals with chronic diseases, and

4 (C) to meet other requirements that may  
5 be established by the Secretary relating to spe-  
6 cialized education and training of health profes-  
7 sionals, participation in peer-reviewed research,  
8 or treatment of patients from outside the geo-  
9 graphic area of the facility.

10 (c) PROVIDER DISCLOSURE AND DUE PROCESS RE-  
11 LATING TO PROVIDER NETWORKS.—

12 (1) DISCLOSURE.—The entity providing for a  
13 managed care arrangement under which health cov-  
14 erage shall provide that before entering into a con-  
15 tract with health care providers with respect to the  
16 entity's provider network, the provider is given infor-  
17 mation concerning the terms and conditions of the  
18 provider's involvement with the network, including  
19 the following:

20 (A) STANDARDS FOR SELECTION OF PRO-  
21 VIDERS FOR NETWORK.—Information concern-  
22 ing the standards (including criteria for quality,  
23 efficiency, credentialing, and services) to be  
24 used by the entity for contracting with health

1 care providers with respect to the entity's pro-  
2 vider network.

3 (B) REVIEW PROCESS.—Information con-  
4 cerning the process under which a provider may  
5 request a review of the entity's decision to ter-  
6 minate or refuse to renew the provider's partici-  
7 pation agreement.

8 (2) WRITTEN NOTICE OF DENIALS.—The entity  
9 providing for the managed care arrangement shall  
10 provide written notice to the provider of any denial  
11 of an application to participate in the provider net-  
12 work.

13 (3) TERMINATION PROCESS.—

14 (A) IN GENERAL.—The entity may not ter-  
15 minate or refuse to renew a participation agree-  
16 ment with a provider in the entity's provider  
17 network unless the entity provides written noti-  
18 fication to the provider of the entity's decision  
19 to terminate or refuse to renew the agreement.  
20 The notification shall include a statement of the  
21 reasons for the entity's decision, consistent with  
22 any standards described in paragraph (1)(A).

23 (B) TIMING OF NOTIFICATION.—The en-  
24 tity shall provide the notification required under  
25 subparagraph (A) at least 30 days prior to the

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

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

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

14 (1) LIMITATION ON RESTRICTIONS ON NET-  
15 WORK PLANS.—Effective as of January 1, 1997—

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

20 (B) a State may not prohibit or limit such  
21 a carrier or plan from limiting coverage of serv-  
22 ices to those provided by a participating pro-  
23 vider;

24 (C) a State may not prohibit or limit the  
25 negotiation of rates and forms of payments for

1 providers by such a carrier or plan with respect  
2 to health coverage;

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

6 (E) a State may not prohibit or limit such  
7 a carrier or plan from requiring that services be  
8 provided (or authorized) by a practitioner se-  
9 lected by the enrollee from a list of available  
10 participating providers or, except as provided in  
11 subsection 1011(d), from requiring enrollees to  
12 obtain referral in order to have coverage for  
13 treatment by a specialist or health institution;  
14 and

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

17 (2) DEFINITIONS.—In this subsection:

18 (A) MANAGED CARE COVERAGE.—The  
19 term “managed care coverage” means health  
20 coverage to the extent the coverage is provided  
21 through a managed care arrangement (as de-  
22 fined in section 1903(11)(A)) that meets the  
23 applicable requirements of this section.

24 (B) PARTICIPATING PROVIDER.—The term  
25 “participating provider” means an entity or in-

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

4 **SEC. 1012. REPORT ON UTILIZATION REVIEW STANDARDS.**

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

7           (1) establishing standards for utilization review  
8           programs, and

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

14          (b) REPORT.—Not later than 18 months after the  
15          date of the enactment of this Act, the Secretary shall sub-  
16          mit to Congress a report on the study under subsection  
17          (a). The Secretary shall include the report recommenda-  
18          tions regarding the application of standards for utilization  
19          review programs to group health plans and carriers pro-  
20          viding health insurance coverage.

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

1 **SEC. 1013. MEDICAL SAVINGS ACCOUNTS.**

2 (a) IN GENERAL.—Chapter 79 of the Internal Reve-  
3 nue Code of 1986 is amended by adding at the end the  
4 following new section:

5 **“SEC. 7705. MEDICAL SAVINGS ACCOUNTS.**

6 “(a) GENERAL RULE.—For purposes of this title, the  
7 term ‘medical savings account’ means a trust created or  
8 organized in the United States for the exclusive benefit  
9 of an individual or his beneficiaries, but only if the written  
10 instrument creating the trust meets the following require-  
11 ments:

12 “(1) Except in the case of a rollover contribu-  
13 tion described in subsection (d)(3), no contribution  
14 will be accepted unless—

15 “(A) it is in cash, and

16 “(B) such individual is an eligible employee  
17 for the period for which such contribution is  
18 made.

19 “(2) The trustee is a bank (as defined in sec-  
20 tion 408(n)), insurance company (as defined in sec-  
21 tion 816), or such other person who demonstrates to  
22 the satisfaction of the Secretary that the manner in  
23 which such other person will administer the trust  
24 will be consistent with the requirements of this sec-  
25 tion.

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

3           “(4) The interest of an individual in the bal-  
4 ance of the account is nonforfeitable.

5           “(5) The assets of the trust will not be commin-  
6 gled with other property except in a common trust  
7 fund or common investment fund.

8           “(b) ELIGIBLE EMPLOYEE.—For purposes of this  
9 section—

10           “(1) IN GENERAL.—The term ‘eligible em-  
11 ployee’ means any employee who has high-deductible  
12 coverage (as defined in section 1103 of the Health  
13 Care Improvement Act of 1995) offered by the em-  
14 ployer.

15           “(2) EXCEPTION.—An employee shall be treat-  
16 ed as not being an eligible employee for any calendar  
17 year if, for any month during such year, it is reason-  
18 ably expected that such employee—

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

24           “(B) is an AFDC recipient or SSI recipi-  
25 ent.



1           “(3) DEFINITIONS.—For purposes of paragraph  
2           (2)—

3                   “(A) AFDC RECIPIENT.—The term  
4           ‘AFDC recipient’ means, for a month, an indi-  
5           vidual who is receiving aid or assistance under  
6           any plan of the State approved under title I, X,  
7           XIV, or XVI, or part A or part E of title IV,  
8           of the Social Security Act for the month.

9                   “(B) SSI RECIPIENT.—The term ‘SSI re-  
10           cipient’ means, for a month, an individual—

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

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

19                   “(iii) who is receiving monthly bene-  
20           fits under section 1619(a) of the Social Se-  
21           curity Act (whether or not pursuant to sec-  
22           tion 1616(c)(3) of such Act) for the  
23           month, or

24                   “(iv) who is treated under section  
25           1619(b) of the Social Security Act as re-

1           ceiving supplemental security income bene-  
2           fits in a month for purposes of title XIX  
3           of such Act.

4           “(c) TAX TREATMENT OF ACCOUNTS.—

5           “(1) ACCOUNT TAXED AS GRANTOR TRUST.—

6           “(A) IN GENERAL.—Except as provided in  
7           subparagraph (B), the account beneficiary of a  
8           medical savings account shall be treated for  
9           purposes of this title as the owner of such ac-  
10          count and shall be subject to tax thereon in ac-  
11          cordance with subpart E of part I of subchapter  
12          J of this chapter (relating to grantors and oth-  
13          ers treated as substantial owners).

14          “(B) TREATMENT OF CAPITAL LOSSES.—

15          With respect to assets held in a medical savings  
16          account, any capital loss for a taxable year  
17          from the sale or exchange of such an asset shall  
18          be allowed only to the extent of capital gains  
19          from such assets for such taxable year. Any  
20          capital loss which is disallowed under the pre-  
21          ceding sentence shall be treated as a capital  
22          loss from the sale or exchange of such an asset  
23          in the next taxable year. For purposes of this  
24          subparagraph, all medical savings accounts of

1 the account beneficiary shall be treated as 1 ac-  
2 count.

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

5 “(A) IN GENERAL.—If, during any taxable  
6 year of the account beneficiary, such beneficiary  
7 engages in any transaction prohibited by section  
8 4975 with respect to the account, the account  
9 shall cease to be a medical savings account as  
10 of the first day of such taxable year.

11 “(B) ACCOUNT TREATED AS DISTRIBUTING  
12 ALL ITS ASSETS.—In any case in which any ac-  
13 count ceases to be a medical savings account by  
14 reason of subparagraph (A) on the first day of  
15 any taxable year, subsection (d) shall be applied  
16 as if—

17 “(i) there were a distribution on such  
18 first day in an amount equal to the fair  
19 market value (on such first day) of all as-  
20 sets in the account (on such first day), and

21 “(ii) no portion of such distribution  
22 were used to pay qualified medical ex-  
23 penses.

24 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-  
25 RITY.—If, during any taxable year, the account ben-

1       eficiary uses the account or any portion thereof as  
2       security for a loan, the portion so used is treated as  
3       distributed and not used to pay qualified medical ex-  
4       penses.

5       “(d) TAX TREATMENT OF DISTRIBUTIONS.—

6               “(1) INCLUSION OF AMOUNTS NOT USED FOR  
7       QUALIFIED MEDICAL EXPENSES.—

8                       “(A) IN GENERAL.—Any amount paid or  
9       distributed out of a medical savings account  
10       which is not used exclusively to pay the quali-  
11       fied medical expenses of the account beneficiary  
12       or of the spouse or dependents (as defined in  
13       section 152) of such beneficiary shall be in-  
14       cluded in the gross income of such beneficiary  
15       to the extent such amount does not exceed the  
16       excess of—

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

21                               “(ii) the aggregate prior payments or  
22       distributions from such account which were  
23       includible in gross income under this para-  
24       graph.

1           “(B) SPECIAL RULES.—For purposes of  
2           subparagraph (A)—

3                   “(i) all medical savings accounts of  
4                   the account beneficiary shall be treated as  
5                   1 account,

6                   “(ii) all payments and distributions  
7                   during any taxable year shall be treated as  
8                   1 distribution, and

9                   “(iii) any distribution of property  
10                  shall be taken into account at its fair mar-  
11                  ket value on the date of the distribution.

12           “(2) PENALTY FOR DISTRIBUTIONS NOT USED  
13           FOR QUALIFIED MEDICAL EXPENSES.—

14                   “(A) IN GENERAL.—The tax imposed by  
15                   chapter 1 on the account beneficiary for any  
16                   taxable year in which there is a payment or dis-  
17                   tribution from a medical savings account of  
18                   such beneficiary which is includible in gross in-  
19                   come under paragraph (1) shall be increased by  
20                   100 percent of the amount which is so includ-  
21                   ible.

22                   “(B) EXCEPTION FOR DEATH.—Subpara-  
23                   graph (A) shall not apply if the payment or dis-  
24                   tribution is made after the account beneficiary  
25                   dies.

1           “(3) ROLLOVER CONTRIBUTION.—An amount is  
2 described in this paragraph as a rollover contribu-  
3 tion if it meets the requirements of subparagraphs  
4 (A) and (B).

5           “(A) IN GENERAL.—Paragraph (1) shall  
6 not apply to any amount paid or distributed  
7 from a medical savings account to the account  
8 beneficiary to the extent the amount received is  
9 paid into a medical savings account for the ben-  
10 efit of such beneficiary not later than the 60th  
11 day after the day on which he receives the pay-  
12 ment or distribution.

13           “(B) LIMITATION.—This paragraph shall  
14 not apply to any amount described in subpara-  
15 graph (A) received by an individual from a  
16 medical savings account if, at any time during  
17 the 1-year period ending on the day of such re-  
18 ceipt, such individual received any other amount  
19 described in subparagraph (A) from a medical  
20 savings account which was not includible in his  
21 gross income because of the application of this  
22 paragraph.

23           “(4) COORDINATION WITH MEDICAL EXPENSE  
24 DEDUCTION.—For purposes of section 213, any pay-  
25 ment or distribution out of a medical savings ac-

1 count for qualified medical expenses shall not be  
2 treated as an expense paid for medical care to the  
3 extent of the amount of such payment or distribu-  
4 tion which is excludable from gross income solely by  
5 reason of paragraph (1)(A).

6 “(e) DEFINITIONS.—For purposes of this section—

7 “(1) QUALIFIED MEDICAL EXPENSES.—The  
8 term ‘qualified medical expenses’ means any expense  
9 for medical care (as defined in section 213(d)); ex-  
10 cept that such term shall not include any amount  
11 paid for insurance.

12 “(2) ACCOUNT BENEFICIARY.—The term ‘ac-  
13 count beneficiary’ means the individual for whose  
14 benefit the medical savings account is maintained.

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

17 “(1) the assets of such account are held by a  
18 bank (as defined in section 408(n)), insurance com-  
19 pany (as defined in section 816), or another person  
20 who demonstrates to the satisfaction of the Sec-  
21 retary that the manner in which he will administer  
22 the account will be consistent with the requirements  
23 of this section, and

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

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

8           “(g) REPORTS.—The trustee of a medical savings ac-  
9 count shall keep such records and make such reports re-  
10 garding such account to the Secretary and to the account  
11 beneficiary with respect to contributions, distributions,  
12 and such other matters as the Secretary may require  
13 under regulations. The reports required by this subsection  
14 shall be filed at such time and in such manner and fur-  
15 nished to such individuals at such time and in such man-  
16 ner as may be required by such regulations.”

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

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

22           “Gross income of an employee does not include—

23           “(1) employer-provided coverage under an acci-  
24 dent or health plan, and



1           “(2) employer contributions to any medical sav-  
2           ings account (as defined in section 7705) of an eligi-  
3           ble employee, but only to the extent that the amount  
4           contributed does not exceed the excess of premium  
5           for standard coverage over the premium for high-de-  
6           ductible coverage (as such terms are defined in sec-  
7           tion 1903 of the Health Care Improvement Act of  
8           1995).”

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

11           (A) SOCIAL SECURITY TAXES.—

12           (i) Subsection (a) of section 3121 of  
13           such Code is amended by striking “or” at  
14           the end of paragraph (20), by striking the  
15           period at the end of paragraph (21) and  
16           inserting “; or”, and by inserting after  
17           paragraph (21) the following new para-  
18           graph:

19           “(22) any payment made to or for the benefit  
20           of an employee if at the time of such payment it is  
21           reasonable to believe that the employee will be able  
22           to exclude such payment from income under section  
23           106(2).”

24           (ii) Subsection (a) of section 209 of  
25           the Social Security Act is amended by

1 striking “or” at the end of paragraph (18),  
2 by striking the period at the end of para-  
3 graph (19) and inserting “; or”, and by in-  
4 serting after paragraph (19) the following  
5 new paragraph:

6 “(20) any payment made to or for the benefit  
7 of an employee if at the time of such payment it is  
8 reasonable to believe that the employee will be able  
9 to exclude such payment from income under section  
10 106(2) of the Internal Revenue Code of 1986.”

11 (B) RAILROAD RETIREMENT TAX.—Sub-  
12 section (e) of section 3231 of such Code is  
13 amended by adding at the end the following  
14 new paragraph:

15 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
16 TIONS.—The term ‘compensation’ shall not include  
17 any payment made to or for the benefit of an em-  
18 ployee if at the time of such payment it is reason-  
19 able to believe that the employee will be able to ex-  
20 clude such payment from income under section  
21 106(2).”

22 (C) UNEMPLOYMENT TAX.—Subsection (b)  
23 of section 3306 of such Code is amended by  
24 striking “or” at the end of paragraph (15), by  
25 striking the period at the end of paragraph (16)

1 and inserting “; or”, and by inserting after  
2 paragraph (16) the following new paragraph:

3 “(17) any payment made to or for the benefit  
4 of an employee if at the time of such payment it is  
5 reasonable to believe that the employee will be able  
6 to exclude such payment from income under section  
7 106(2).”

8 (D) WITHHOLDING TAX.—Subsection (a)  
9 of section 3401 of such Code is amended by  
10 striking “or” at the end of paragraph (19), by  
11 striking the period at the end of paragraph (20)  
12 and inserting “; or”, and by inserting after  
13 paragraph (20) the following new paragraph:

14 “(21) any payment made to or for the benefit  
15 of an employee if at the time of such payment it is  
16 reasonable to believe that the employee will be able  
17 to exclude such payment from income under section  
18 106(2).”

19 (c) TECHNICAL AMENDMENTS.—

20 (1) TAX ON PROHIBITED TRANSACTIONS.—Sec-  
21 tion 4975 of such Code (relating to prohibited trans-  
22 actions) is amended—

23 (A) by adding at the end of subsection (c)  
24 the following new paragraph:

1           “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
2           COUNTS.—An individual for whose benefit a medical  
3           savings account (within the meaning of section  
4           7705) is established shall be exempt from the tax  
5           imposed by this section with respect to any trans-  
6           action concerning such account (which would other-  
7           wise be taxable under this section) if, with respect  
8           to such transaction, the account ceases to be a medi-  
9           cal savings account by reason of the application of  
10          section 7705(c)(2)(A) to such account.”, and

11                   (B) by inserting “or a medical savings ac-  
12                   count described in section 7705” in subsection  
13                   (e)(1) after “described in section 408(a)”.

14          (2) FAILURE TO PROVIDE REPORTS ON MEDI-  
15          CAL SAVINGS ACCOUNTS.—Section 6693 of such  
16          Code (relating to failure to provide reports on indi-  
17          vidual retirement account or annuities) is amend-  
18          ed—

19                   (A) by inserting “**OR ON MEDICAL SAV-**  
20                   **INGS ACCOUNTS**” after “**ANNUITIES**” in the  
21                   heading of such section, and

22                   (B) by adding at the end of subsection (a)  
23                   the following: “The person required by section  
24                   7705(g) to file a report regarding a medical  
25                   savings account at the time and in the manner

1 required by such section shall pay a penalty of  
2 \$50 for each failure unless it is shown that  
3 such failure is due to reasonable cause.”

4 (3) CLERICAL AMENDMENTS.—

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

“Sec. 7705. Medical savings accounts.”

8 (B) The table of sections for subchapter B  
9 of chapter 68 of such Code is amended by in-  
10 sserting “or on medical savings accounts” after  
11 “annuities” in the item relating to section  
12 6693.

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

16 **PART 3—FAIR RATING PRACTICES**

17 **SEC. 1021. USE OF FAIR RATING PRACTICES.**

18 (a) USE OF FAIR RATING PRACTICES.—The pre-  
19 mium rate established by a carrier for health insurance  
20 coverage in the individual/small group market (including  
21 the premium rate for coverage for a small employer  
22 through a multiple employer welfare arrangement that is  
23 fully-insured) may not vary except by the following:

1           (1) AGE.—By age, based on classes of age es-  
2           tablished by the Secretary, in consultation with the  
3           NAIC, consistent with subsection (b).

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

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

12          (4) BENEFIT DESIGN.—By benefit design of  
13          coverage, including by type of coverage, such as  
14          standard coverage and high-deductible coverage, and  
15          by type of coverage option (described in section  
16          1903(14)) with respect to standard coverage.

17          (5) ADMINISTRATIVE CATEGORIES.—By per-  
18          mitted expense category, based on differences in ex-  
19          penses among such categories, consistent with sub-  
20          section (d).

21 The premiums shall be established for the different benefit  
22 designs (including standard coverage and high-deductible  
23 coverage) based on the actuarial value of the coverage for  
24 the population of the individual/small group market in the  
25 fair rating area, without regard to the distribution of such

1 population among the types of coverage or type of cov-  
2 erage options.

3 (b) LIMITATION ON VARIATION BY AGE.—

4 (1) IN GENERAL.—Any variation in premium  
5 rates by age under subsection (a)(1) for age classes  
6 of individuals under 65 years of age may not result  
7 in the ratio of the highest age rate to the lowest age  
8 rate exceeding the limiting ratio described in para-  
9 graph (2).

10 (2) LIMITING RATIO.—For purposes of para-  
11 graph (1), the limiting ratio described in this para-  
12 graph is—

13 (A) 4-to-1, for premiums for months in  
14 1997,

15 (B) 3.67-to-1, for premiums for months in  
16 1998,

17 (C) 3.33-to-1, for premiums for months in  
18 1999, and

19 (D) 3-to-1, for premiums for months in  
20 2000 and any succeeding year.

21 (3) SEPARATE AGE CLASSES FOR INDIVIDUALS  
22 65 YEARS OF AGE OR OLDER.—The Secretary shall  
23 establish one or more separate age classes for indi-  
24 viduals 65 years of age or older.

1           (4) PREEMPTION.—For preemption of State  
2 laws relating to establishment of premium rates, see  
3 section 5005.

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

6           (1) may not identify an area that divides a 3-  
7 digit zip code, a county, or all portions of a metro-  
8 politan statistical area,

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

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

16           (d) ADMINISTRATIVE VARIATIONS.—

17           (1) EXPENSE CATEGORIES.—Expense cat-  
18 egories shall be established under subsection (a)(5)  
19 by a carrier in a manner that only reflects dif-  
20 ferences based on marketing, commissions, and simi-  
21 lar expenses. Such categories shall take into account  
22 health plan purchasing organizations.

23           (2) LIMITATION ON VARIATIONS.—The vari-  
24 ation provided among expense categories under sub-  
25 section (a)(5) may not result in a premium for the



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

3 (e) PREMIUM RATING IN GROUP HEALTH PLANS.—

4 The premium rate established under a group health plan  
5 for health insurance coverage may not vary within a bene-  
6 fit design except by the factors described in subsection (a)  
7 and subject to the limitation specified in subsection (b).

8 (f) ACTUARIAL CERTIFICATION.—Each carrier that  
9 offers health insurance coverage in a State shall file annu-  
10 ally with the State commissioner of insurance a written  
11 statement by a member of the American Academy of Actu-  
12 aries (or other individual acceptable to the commissioner)  
13 that, based upon an examination by the individual which  
14 includes a review of the appropriate records and of the  
15 actuarial assumptions of the carrier and methods used by  
16 the carrier in establishing premium rates for applicable  
17 health insurance coverage—

18 (1) the carrier is in compliance with the appli-  
19 cable provisions of this section, and

20 (2) the rating methods are actuarially sound.

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

23 (g) CONSTRUCTION.—The provisions of this section  
24 shall apply to premium rates established by carriers for  
25 multiple employer welfare arrangements that are fully-in-

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

7 **SEC. 1022. COORDINATION WITH PREMIUM ASSISTANCE**  
8 **CERTIFICATE PROGRAM.**

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

14 **SEC. 1023. ESTABLISHMENT OF RISK ADJUSTMENT MECHA-**  
15 **NISMS.**

16 (a) ESTABLISHMENT OF STANDARDS.—

17 (1) DEVELOPMENT OF MODELS.—

18 (A) IN GENERAL.—The Secretary shall re-  
19 quest the NAIC to develop, within 9 months  
20 after the date of the enactment of this Act and  
21 in consultation with the American Academy of  
22 Actuaries, a model risk adjustment system com-  
23 posed of one or more risk adjustment mecha-  
24 nisms under which premiums applicable to  
25 health insurance coverage in the individual/

1 small group market and coverage under mul-  
2 tiple employer welfare arrangements that are  
3 fully insured (without regard to whether such  
4 an arrangement is offered through an associa-  
5 tion) would be adjusted to take into account  
6 such factors as may be appropriate to predict  
7 the future need and the efficient use of services  
8 by covered individuals in the market. Such fac-  
9 tors may include the age, gender, geographic  
10 residence, health status, or other demographic  
11 characteristics of individuals enrolled in such  
12 plans and shall include consideration of enroll-  
13 ment of a disproportionate share of individuals  
14 who enroll during the initial open enrollment  
15 period under section 1005(b)(1).

16 (B) PROMULGATION AS PROPOSED  
17 RULE.—If the NAIC develops such model with-  
18 in such period, the Secretary shall publish the  
19 model as a proposed rule under section 553 of  
20 title 5, United States Code. If the NAIC has  
21 not developed such model within such period,  
22 the Secretary shall publish (not later than 60  
23 days after the end of such period) a proposed  
24 rule that specifies a proposed model that pro-  
25 vides for effective risk adjustment mechanisms.

1           (2) RULE MAKING PROCESS.—The Secretary  
2 shall provide for a period (described in section  
3 553(c) of title 5, United States Code) of not less  
4 than 30 days for public comment on a proposed rule  
5 published under paragraph (1)(B). The Secretary  
6 shall publish a final rule, by not later than January  
7 1, 1996, that specifies risk adjustment mechanisms  
8 that the Secretary finds are effective for purposes of  
9 carrying out this section. Such rule shall include  
10 models developed by the NAIC if the Secretary finds  
11 that such models provide for effective risk adjust-  
12 ment mechanisms.

13           (3) MODIFICATION.—The Secretary, at the re-  
14 quest of the NAIC or otherwise, may by regulation  
15 modify the model risk adjustment system established  
16 under this subsection.

17           (b) IMPLEMENTATION OF RISK ADJUSTMENT SYS-  
18 TEM.—Each State shall establish and maintain a risk ad-  
19 justment system that conforms with the model established  
20 under this section by not later than January 1, 1997. A  
21 State may establish and maintain such a system jointly  
22 with one or more other States.

1                   **PART 4—CONSUMER PROTECTIONS**  
2   **SEC. 1031. REQUIREMENT FOR PROVISION OF INFORMA-**  
3                   **TION.**

4           (a) CARRIERS.—

5               (1) IN GENERAL.—Each carrier that offers  
6           health insurance coverage to small employers (or eli-  
7           gible employees of small employers) or qualifying in-  
8           dividuals must disclose to such prospective enrollees,  
9           to brokers, and to health plan purchasing organiza-  
10          tions the information that the Secretary may specify  
11          relating to the performance of the carrier in provid-  
12          ing such coverage and relating to differences be-  
13          tween the coverage provided and the most similar  
14          model benefit package established under section  
15          1104(b)(2). If a carrier offers to individuals or em-  
16          ployers coverage the actuarial value of which is more  
17          than the actuarial value for high-deductible coverage  
18          but less than such value for standard coverage, the  
19          carrier must disclose to such employers or individ-  
20          uals detailed information on how the coverage of-  
21          fered compares to any standard and high-deductible  
22          coverage offered by the carrier to such individuals  
23          and employers.

24               (2) MARKETING MATERIAL.—Each carrier that  
25          provides any health insurance coverage in a State  
26          shall file with the State those marketing materials

1 relating to the offer and sale of health insurance  
2 coverage to be used for distribution before the mate-  
3 rials are used. Such materials shall be in a uniform  
4 format specified under the standards established  
5 under section 1301.

6 (b) GROUP HEALTH PLANS.—Each group health  
7 plan that provides health coverage must disclose to enroll-  
8 ees and potential enrollees information, similar to the in-  
9 formation described in subsection (a), relating to perform-  
10 ance of the plan in providing such coverage and relating  
11 to differences between the coverage provided and the most  
12 similar model benefit package established under section  
13 1104(b)(2).

14 (c) INFORMATION RELATING TO RISK ADJUST-  
15 MENT.—Each carrier or group health plan providing cov-  
16 erage in the individual/small group market (including mul-  
17 tiple employer health plans that are fully insured, without  
18 regard to whether such an arrangement or plan is offered  
19 through an association) shall provide to the State such in-  
20 formation as the State may require in order to carry out  
21 section 1023 (relating to risk adjustment mechanisms).

22 **SEC. 1032. PROHIBITION OF IMPROPER INCENTIVES.**

23 (a) LIMITATION ON FINANCIAL INCENTIVES.—No  
24 carrier that provides health insurance coverage may vary  
25 the commission or financial or other remuneration to a

1 person based on the claims experience or health status of  
2 individuals enrolled by or through the person.

3 (b) NONDISCRIMINATION IN AGENT COMPENSA-  
4 TION.—A carrier—

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

11 (2) may not terminate, fail to renew, or limit its  
12 contract or agreement of representation with an  
13 agent or broker for any reason related to the health  
14 status or claims experience of any individuals en-  
15 rolled with the carrier through the agent or broker.

16 (c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No  
17 carrier that offers health insurance coverage may require  
18 the purchase of any other insurance or product as a condi-  
19 tion for the purchase of such coverage.

20 **SEC. 1033. WRITTEN POLICIES AND PROCEDURES RESPECT-**  
21 **ING ADVANCE DIRECTIVES.**

22 A carrier and a group health plan offering health cov-  
23 erage shall meet the requirements of section 1866(f) of  
24 the Social Security Act (relating to maintaining written  
25 policies and procedures respecting advance directives), in-

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

3 **Subtitle B—Benefits**

4 **SEC. 1101. QUALIFIED HEALTH COVERAGE.**

5 In this Act, the term “qualified health coverage”  
6 means health coverage that—

7 (1) provides—

8 (A) standard coverage consistent with sec-  
9 tion 1102(a); or

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

12 (2) meets other requirements of subtitle A ap-  
13 plicable to the coverage and the carrier or group  
14 health plan providing the coverage.

15 **SEC. 1102. STANDARD COVERAGE.**

16 (a) IN GENERAL.—Health insurance coverage is con-  
17 sidered to provide standard coverage consistent with this  
18 subsection and for preventive benefits under subsection

19 (b)(4) if—

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

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



1           (3) the benefits comply with the minimum re-  
2           quirements specified in subsection (d).

3           (b) REQUIRED CATEGORIES OF COVERED BENE-  
4           FITS.—

5           (1) IN GENERAL.—The categories of covered  
6           benefits described in this paragraph are the types of  
7           benefits specified in each of subparagraphs (A), (B),  
8           (C), (D), (E), and (F) of paragraph (1), and sub-  
9           paragraphs (E) and (F) of paragraph (2), of section  
10          8904(a) of title 5, United States Code (relating to  
11          types of benefits required to be in health insurance  
12          offered to Federal employees).

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

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

21               (B) ROUTINE MEDICAL COSTS DEFINED.—  
22               In subparagraph (A), the term “routine medical  
23               costs” means the cost of health services re-  
24               quired to provide treatment according to the de-  
25               sign of the trial, except those costs normally

1           paid for by other funding sources (as defined by  
2           the Secretary). Such costs do not include the  
3           cost of the investigational agent, devices or pro-  
4           cedures themselves, the costs of any nonhealth  
5           services that might be required for a person to  
6           receive the treatment, or the costs of managing  
7           the research.

8           (C) APPROVED RESEARCH TRIAL DE-  
9           FINED.—In subparagraph (A), the term “ap-  
10          proved research trial” means a trial—

11                   (i) conducted for the primary purpose  
12                   of determining the safety, effectiveness, ef-  
13                   ficacy, or health outcomes of a treatment,  
14                   compared with the best available alter-  
15                   native treatment, and

16                   (ii) approved by the Secretary.

17          A trial is deemed to be approved under clause  
18          (ii) if it is approved by the National Institutes  
19          of Health, the Food and Drug Administration  
20          (through an investigational new drug exemp-  
21          tion), the Department of Veterans Affairs, or  
22          by a qualified nongovernmental research entity  
23          (as identified in guidelines issued by one or  
24          more of the National Institutes of Health).

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

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

14           (A) NEWBORN, WELL-BABY AND WELL-  
15 CHILD CARE.—Newborn care, well-baby care,  
16 and well-child care for individuals under 19  
17 years of age, including routine physical exami-  
18 nations, routine immunizations, and routine  
19 tests, as specified by the Secretary based on the  
20 schedule recommended by the American Acad-  
21 emy of Pediatricians.

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

1 mammogram every 2 years for a woman who is  
2 at least 40 (but less than 50) years of age, and  
3 1 mammogram every year for a woman who is  
4 at least 50 years of age.

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

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

15 (E) SCREENING TUBERCULIN TESTS.—  
16 Screening tuberculin tests annually for individ-  
17 uals at risk of contracting tuberculosis.

18 (F) PRENATAL CARE.—Prenatal care.

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

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

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

3           (c) STANDARD ACTUARIAL VALUE.—

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

13          (2) STANDARD ACTUARIAL VALUE DE-  
14          SCRIBED.—The standard actuarial value described  
15          in this paragraph for coverage in a geographic area  
16          is the actuarial value of benchmark coverage during  
17          1994 in such area. Such actuarial value shall be de-  
18          termined using the adjustment under paragraph (3)  
19          for a standardized population and set of standard-  
20          ized utilization and cost factors and updated annu-  
21          ally in accordance with section 1104(a).

22          (3) ADJUSTMENTS FOR STANDARDIZED POPU-  
23          LATION, STANDARDIZED UTILIZATION AND COST  
24          FACTORS, AND GEOGRAPHIC AREA.—The adjustment  
25          under this paragraph—

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

6 (B)(i) except as provided in clause (ii), for  
7 a geographic area shall be made in a manner  
8 that reflects the ratio of the actuarial value of  
9 benchmark coverage in such geographic area  
10 (as adjusted under subparagraph (A)) to such  
11 actuarial value for such benchmark coverage for  
12 the United States as a whole, taking into ac-  
13 count standardized actuarial utilization and  
14 cost factors, and

15 (ii) in the case of a group health plan oper-  
16 ating in more than one geographic area, the  
17 ratio described in clause (i) shall be determined  
18 in accordance with regulations promulgated by  
19 the Secretary.

20 At the election of a group health plan under sub-  
21 paragraph (B)(ii), the ratio under such subpara-  
22 graph shall be 1.

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

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

8 (e) NO COVERAGE OF SPECIFIC TREATMENT, PRO-  
9 CEDURES, OR CLASSES REQUIRED.—Nothing in this sec-  
10 tion (or section 1103) may be construed to require the  
11 coverage of any specific procedure or treatment or class  
12 of service in health coverage under this Act or through  
13 regulation.

14 (f) CONSTRUCTION.—Nothing in this section (or sec-  
15 tion 1103) shall be construed as requiring coverage to in-  
16 clude benefits for items and services that are not medically  
17 necessary or appropriate.

18 **SEC. 1103. HIGH-DEDUCTIBLE COVERAGE.**

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

21 (1) benefits under such coverage comply with—

22 (A) the requirements described in section  
23 1102(b) (relating to required categories of cov-  
24 ered benefits), and

1 (B) the requirements described in section  
2 1102(d) (relating to minimum requirements  
3 within a category);

4 (2) the deductible amount is the amount estab-  
5 lished under section 1104(b)(1);

6 (3) benefits under the coverage in any year  
7 (other than preventive benefits described in section  
8 1102(b)(4)) are covered only to the extent expenses  
9 incurred for items and services included in the cov-  
10 erage for the year exceed the deductible amount  
11 specified in paragraph (2); and

12 (4) the actuarial value of the coverage (as de-  
13 termined under rules consistent with section  
14 1102(c)) is equivalent to 80 percent of the actuarial  
15 value established under such section for standard  
16 coverage.

17 **SEC. 1104. ACTUARIAL VALUATION OF BENEFITS.**

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

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



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

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

14 **SEC. 1105. LIMITATION ON OFFERING SUPPLEMENTAL BEN-**  
15 **EFITS.**

16       A carrier or group health plan offering qualified  
17 health coverage may offer coverage of items and services  
18 only in addition to the qualified standard coverage offered  
19 (whether in the form of coverage of additional items and  
20 services or a reduction in cost sharing) and only if—

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

1           (2) the purchase of the qualified health cov-  
2           erage is not conditioned upon the purchase of such  
3           supplemental coverage; and

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

11 **SEC. 1106. FAMILY COVERAGE OPTION; SUPPLEMENTAL**  
12 **COVERAGE.**

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

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

23 **SEC. 1107. LEVEL PLAYING FIELD FOR PROVIDERS.**

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

1 class of provider, among the providers that are legally au-  
2 thorized to provide such treatment.

3 (b) COVERAGE OF CERTAIN OTHER PROVIDERS.—

4 (1) IN GENERAL.—For purposes of this sub-  
5 title, benefits under standard coverage shall include  
6 the following:

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

10 (B) Coverage provided in a Christian  
11 Science Sanatorium (as defined in section  
12 1861(y) of the Social Security Act), including  
13 coverage provided by a Christian Science practi-  
14 tioner.

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

21 **Subtitle C—Standards and Certifi-**  
22 **cation; Enforcement; Preemp-**  
23 **tion; General Provisions**

24 **SEC. 1201. ESTABLISHMENT OF STANDARDS.**

25 (a) ROLE OF NAIC.—

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

7           (2) REVIEW OF STANDARDS.—If the NAIC de-  
8           velops recommended regulations specifying such  
9           standards within such period, the Secretary shall re-  
10          view the standards. Such review shall be completed  
11          within 60 days after the date the regulations are de-  
12          veloped. Unless the Secretary determines within  
13          such period that the standards do not meet the re-  
14          quirements, such standards shall serve as the stand-  
15          ards under this subtitle, with such amendments as  
16          the Secretary deems necessary.

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

1 **SEC. 1202. APPLICATION OF STANDARDS TO CARRIERS**  
2 **THROUGH STATES.**

3 (a) APPLICATION OF STANDARDS.—

4 (1) IN GENERAL.—Each State shall submit to  
5 the Secretary, by the deadline specified in paragraph  
6 (2), a report on steps the State is taking to imple-  
7 ment and enforce the standards established under  
8 section 1201 with respect to carriers and health in-  
9 surance coverage offered or renewed not later than  
10 such deadline.

11 (2) DEADLINE FOR REPORT.—The deadline  
12 under this paragraph is 1 year after the date the  
13 standards are established under section 1201.

14 (b) FEDERAL ROLE.—

15 (1) NOTICE OF DEFICIENCY.—If the Secretary  
16 determines that a State has failed to submit a report  
17 by the deadline specified under subsection (a)(2) or  
18 finds that the State has not implemented and pro-  
19 vided adequate enforcement of the standards estab-  
20 lished under section 1201, the Secretary shall notify  
21 the State and provide the State a period of 60 days  
22 in which to submit such report or to implement and  
23 enforce such standards.

24 (2) IMPLEMENTATION OF ALTERNATIVE.—

25 (A) IN GENERAL.—If, after such 60-day  
26 period, the Secretary finds that such a failure

1 has not been corrected, the Secretary shall pro-  
2 vide for such mechanism for the implementation  
3 and enforcement of such standards in the State  
4 as the Secretary determines to be appropriate.

5 (B) EFFECTIVE PERIOD.—Such implemen-  
6 tation and enforcement shall take effect with  
7 respect to carriers, and health insurance cov-  
8 erage offered or renewed, on or after 3 months  
9 after the date of the Secretary’s finding under  
10 subparagraph (A), and until the date the Sec-  
11 retary finds that such a failure has been cor-  
12 rected.

13 **SEC. 1203. APPLICATION TO GROUP HEALTH PLANS.**

14 (a) IN GENERAL.—Subject to subsection (b), sections  
15 1201 and 1202 shall apply to group health plans providing  
16 health coverage in the same manner as they apply to car-  
17 riers providing health insurance coverage.

18 (b) SUBSTITUTION OF REFERENCES.—For purposes  
19 of subsection (a), any reference in section 1201 or 1202  
20 to—

21 (1) a State or the Secretary of Health and  
22 Human Services is deemed a reference to the Sec-  
23 retary of Labor, and

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

4 **SEC. 1204. ENFORCEMENT.**

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

7           (1) IN GENERAL.—For purposes of part 5 of  
8 subtitle B of title I of the Employee Retirement In-  
9 come Security Act of 1974, the provisions of this  
10 title insofar as they relate to group health plans or  
11 employers shall be deemed to be provisions of title  
12 I of such Act irrespective of exclusions under section  
13 4(b) of such Act.

14           (2) REGULATORY AUTHORITY.—With respect to  
15 the regulatory authority of the Secretary of Labor  
16 under this subtitle pursuant to paragraph (1), sec-  
17 tion 505 of the Employee Retirement Income Secu-  
18 rity Act of 1974 (29 U.S.C. 1135) shall apply.

19           (b) ENFORCEMENT BY EXCISE TAX FOR CAR-  
20 RIERS.—

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

1 **“SEC. 4980C. FAILURE OF CARRIER TO COMPLY WITH**  
2 **HEALTH INSURANCE STANDARDS.**

3 “(a) IMPOSITION OF TAX.—

4 “(1) IN GENERAL.—There is hereby imposed a  
5 tax on the failure of a carrier to comply with the re-  
6 quirements applicable to the carrier under parts 1  
7 through 4 of subtitle A and subtitle B of title I of  
8 the Health Care Improvement Act of 1995.

9 “(2) EXCEPTION.—Paragraph (1) shall not  
10 apply to a failure by a carrier in a State if the Sec-  
11 retary of Health and Human Services determines  
12 that the State has in effect a regulatory enforcement  
13 mechanism that provides adequate sanctions with re-  
14 spect to such a failure by such a carrier.

15 “(b) AMOUNT OF TAX.—

16 “(1) IN GENERAL.—Subject to paragraph (2),  
17 the amount of the tax imposed by subsection (a)  
18 shall be \$100 for each day during which such failure  
19 persists for each individual to which such failure re-  
20 lates. A rule similar to the rule of section  
21 4980B(b)(3) shall apply for purposes of this section.

22 “(2) LIMITATION.—The amount of the tax im-  
23 posed by subsection (a) for a carrier with respect to  
24 health insurance coverage shall not exceed 25 per-  
25 cent of the amounts received for such coverage dur-  
26 ing the period such failure persists.



1       “(c) LIABILITY FOR TAX.—The tax imposed by this  
2 section shall be paid by the carrier.

3       “(d) EXCEPTIONS.—

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

7               “(A) such failure was due to reasonable  
8 cause and not to willful neglect, and

9               “(B) such failure is corrected within the  
10 30-day period beginning on the earliest date the  
11 carrier knew, or exercising reasonable diligence  
12 would have known, that such failure existed.

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

19       “(e) DEFINITIONS.—For purposes of this section, the  
20 terms ‘health insurance coverage’ and ‘carrier’ have the  
21 respective meanings given such terms in section 1903 of  
22 the Health Care Improvement Act of 1995.”

1           (2) CLERICAL AMENDMENT.—The table of sec-  
2           tions for chapter 43 of such Code is amended by  
3           adding at the end thereof the following new item:

                  “Sec. 4980C. Failure of carrier to comply with health insurance  
                  standards.”

4   **SEC. 1205. LIMITATION ON SELF INSURANCE FOR SMALL**  
5                           **EMPLOYERS.**

6           A single employer plan (as defined in section  
7   3(40)(B) of the Employee Retirement Income Security  
8   Act of 1974) may not offer health coverage other than  
9   through a carrier unless the plan has at least 100 eligible  
10 employees.

11           **Subtitle D—Definitions; General**  
12                           **Provisions**

13   **SEC. 1901. GENERAL DEFINITIONS.**

14           For purposes of this Act:

15           (1) APPLICABLE REGULATORY AUTHORITY.—

16           The term “applicable regulatory authority” means,  
17           with respect to a carrier operating in a State—

18                       (A) the State insurance commissioner, or

19                       (B) the Secretary, in the case described in  
20           section 1202(b)(2).

21           (2) FAMILY MEMBER.—

22                       (A) IN GENERAL.—Individuals are consid-  
23           ered to be members of a family if—

24                               (i) they are married, or

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

4 (I) under 19 years of age,

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

7 (III) an unmarried dependent re-  
8 gardless of age who is incapable of  
9 self-support because of mental or  
10 physical disability which existed before  
11 age 22.

12 (B) SPECIAL RULES.—Family members—

13 (i) include an adopted child and a rec-  
14 ognized natural child;

15 (ii) include a stepchild or foster child  
16 with respect to an individual but only if  
17 the child lives with the individual in a reg-  
18 ular parent-child relationship; and

19 (iii) include such other children as the  
20 Secretary may specify, but shall not in-  
21 clude an emancipated minor.

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

1           (4) SECRETARY.—The term “Secretary” means  
2           the Secretary of Health and Human Services.

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

7   **SEC. 1902. DEFINITIONS RELATING TO EMPLOYMENT.**

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

13          (b) ADDITIONAL DEFINITIONS.—For purposes of this  
14          title:

15               (1) COUNTABLE EMPLOYEE.—The term “count-  
16               able employee” means, with respect to an employer  
17               for a month, any employee other than an employee  
18               whose normal work week is less than 10 hours.

19               (2) LARGE EMPLOYER.—The term “large em-  
20               ployer” means an employer that is not a small em-  
21               ployer (as defined in paragraph (4)).

22               (3) QUALIFYING EMPLOYEE.—

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

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

4 (ii) an employee who is a child de-  
5 scribed in section 1901(2)(A)(ii).

6 (B) PART-TIME, SEASONAL, OR TEM-  
7 PORARY EMPLOYEE DEFINED.—For purposes of  
8 subparagraph (A), the term “part-time, sea-  
9 sonal, or temporary employee” means any of  
10 the following employees with respect to a  
11 month:

12 (i) CERTAIN PART-TIME EMPLOY-  
13 EES.—Any employee whose normal work  
14 week is reasonably expected as of the first  
15 day of such month to be less than 20  
16 hours.

17 (ii) SEASONAL OR TEMPORARY EM-  
18 PLOYEES.—Any employee who is not rea-  
19 sonably expected as of the first day of such  
20 month to be employed by the employer for  
21 a period of 120 consecutive days during  
22 any 365-day period that includes such first  
23 day.

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

1 work week is reasonably expected as of the  
2 first day of such month to be at least 20  
3 hours, but less than 35 hours, and the nor-  
4 mal work week of the employee during the  
5 preceding 3 months was less than 20  
6 hours.

7 (4) SMALL EMPLOYER.—The term “small em-  
8 ployer” means, with respect to a calendar year, an  
9 employer that normally employs more than 1 but  
10 less than 100 countable employees on a typical busi-  
11 ness day. For the purposes of this paragraph, the  
12 term “employee” includes a self-employed individual.  
13 For purposes of determining if an employer is a  
14 small employer, rules similar to the rules of sub-  
15 section (b) and (c) of section 414 of the Internal  
16 Revenue Code of 1986 shall apply.

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

19 Except as otherwise provided, for purposes of this  
20 Act:

21 (1) BENCHMARK COVERAGE.—The term  
22 “benchmark coverage” means the standard option of  
23 the Blue Cross-Blue Shield plan offered under the  
24 Federal Employees Health Benefits Program under

1 chapter 89 of title 5, United States Code, as in ef-  
2 fect during 1994.

3 (2) CARRIER.—The term “carrier” means a li-  
4 censed insurance company, an entity offering pre-  
5 paid hospital or medical services, and a health main-  
6 tenance organization, and includes a similar organi-  
7 zation regulated under State law for solvency.

8 (3) CLASS OF FAMILY COVERAGE.—The term  
9 “class of family coverage” means the 4 classes de-  
10 scribed in section 1021(a)(3).

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

14 (5) GROUP HEALTH PLAN.—The term “group  
15 health plan” means an employee welfare benefit plan  
16 providing medical care (as defined in section 213(d)  
17 of the Internal Revenue Code of 1986) to partici-  
18 pants or beneficiaries directly or through insurance,  
19 reimbursement, or otherwise, but does not include  
20 any type of coverage excluded from the definition of  
21 a health insurance coverage under paragraph (7)(B).

22 (6) HEALTH COVERAGE.—The term “health  
23 coverage” means health insurance coverage provided  
24 by a carrier or medical care provided under a group  
25 health plan.

1 (7) HEALTH INSURANCE COVERAGE.—

2 (A) IN GENERAL.—Except as provided in  
3 subparagraph (B), the term “health insurance  
4 coverage” means any hospital or medical service  
5 policy or certificate, hospital or medical service  
6 plan contract, or health maintenance organiza-  
7 tion group contract offered by a carrier.

8 (B) EXCEPTION.—Such term does not in-  
9 clude any of the following (or any combination  
10 of the following):

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

14 (ii) Medicare supplemental health in-  
15 surance.

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

18 (iv) Liability insurance, including gen-  
19 eral liability insurance and automobile li-  
20 ability insurance.

21 (v) Workers’ compensation or similar  
22 insurance.

23 (vi) Automobile medical-payment in-  
24 surance.



1 (vii) Coverage for a specified disease  
2 or illness.

3 (viii) A hospital or fixed indemnity  
4 policy.

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

7 (8) HEALTH MAINTENANCE ORGANIZATION.—  
8 The term “health maintenance organization” in-  
9 cludes, as defined in standards established under  
10 section 1103, an organization that provides health  
11 insurance coverage which meets specified standards  
12 and under which health services are offered to be  
13 provided on a prepaid, at-risk basis primarily  
14 through a defined set of providers.

15 (9) HEALTH PLAN PURCHASING ORGANIZA-  
16 TION.—The term “health plan purchasing organiza-  
17 tion” means an organization established under sub-  
18 title A of title VI.

19 (10) INDIVIDUAL/SMALL GROUP MARKET.—The  
20 term “individual/small group market” means the in-  
21 surance market offered—

22 (A) to individuals seeking health insurance  
23 coverage on behalf of themselves (and their de-  
24 pendents) insofar as no employer is seeking  
25 such coverage on behalf of the individual, and

1 (B) to small employers seeking health in-  
2 surance coverage on behalf of their employees  
3 (and their dependents),  
4 regardless of whether or not such coverage is made  
5 available directly or through a multiple employer  
6 welfare arrangement, association, or otherwise.

7 (11) MANAGED CARE ARRANGEMENTS.—

8 (A) MANAGED CARE ARRANGEMENT.—The  
9 term “managed care arrangement” means, with  
10 respect to a group health plan or under health  
11 insurance coverage, an arrangement under such  
12 plan or coverage under which providers agree to  
13 provide items and services covered under the ar-  
14 rangement to individuals covered under the  
15 plan or who have such coverage.

16 (B) PROVIDER NETWORK.—The term  
17 “provider network” means, with respect to a  
18 group health plan or health insurance coverage,  
19 providers who have entered into an agreement  
20 described in subparagraph (A).

21 (12) MULTIPLE EMPLOYER WELFARE AR-  
22 RANGEMENT.—The term “multiple employer welfare  
23 arrangement” shall have the meaning applicable  
24 under section 3(40) of the Employee Retirement In-  
25 come Security Act of 1974.

1           (13) NAIC.—The term “NAIC” means the Na-  
2           tional Association of Insurance Commissioners.

3           (14) OPTIONS.—Each of the following is a  
4           “type of coverage option” in relation to standard  
5           coverage:

6                   (A) FEE-FOR-SERVICE OPTION.—Standard  
7                   coverage is considered to provide a “fee-for-  
8                   service option” if, regardless of whether covered  
9                   individuals may receive benefits through a pro-  
10                  vider network, benefits with respect to the cov-  
11                  ered items and services in the coverage are  
12                  made available for such items and services pro-  
13                  vided through any lawful provider of such cov-  
14                  ered items and services and payment is made to  
15                  such a provider whether or not there is a con-  
16                  tractual arrangement between the provider and  
17                  the carrier or plan.

18                  (B) MANAGED CARE OPTION.—Standard  
19                  coverage is considered to provide a “managed  
20                  care option” if benefits with respect to the cov-  
21                  ered items and services in the coverage are  
22                  made available exclusively through a provider  
23                  network, except in the case of emergency serv-  
24                  ices and as otherwise required under law.

1           (C) POINT-OF-SERVICE OPTION.—Standard  
2 coverage is considered to provide a “point-of-  
3 service option” if the benefits with respect to  
4 covered items and services in the coverage are  
5 made available principally through a managed  
6 care arrangement, with the choice of the en-  
7 rollee to obtain such benefits for items and  
8 services provided through any lawful provider of  
9 such covered items and services. The coverage  
10 may provide for different cost sharing schedules  
11 based on whether the items and services are  
12 provided through such an arrangement or out-  
13 side such an arrangement.

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

17           (16) STANDARD COVERAGE.—The term “stand-  
18 ard coverage” means coverage provided consistent  
19 with section 1102(a).

20           (17) STATE COMMISSIONER OF INSURANCE.—  
21 The term “State commissioner of insurance” in-  
22 cludes a State superintendent of insurance.

1 **SEC. 1904. DEFINITIONS RELATING TO RESIDENCE AND IM-**  
2 **MIGRATION STATUS.**

3 Except as otherwise provided, for purposes of this  
4 Act:

5 (1) ALIEN PERMANENTLY RESIDING IN THE  
6 UNITED STATES UNDER COLOR OF LAW.—The term  
7 “alien permanently residing in the United States  
8 under color of law” means an alien lawfully admitted  
9 for permanent residence (within the meaning of sec-  
10 tion 101(a)(20) of the Immigration and Nationality  
11 Act), and includes any of the following (such status  
12 not having changed):

13 (A) An alien who is admitted as a refugee  
14 under section 207 of the Immigration and Na-  
15 tionality Act.

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

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

20 (D) An alien whose deportation is sus-  
21 pended pursuant to section 244 of such Act.

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

1           (F) An alien who is admitted for tem-  
2           porary residence under section 210, 210A, or  
3           245A of such Act.

4           (G) An alien who is within a class of aliens  
5           lawfully present in the United States pursuant  
6           to any other provision of such Act, if (i) the At-  
7           torney General determines that the continued  
8           presence of such class of aliens serves a human-  
9           itarian or other compelling public interest, and  
10          (ii) the Secretary determines that such interest  
11          would be further served by treating each such  
12          alien within such class as a “legal permanent  
13          resident” for purposes of this Act or who has  
14          been granted extended voluntary departure as a  
15          member of a nationality group.

16          (H) An alien who is the spouse or unmar-  
17          ried child under 21 years of age of a citizen of  
18          the United States, or the parent of such a citi-  
19          zen if the citizen is over 21 years of age, and  
20          with respect to whom an application for adjust-  
21          ment to lawful permanent residence is pending.

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

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

6           (3) QUALIFYING INDIVIDUAL.—The term  
7           “qualifying individual” means, an individual who is  
8           a resident of the United States, who is not a pris-  
9           oner, and is—

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

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

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

17 **SEC. 1905. EFFECTIVE DATES.**

18           The requirements of this title shall apply with respect  
19 to—

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

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

1 **TITLE II—REMOVAL OF FINAN-**  
 2 **CIAL BARRIERS TO ACCESS**  
 3 **Subtitle A—Tax Deductibility for**  
 4 **Individuals and Self-Employed**

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

8 (a) IN GENERAL.—Paragraph (1) of section 162(l)  
 9 of the Internal Revenue Code of 1986 (relating to special  
 10 rules for health insurance costs of self-employed individ-  
 11 uals) is amended by striking “25 percent” and inserting  
 12 “the applicable percentage”.

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

16 “(6) APPLICABLE PERCENTAGE.—For purposes  
 17 of paragraph (1)—

<b>“In the case of taxable years begin- ning in calendar year:</b>	<b>The applicable percentage is:</b>
1996, 1997, or 1998 .....	30 percent
1999 .....	50 percent
2000 or thereafter .....	100 percent.”

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



1 **SEC. 2002. DEDUCTION FOR HEALTH INSURANCE COSTS OF**  
2 **INDIVIDUALS WHO ARE NOT SELF-EM-**  
3 **PLOYED.**

4 (a) IN GENERAL.—Part VII of subchapter B of chap-  
5 ter 1 of the Internal Revenue Code of 1986 (relating to  
6 additional itemized deductions) is amended by redesignat-  
7 ing section 220 as section 221 and by inserting after sec-  
8 tion 219 the following new section:

9 **“SEC. 220. HEALTH INSURANCE COSTS OF INDIVIDUALS**  
10 **WHO ARE NOT SELF-EMPLOYED.**

11 “(a) IN GENERAL.—In the case of an individual who  
12 is not a self-employed individual (as defined in section  
13 401(c)(1)), there shall be allowed as a deduction an  
14 amount equal to 25 percent of the amount paid during  
15 the taxable year for insurance which constitutes medical  
16 care for the taxpayer, his spouse, and dependents.

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

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

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

3 “(d) COORDINATION WITH MEDICAL DEDUCTION,  
4 ETC.—Any amount paid by a taxpayer for insurance to  
5 which subsection (a) applies shall not be taken into ac-  
6 count in computing the amount allowable to the taxpayer  
7 as a deduction under section 213(a).”

8 (b) DEDUCTION ALLOWED WHETHER OR NOT TAX-  
9 PAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
10 of section 62 of such Code is amended by adding at the  
11 end the following new paragraph:

12 “(16) HEALTH INSURANCE COSTS.—The deduc-  
13 tion allowed by section 220.”

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

“Sec. 220. Health insurance costs of individuals who are not self-  
employed.

“Sec. 221. Cross reference.”

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

1 **SEC. 2003. RESTRICTIONS ON HEALTH BENEFITS PRO-**  
2 **VIDED THROUGH CAFETERIA PLANS AND**  
3 **FLEXIBLE SPENDING ARRANGEMENTS.**

4 (a) FLEXIBLE SPENDING ARRANGEMENTS.—Section  
5 106 of the Internal Revenue Code of 1986 (relating to  
6 contributions by employer to accident and health plans)  
7 is amended to read as follows:

8 **“SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT**  
9 **AND HEALTH PLANS.**

10 “(a) GENERAL RULE.—Except as otherwise provided  
11 in this section, gross income of an employee does not in-  
12 clude employer-provided coverage under an accident or  
13 health plan.

14 “(b) INCLUSION OF CERTAIN BENEFITS PROVIDED  
15 THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—  
16 Gross income of an employee shall include such employer-  
17 provided coverage which is provided through a flexible  
18 spending or similar arrangement if any amount of deduct-  
19 ible, copayment, coinsurance, or similar cost-sharing may  
20 be paid for or reimbursed under such arrangement.”

21 (b) CAFETERIA PLANS.—Subsection (f) of section  
22 125 of such Code (defining qualified benefits) is amended  
23 by adding at the end thereof the following new sentence:  
24 “Such term shall not include any benefits or coverage  
25 under an accident or health plan if any amount of deduct-  
26 ible, copayment, coinsurance, or similar cost-sharing

1 under such a plan, or more than 20 percent of any pre-  
2 mium (or comparable amount in the case of a plan not  
3 provided through insurance) for such a plan, may be paid  
4 for or reimbursed under the cafeteria plan.”

5 (c) EMPLOYMENT TAX TREATMENT.—

6 (1) SOCIAL SECURITY TAX.—

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

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

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

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

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

1       pensation' any amount which is required to be in-  
2       cluded in gross income under section 106(b).''

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

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

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

12      “Nothing in the preceding provisions of this subsection  
13      shall exclude from the term ‘wages’ any amount which is  
14      required to be included in gross income under section  
15      106(b).’’

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

18      (e) TRANSFERS FROM FLEXIBLE SPENDING AR-  
19      RANGEMENTS TO MEDICAL SAVINGS ACCOUNTS PER-  
20      MITTED DURING 1997.—A flexible spending arrangement  
21      for health shall not cease to be treated as such an arrange-  
22      ment, and no amount shall be includible in the gross in-  
23      come of the employee, solely because amounts not paid out  
24      as reimbursements under such arrangement during 1996  
25      are contributed to a medical savings account (as defined

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

6 **Subtitle B—Premium and Cost-**  
7 **Sharing Subsidy Program and**  
8 **Supplemental Benefits Program**  
9 **for Low-Income Individuals**

10 **SEC. 2101. STATE PREMIUM AND COST-SHARING SUBSIDY**  
11 **PROGRAMS AND SUPPLEMENTAL BENEFITS**  
12 **PROGRAMS.**

13 (a) REQUIREMENTS FOR PROGRAMS.—The Social Se-  
14 curity Act is amended by adding at the end the following  
15 new title:

16 “TITLE XXI—STATE ACUTE CARE BENEFITS  
17 PROGRAMS FOR LOW-INCOME INDIVIDUALS

18 “PART A—STATE PREMIUM AND COST-SHARING  
19 SUBSIDY PROGRAMS

20 “**SEC. 2101. ESTABLISHMENT OF STATE PROGRAMS.**

21 “(a) IN GENERAL.—As a requirement under section  
22 1902(a)(63), effective January 1, 1998, each State shall  
23 establish and maintain a premium and cost-sharing sub-  
24 sidy program (in this title referred to as a ‘State subsidy  
25 program’) that provides for—

1           “(1) premium assistance described in section  
2           2103 to premium assistance eligible individuals de-  
3           scribed in section 2102(a) in accordance with this  
4           part,

5           “(2) cost-sharing assistance described in section  
6           2103 to cost-sharing assistance eligible individuals  
7           described in section 2102(b) in accordance with this  
8           part, and

9           “(3) State maintenance-of-effort payments in  
10          accordance with section 2107.

11          “(b) AVAILABILITY OF FUNDS.—Each State with a  
12          State subsidy program approved under this part is enti-  
13          tled, for calendar quarters beginning on or after January  
14          1, 1998, to payment under section 2106.

15          “(c) APPROVAL OF STATE PROGRAMS.—The Sec-  
16          retary may not approve a State subsidy program unless  
17          the State has submitted a detailed description that speci-  
18          fies the form and manner in which it will carry out the  
19          program and the Secretary finds that the program meets  
20          the requirements of this part.

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

1 **“SEC. 2102. ELIGIBILITY.**

2 “(a) ASSISTANCE.—

3 “(1) PREMIUM ASSISTANCE.—Each premium  
4 assistance eligible individual (as defined in sub-  
5 section (b)) is entitled to premium assistance under  
6 section 2103(a)(1).

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

11 “(b) PREMIUM ASSISTANCE ELIGIBLE INDIVIDUAL  
12 DEFINED.—

13 “(1) IN GENERAL.—In this title, subject to the  
14 succeeding provisions of this section, the term ‘pre-  
15 mium assistance eligible individual’ means an indi-  
16 vidual who has been determined under section 2104  
17 to have family modified adjusted income below 100  
18 percent of the applicable poverty line (as defined in  
19 section 2144(2)).

20 “(2) SPECIAL RULE FOR CHILDREN AND PREG-  
21 NANT WOMEN.—In this title, subject to the succeed-  
22 ing provisions of this section, the term ‘premium as-  
23 sistance eligible individual’ includes an individual  
24 who is a child under 19 years of age or a pregnant  
25 woman and who has been determined under section



1       2104 to have family modified adjusted income below  
2       185 percent of the applicable poverty line.

3       “(c) COST-SHARING ASSISTANCE ELIGIBLE INDIVID-  
4 UAL DEFINED.—In this title, subject to the succeeding  
5 provisions of this section, the term ‘cost-sharing assistance  
6 eligible individual’ means an individual who has been de-  
7 termined under section 2104 to have family modified ad-  
8 justed income below 100 percent of the applicable poverty  
9 line.

10       “(d) EXCLUSION OF CERTAIN INDIVIDUALS.—In this  
11 title—

12               “(1) IN GENERAL.—The terms ‘premium assist-  
13 ance eligible individual’ and ‘cost-sharing assistance  
14 eligible individual’ do not include, with respect to a  
15 month, any of the following individuals:

16                       “(A) MEDICARE BENEFICIARY.—An indi-  
17 vidual who is entitled to benefits under part A  
18 or B of title XVIII for the month.

19                       “(B) INMATES.—An individual who as of  
20 the first day of the month is an inmate of a  
21 public institution (except as a patient of a med-  
22 ical institution).

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

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

3 “(D) NONRESIDENTS.—An individual who  
4 is not residing in any State.

5 “(2) ALIEN PERMANENTLY RESIDING IN THE  
6 UNITED STATES UNDER COLOR OF LAW.—The term  
7 ‘alien permanently residing in the United States  
8 under color of law’ means an alien lawfully admitted  
9 for permanent residence (within the meaning of sec-  
10 tion 101(a)(20) of the Immigration and Nationality  
11 Act), and includes any of the following:

12 “(A) An alien who is admitted as a refugee  
13 under section 207 of the Immigration and Na-  
14 tionality Act.

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

17 “(C) An alien whose deportation is with-  
18 held under section 243(h) of such Act.

19 “(D) An alien whose deportation is sus-  
20 pended under section 244 of such Act.

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

1           “(F) An alien who is admitted for tem-  
2           porary residence under section 210, 210A, or  
3           245A of such Act.

4           “(G) An alien who has been paroled into  
5           the United States under section 212(d)(5) of  
6           such Act for an indefinite period or who has  
7           been granted extended voluntary departure as a  
8           member of a nationality group.

9           “(H) An alien who is the spouse or unmar-  
10          ried child under 21 years of age of a citizen of  
11          the United States, or the parent of such a citi-  
12          zen if the citizen is over 21 years of age, and  
13          with respect to whom an application for adjust-  
14          ment to lawful permanent residence is pending.

15          “(e) PROTECTION OF CURRENT BENEFICIARIES.—

16               “(1) IN GENERAL.—In this title, the term ‘pre-  
17               mium assistance eligible individual’ also includes,  
18               with respect to a State as of December 31, 1997, an  
19               individual described in paragraph (2) whose eligi-  
20               bility for premium assistance has not terminated  
21               under paragraph (3).

22               “(2) CURRENT BENEFICIARIES DESCRIBED.—  
23               An individual described in this paragraph is an indi-  
24               vidual who—

25                       “(A) is not excluded under subsection (d),

1           “(B) is enrolled to receive medical assist-  
2           ance under the State plan under title XIX (and  
3           for which Federal financial participation was  
4           available) as of December 31, 1997, and

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

9           “(3) LIMITATION.—An individual is a premium  
10          assistance eligible individual pursuant to this sub-  
11          section only until the earlier of—

12           “(A) June 30, 1998, or

13           “(B) the first date after December 31,  
14          1997, on which the individual’s eligibility for  
15          medical assistance under the State plan under  
16          title XIX would have been terminated if the  
17          amendments made by the Health Care Improve-  
18          ment Act of 1995 had not been enacted.

19   **“SEC. 2103. PREMIUM AND COST-SHARING ASSISTANCE.**

20          “(a) IN GENERAL.—

21           “(1) PREMIUM ASSISTANCE.—

22           “(A) IN GENERAL.—The premium assist-  
23          ance under a State subsidy program shall be in  
24          the form of a premium assistance certificate  
25          that is in the amount computed under sub-

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

9 “(B) QUALIFYING COVERAGE DEFINED.—

10 For purposes of this part—

11 “(i) IN GENERAL.—Except as pro-  
12 vided in clause (ii), the term ‘qualifying  
13 coverage’ means standard coverage de-  
14 scribed in section 1102 of the Health Care  
15 Improvement Act of 1995.

16 “(ii) OPTIONAL USE OF HIGH-DE-  
17 DUCTIBLE COVERAGE.—At the election of  
18 a premium assistance eligible individual,  
19 the term ‘qualifying coverage’ includes  
20 high-deductible coverage described in sec-  
21 tion 1103 of the Health Care Improvement  
22 Act of 1995 with respect to an individual,  
23 but only if the individual—

24 “(I) is not described in section  
25 2102(a)(2) and has been determined

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

5 “(II) demonstrates to the satis-  
6 faction of the State that the individual  
7 meets the requirements of section  
8 1101(b)(2) of the Health Care Im-  
9 provement Act of 1995 (relating to re-  
10 quirement for available assets).

11 “(2) COST-SHARING ASSISTANCE.—The cost-  
12 sharing assistance under a State subsidy program  
13 shall be in the form of a cost-sharing assistance cer-  
14 tificate (or other means) that may be applied with  
15 respect to standard coverage. A carrier providing  
16 health insurance coverage or a group health plan  
17 that is tendered such a certificate with respect to an  
18 individual shall reduce the cost-sharing otherwise  
19 imposed with respect to health coverage to amounts  
20 that are nominal (as specified by the State, consist-  
21 ent with the regulations established to carry out sec-  
22 tion 1916(a)(3)) and shall not impose any cost-shar-  
23 ing in the case of preventive benefits described in  
24 section 1102(b)(4) of the Health Care Improvement  
25 Act of 1995.

1           “(3) CONSOLIDATED AND ELECTRONIC CER-  
2           TIFICATES.—Nothing in this section shall be con-  
3           strued as preventing a State from—

4                   “(A) in the case of an individual who is  
5                   both a premium assistance eligible individual  
6                   and a cost-sharing assistance eligible individual,  
7                   from consolidating the premium and cost-shar-  
8                   ing certificates of the individual, and

9                   “(B) providing premium and cost-sharing  
10                  assistance certificates through electronic or  
11                  other means.

12          “(b) AMOUNT OF PREMIUM ASSISTANCE.—

13                  “(1) AMOUNT OF ASSISTANCE.—

14                   “(A) IN GENERAL.—Subject to subpara-  
15                   graph (B), the amount of premium assistance  
16                   under this subsection for a month for an indi-  
17                   vidual is the lesser of—

18                           “(i) the premium assistance reference  
19                           amount determined under paragraph (2),  
20                           or

21                           “(ii) the amount of the monthly pre-  
22                           mium for the qualifying coverage provided  
23                           to the individual.

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

1 contribution for the health coverage of a pre-  
2 mium assistance eligible individual, the amount  
3 of the premium assistance under this subsection  
4 for a month shall not exceed the amount by  
5 which the premium amount described in sub-  
6 paragraph (A)(ii) exceeds the amount of the  
7 employer contribution.

8 “(2) PREMIUM ASSISTANCE REFERENCE  
9 AMOUNT DETERMINED.—

10 “(A) IN GENERAL.—Subject to paragraph  
11 (4), the premium assistance reference amount  
12 determined under this paragraph is an amount  
13 equal to  $\frac{1}{12}$  of the weighted average annual  
14 premium (determined in accordance with sub-  
15 paragraph (B)) for the individual’s family class  
16 of enrollment for qualified standard health cov-  
17 erage offered in the fair rating area (as defined  
18 in section 1903 of the Health Care Improve-  
19 ment Act of 1995) in the individual/small group  
20 market in which the individual resides.

21 “(B) DETERMINATION OF WEIGHTED AV-  
22 ERAGE ANNUAL PREMIUM.—For purposes of  
23 subparagraph (A), the weighted average annual  
24 premium for a family class of enrollment for  
25 qualified standard health coverage shall be



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

4 “(C) FAMILY CLASS OF ENROLLMENT.—In  
5 this paragraph, the term ‘family class of enroll-  
6 ment’ means a class of enrollment described in  
7 section 1021(a)(3) of the Health Care Improve-  
8 ment Act of 1995.

9 “(c) PAYMENTS OF ASSISTANCE.—

10 “(1) PREMIUM ASSISTANCE.—

11 “(A) IN GENERAL.—The State issuing a  
12 premium assistance certificate shall, upon ten-  
13 der to the State of such certificate by the car-  
14 rier or group health plan providing qualifying  
15 coverage, pay the carrier or plan the amount of  
16 the certificate.

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

23 “(C) TREATMENT OF SURPLUSES AND  
24 DEFICITS.—

1           “(i) DEFICIT.—If the premium for  
2           coverage is greater than the amount of the  
3           premium assistance for an individual, the  
4           individual is responsible for payment of  
5           any difference.

6           “(ii) SURPLUS.—If the premium for  
7           coverage is less than the amount of the  
8           premium assistance for an individual, the  
9           difference shall not be paid to the individ-  
10          ual or the carrier or plan but shall revert  
11          to the Federal Government.

12          “(2) COST-SHARING ASSISTANCE.

13           “(A) IN GENERAL.—The State issuing a  
14           cost-sharing assistance certificate shall, upon  
15           presentation to the State of evidence of such  
16           certificate by the carrier or group health plan  
17           providing coverage and evidence of cost-sharing  
18           amounts otherwise incurred for which a reduc-  
19           tion in cost-sharing is available under the cer-  
20           tificate, pay the carrier or plan the amount of  
21           the reduction in cost-sharing in relation to  
22           standard coverage.

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

1           ard health coverage, is determined under sec-  
2           tion 2104 to be a cost-sharing assistance eligi-  
3           ble individual, and has incurred health care ex-  
4           penses of the type for which a cost-sharing re-  
5           duction is available under subparagraph (A).

6           “(3) ADMINISTRATIVE ERRORS.—A State is fi-  
7           nancially responsible for premium or cost-sharing as-  
8           sistance paid based on an eligibility determination  
9           error to the extent the State’s error rate for eligi-  
10          bility determinations exceeds a maximum permissible  
11          error rate to be specified by the Secretary.

12       **“SEC. 2104. ELIGIBILITY DETERMINATIONS.**

13          “(a) IN GENERAL.—The Secretary shall promulgate  
14          regulations specifying requirements for State subsidy pro-  
15          grams with respect to determining eligibility for premium  
16          and cost-sharing assistance, including requirements with  
17          respect to—

18               “(1) application procedures;

19               “(2) information verification procedures;

20               “(3) timeliness of eligibility determinations;

21               “(4) procedures for applicants to appeal adverse  
22          decisions; and

23               “(5) any other matters determined appropriate  
24          by the Secretary.

1       “(b) SPECIFICATIONS FOR REGULATIONS.—The reg-  
2       ulations promulgated by the Secretary under subsection  
3       (a) shall include the following requirements:

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

8               “(2) APPLICATION FORM.—A State program  
9       shall provide for the use of an application form de-  
10      veloped by the Secretary under subsection (c)(2).

11              “(3) DISTRIBUTION OF APPLICATIONS.—A  
12      State program shall distribute applications for as-  
13      sistance widely, including to employers, health plan  
14      purchasing organizations, brokers for health cov-  
15      erage, and appropriate public agencies.

16              “(4) CONVENIENT LOCATION TO SUBMIT APPLI-  
17      CATIONS.—A State program shall provide convenient  
18      locations for premium and cost-sharing assistance el-  
19      igible individuals to apply for premium and cost-  
20      sharing assistance.

21              “(5) REQUIREMENT TO SUBMIT REVISED AP-  
22      PLICATION.—A State program shall, in accordance  
23      with regulations promulgated by the Secretary, re-  
24      quire individuals to submit revised applications dur-  
25      ing a year to reflect changes in estimated family in-

1 comes, including changes in employment status of  
2 family members, and changes in eligibility status de-  
3 scribed in section 2002(c) during the year. The  
4 State shall revise the amount of any premium and  
5 cost-sharing assistance based on such a revised ap-  
6 plication.

7 “(6) AFDC AND SSI APPLICANTS.—A State  
8 program shall include a procedure under which indi-  
9 viduals applying for benefits under part A of title IV  
10 or title XVI shall have an opportunity to apply for  
11 assistance under this part in connection with such  
12 application.

13 “(7) VERIFICATION.—A State program shall  
14 provide for verification of the information supplied  
15 in applications under this part. Such verification  
16 may include examining return information disclosed  
17 to the State for such purpose under section  
18 6103(l)(15) of the Internal Revenue Code of 1986.

19 “(c) ADMINISTRATION OF STATE PROGRAM.—

20 “(1) IN GENERAL.—The Secretary shall estab-  
21 lish standards for States operating programs under  
22 this part which ensure that such programs are oper-  
23 ated in a uniform manner with respect to application  
24 procedures, data standards, and such other adminis-

1 trative activities as the Secretary determines to be  
2 necessary.

3 “(2) APPLICATION FORMS.—The Secretary  
4 shall develop an application form for assistance  
5 which shall—

6 “(A) be simple in form and understandable  
7 to the average individual;

8 “(B) require the provision of information  
9 necessary to make a determination as to wheth-  
10 er an individual is a premium or cost-sharing  
11 assistance eligible individual including a dec-  
12 laration of estimated family income by the indi-  
13 vidual; and

14 “(C) require attachment of such docu-  
15 mentation as deemed necessary by the Sec-  
16 retary in order to ensure eligibility for assist-  
17 ance.

18 “(3) OUTREACH ACTIVITIES.—A State operat-  
19 ing a program under this part shall conduct such  
20 outreach activities as the Secretary determines ap-  
21 propriate.

22 “(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM  
23 AND COST-SHARING ASSISTANCE.—A determination by a  
24 State that an individual is a premium or cost-sharing as-  
25 sistance eligible individual shall be effective for the cal-

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

5 “(e) PENALTIES FOR MATERIAL MISREPRESENTA-  
6 TIONS.—

7 “(1) IN GENERAL.—Any individual who know-  
8 ingly makes a material misrepresentation of infor-  
9 mation in an application for assistance under this  
10 part shall be liable to the Federal Government for  
11 the amount any premium and cost-sharing assist-  
12 ance received by an individual on the basis of a mis-  
13 representation and interest on such amount at a  
14 rate specified by the Secretary, and shall, in addi-  
15 tion, be liable to the Federal Government for \$2,000  
16 or, if greater, 3 times the amount any premium and  
17 cost-sharing assistance provided on the basis of a  
18 misrepresentation.

19 “(2) COLLECTION OF PENALTY AMOUNTS.—A  
20 State which receives an application for assistance  
21 with respect to which a material misrepresentation  
22 has been made shall collect the penalty amount re-  
23 quired under paragraph (1) and submit 50 percent  
24 of such amount to the Secretary in a timely manner.

1 **“SEC. 2105. END-OF-YEAR RECONCILIATION FOR PREMIUM**  
2 **ASSISTANCE.**

3 “(a) IN GENERAL.—

4 “(1) REQUIREMENT TO FILE STATEMENT.—An  
5 individual who received premium assistance under  
6 this part from a State for any month in a calendar  
7 year shall file with the State an income reconcili-  
8 ation statement to verify the individual’s family in-  
9 come for the year. Such a statement shall be filed  
10 at such time, and contain such information, as the  
11 State may specify in accordance with regulations  
12 promulgated by the Secretary.

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

18 “(b) RECONCILIATION OF PREMIUM ASSISTANCE  
19 BASED ON ACTUAL INCOME.—

20 “(1) IN GENERAL.—Based on and using the in-  
21 come reported in the reconciliation statement filed  
22 under subsection (a) with respect to an individual,  
23 the State shall compute the amount of premium as-  
24 sistance that should have been provided under this  
25 part with respect to the individual for the year in-  
26 volved.



1           “(2) OVERPAYMENT OF ASSISTANCE.—If the  
2 total amount of the premium assistance provided  
3 was greater than the amount computed under para-  
4 graph (1), the excess amount shall be treated as an  
5 underpayment of a tax imposed by chapter 1 of the  
6 Internal Revenue Code of 1986.

7           “(3) UNDERPAYMENT OF ASSISTANCE.—If the  
8 total amount of the premium assistance provided  
9 was less than the amount computed under para-  
10 graph (1), the amount of the difference shall be  
11 treated as an overpayment of tax imposed by such  
12 chapter, or in the event the taxpayer involved is enti-  
13 tled to a refund of such a tax, subject to the provi-  
14 sions of section 6402(d) of such Code.

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

20           “(d) PENALTIES FOR FAILURE TO FILE.—In the  
21 case of an individual who is required to file a statement  
22 under this section in a year who fails to file such a state-  
23 ment by such date as the Secretary shall specify in regula-  
24 tions, the entire amount of the premium assistance pro-  
25 vided in such year shall be considered an excess amount

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

8 “(e) PENALTIES FOR FALSE INFORMATION.—Any in-  
9 dividual who provides false information in a statement  
10 filed under subsection (a) is subject to the same penalties  
11 as are provided under section 2104(e) for a misrepresenta-  
12 tion of material fact described in such section.

13 “(f) NO RECONCILIATION FOR COST-SHARING AS-  
14 SISTANCE.—No reconciliation statement is required under  
15 this section with respect to cost-sharing assistance.

16 **“SEC. 2106. PAYMENTS TO STATES.**

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

21 “(1) the Federal title XXI matching percentage  
22 (specified under section 2107(a)) of the amount ex-  
23 pended by the State under the program during the  
24 quarter for premium assistance on behalf of pre-  
25 mium assistance eligible individuals and for cost-

1 sharing assistance on behalf of cost-sharing assist-  
2 ance eligible individuals; plus

3 “(2) 50 percent of the amounts expended by  
4 the State during the quarter as found necessary by  
5 the Secretary for the proper and efficient adminis-  
6 tration of such program in the State.

7 “(b) LIMITATION ON PAYMENTS.—

8 “(1) IN GENERAL.—The total amount of pay-  
9 ments that may be made to a State under subsection  
10 (a)(1) for all quarters in a calendar year may not  
11 exceed the lesser of—

12 “(A) subject to paragraph (3), the product  
13 of—

14 “(i) the per capita core benefit Fed-  
15 eral payment limit applicable to the cal-  
16 endar year under subsection (c), and

17 “(ii) the average monthly number of  
18 premium assistance eligible individuals in  
19 the State in the year; or

20 “(B) 110 percent of the total amount that  
21 would otherwise have been paid to the State  
22 under title XIX in the year with respect to  
23 medical assistance described in section  
24 1903(i)(16).

1           “(2) ESTIMATIONS AND ADJUSTMENTS.—The  
2 Secretary shall—

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

7           “(B) notifying each State of the esti-  
8 mations and adjustments referred to in sub-  
9 paragraph (A).

10          “(3) ADJUSTMENT FOR CERTAIN STATES.—In  
11 the case of a State in a year in which the product  
12 described in paragraph (1)(A) (as adjusted under  
13 this paragraph) exceeds the amount described in  
14 paragraph (1)(B), the amount described in para-  
15 graph (1)(A) shall be increased by a proportion  
16 equal to the ratio of—

17           “(A) the total amount of the reductions in  
18 payment made by the application of paragraph  
19 (1)(B) in the year, to

20           “(B) the total of the limitations in pay-  
21 ment for all such States in the year under para-  
22 graph (1)(A), determined without regard to any  
23 adjustment under this paragraph.

24          “(c) PER CAPITA CORE BENEFIT FEDERAL PAY-  
25 MENT LIMIT DEFINED.—

1           “(1) IN GENERAL.—For purposes of subsection  
2           (b)(1)(A), the ‘per capita core benefit Federal pay-  
3           ment limit’ for a State for a year is equal to the  
4           base per capita core Federal payments (described in  
5           paragraph (2)) increased by the FEHBP State roll-  
6           ing increase percentage (as defined in subsection  
7           (d)(2)) for each year after 1995 and up to the year  
8           involved.

9           “(2) BASE PER CAPITA CORE FEDERAL PAY-  
10          MENTS.—For purposes of paragraph (1), the ‘base  
11          per capita core Federal payments’ described in this  
12          paragraph, for a State, is—

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

16                 “(B) the number of AFDC recipients, SSI  
17                 recipients, and non-cash medicaid beneficiaries  
18                 (as described in section 1931(a)(2)) enrolled in  
19                 the State plan under title XIX in 1995, as de-  
20                 termined under paragraph (4).

21           “(3) DETERMINATION OF BASELINE FEDERAL  
22          MEDICAID CORE PAYMENTS.—

23                 “(A) IN GENERAL.—For purposes of para-  
24                 graph (2)(A), the ‘baseline Federal medicaid  
25                 core payments’ for a State is the amount of

1 Federal payments made under section  
2 1903(a)(1) with respect to medical assistance  
3 furnished for core benefits (as defined in sec-  
4 tion 1931(b)(1)) for AFDC recipients, SSI re-  
5 cipients, and non-cash medicaid beneficiaries  
6 for all calendar quarters in 1995.

7 “(B) DISPROPORTIONATE SHARE PAY-  
8 MENTS NOT INCLUDED.—In applying subpara-  
9 graph (A), payments attributable to section  
10 1923 shall not be counted in the amount of  
11 payments.

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

16 “(4) APPLICATION TO PARTICULAR ITEMS AND  
17 SERVICES.—For purposes of this subsection, in de-  
18 termining the per capita core benefit expenditure  
19 limit for a category of items and services (within  
20 core benefits) furnished in a State, there shall be  
21 counted only that proportion of such expenditures  
22 (determined only with respect to medical assistance  
23 furnished to AFDC recipients, SSI recipients, and  
24 non-cash medicaid beneficiaries) that were attrib-  
25 utable to items and services included in the core

1 benefits (taking into account any limitation on  
2 amount, duration, or scope of items and services in-  
3 cluded in such benefits).

4 “(5) DETERMINATION OF NUMBER OF RECIPI-  
5 ENTS AND BENEFICIARIES.—For purposes of para-  
6 graph (2)(B), the number of AFDC recipients, SSI  
7 recipients, and non-cash medicaid beneficiaries for a  
8 State for 1995 shall be determined based on actual  
9 reports submitted by the State to the Secretary. In  
10 the case of individuals who were not recipients or  
11 beneficiaries for the entire fiscal year, the number  
12 shall take into account only the portion of the year  
13 in which they were such recipients. The Secretary  
14 may audit such reports.

15 “(d) FEHBP NATIONAL AND STATE ROLLING IN-  
16 CREASE PERCENTAGES.—

17 “(1) NATIONAL INCREASE PERCENTAGE.—For  
18 purposes of this title, the term ‘FEHBP national  
19 rolling increase percentage’ means, for a year, the 5-  
20 year weighted average of the annual national per-  
21 centage increase in the premiums for health plans  
22 offered under the Federal Employees Health Bene-  
23 fits Program (under chapter 89 of title 5, United  
24 States Code) for the 5-year period ending with the  
25 previous year.

1           “(2) STATE INCREASE PERCENTAGE.—For pur-  
2           poses of this title, the term ‘FEHBP State rolling  
3           increase percentage’ means, for a year with respect  
4           to a State, the 5-year weighted average of the an-  
5           nual percentage increase in the premiums for health  
6           plans offered in the State under the Federal Em-  
7           ployees Health Benefits Program (under chapter 89  
8           of title 5, United States Code) for the 5-year period  
9           ending with the previous year.

10           “(3) DETERMINATION.—The increase percent-  
11           ages under paragraphs (1) and (2) shall be deter-  
12           mined by the Secretary, in consultation with the Di-  
13           rector of Office of Personnel Management, based on  
14           the best information available. Such increases shall  
15           be adjusted—

16                   “(A) to take into account the age distribu-  
17                   tion in the Federal workforce (not taking into  
18                   account individuals 65 years of age or older,  
19                   employees of the United States Postal Service,  
20                   retirees, and annuitants) relative to the age dis-  
21                   tribution in the population of AFDC recipients  
22                   and non-cash medicaid beneficiaries, and

23                   “(B) to disregard any changes due to  
24                   changes in the benefit package under the Fed-



1           eral Employees Health Benefits Program after  
2           1994.

3 **“SEC. 2107. FEDERAL TITLE XXI MATCHING PERCENTAGE.**

4           “(a) COMPUTATION.—

5           “(1) IN GENERAL.—In this title, except as pro-  
6           vided in subsections (c) and (e), the term ‘Federal  
7           title XXI matching percentage’ means, for each of  
8           the 50 States, 100 percent reduced by the product  
9           of the applicable percentage (as defined in para-  
10          graph (2)) and the ratio of—

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

13                   “(B) the population in poverty ratio (as  
14                   defined in paragraph (4)) of the State.

15           “(2) APPLICABLE PERCENTAGE.—For purposes  
16           of this section, the term ‘applicable percentage’  
17           means a percentage estimated by the Secretary with  
18           the advice of the General Accounting Office that, if  
19           it were substituted for the Federal medical assist-  
20           ance percentage for purposes of title XIX with re-  
21           spect to core benefits, would have resulted in an  
22           amount of aggregate payments under section  
23           1903(a) for calendar years 1994 through 1998 equal  
24           to the amount of aggregate payments that would  
25           have been made under such section for quarters in

1 such years if such percentage had not been so sub-  
2 stituted. The applicable percentage estimated by the  
3 Secretary under the previous sentence shall apply  
4 with respect to quarters beginning on or after Janu-  
5 ary 1, 1998.

6 “(3) TOTAL TABLE RESOURCES RATIO DE-  
7 FINED.—For purposes of this section, the term  
8 ‘total taxable resources ratio’ means—

9 “(A) an amount equal to the most recent  
10 3-year average of the total taxable resources of  
11 the State, as determined by the Secretary of the  
12 Treasury, divided by

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

16 “(4) POPULATION IN POVERTY RATIO DE-  
17 FINED.—For purposes of this section, the term ‘pop-  
18 ulation in poverty ratio’ means—

19 “(A) an amount equal to the 3-year-aver-  
20 age of the number of individuals in the State  
21 whose family income is below 100 percent of  
22 the income official poverty line (as defined by  
23 the Office of Management and Budget and re-  
24 vised annually in accordance with section

1           673(2) of the Omnibus Budget Reconciliation  
2           Act of 1981), divided by

3           “(B) an amount equal to the sum of the  
4           averages determined under subparagraph (A)  
5           for the 50 States.

6           “(b) RULE FOR TERRITORIES AND THE DISTRICT OF  
7 COLUMBIA.—The Federal title XXI matching percent-  
8 age—

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

12          “(2) for the District of Columbia shall be 50  
13          percent.

14          “(c) LIMITATION FOR STATES.—

15          “(1) IN GENERAL.—Except as provided in para-  
16          graph (2) and subsections (b) and (e), the Federal  
17          title XXI matching percentage shall in no case be  
18          less than 50 percent or greater than 75 percent.

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

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

4       “(d) 3 PERCENT BONUS FOR PROMOTING PURCHAS-  
5       ING MECHANISMS.—Except in the case described in sub-  
6       section (c) or in subsection (e), in the case of a State that  
7       has established and is operating a system of health plan  
8       purchasing organizations or other mechanism that—

9               “(1) promotes pooling of risk and competition  
10       among carriers offering qualified health coverage to  
11       residents of the State (including premium subsidy el-  
12       igible individuals), and

13               “(2) provides information to such consumers  
14       about their health plan options,

15       the Federal title XXI matching percentage otherwise com-  
16       puted (without regard to this subsection) shall be in-  
17       creased by 3 percentage points.

18       “PART B—STATE SUPPLEMENTAL ACUTE CARE

19                               BENEFITS PROGRAMS

20       “**SEC. 2121. ESTABLISHMENT OF STATE SUPPLEMENTAL**  
21                               **ACUTE CARE BENEFITS PROGRAMS.**

22       “(a) IN GENERAL.—Each State shall establish a  
23       State supplemental acute care benefits program (each in  
24       this part referred to as a ‘State supplemental acute care

1 benefits program’) that provides supplemental acute care  
2 benefits for supplemental benefit eligible individuals.

3 “(b) AVAILABILITY OF FUNDS.—Each State with a  
4 State supplemental acute care benefits program approved  
5 under this part is entitled, for calendar quarters beginning  
6 on or after January 1, 1998, to payment under section  
7 2124.

8 “(c) APPROVAL OF STATE PROGRAMS; PROGRAM DE-  
9 SCRIPTIONS.—The Secretary may not approve a State  
10 supplemental acute care benefits program unless the State  
11 has submitted a detailed description of the form and man-  
12 ner in which it will carry out the program (consistent with  
13 the applicable requirements of this part) and the Secretary  
14 finds that the program meets such applicable require-  
15 ments.

16 **“SEC. 2122. ELIGIBILITY.**

17 “(a) IN GENERAL.—In this part, the term ‘supple-  
18 mental benefit eligible individual’ means an individual  
19 who, as of the time of provision of supplemental acute care  
20 benefits, is a premium assistance eligible individual (as de-  
21 fined in section 2102(a)).

22 “(b) CONSTRUCTION.—Nothing in this part shall be  
23 construed to create an entitlement for any specific supple-  
24 mental benefit eligible individual.

1 **“SEC. 2123. SCOPE AND PROVISION OF BENEFITS; BENE-**  
2 **FITS ADMINISTRATION.**

3 “(a) IN GENERAL.—The supplemental acute care  
4 benefits that may be made available under a State supple-  
5 mental acute care benefits program may include supple-  
6 mental acute care benefits (as defined in section  
7 1931(a)(2)(F)).

8 “(b) COVERAGE OF BENEFITS.—Each State supple-  
9 mental acute care benefits program—

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

15 “(2) in providing benefits for supplemental ben-  
16 efit eligible individuals—

17 “(A) may vary the supplemental acute care  
18 benefits provided among reasonable classes of  
19 such individuals, and

20 “(B) may take into account the individual  
21 needs of individuals; and

22 “(3) shall coordinate the provision of such bene-  
23 fits with other health insurance coverage and health  
24 benefit programs in a manner that avoids duplica-  
25 tion of benefits.

1       “(c) PAYMENT METHODS.—Benefits under a pro-  
2 gram may be made available in the form of direct provi-  
3 sion of services, reimbursement of providers, prepayment  
4 to providers or health plans on a capitation basis, reim-  
5 bursement of supplemental benefit eligible individuals for  
6 expenses incurred for supplemental acute care benefits, or  
7 a combination of these methods.

8       “(d) ADMINISTRATION.—

9               “(1) STATE AGENCY.—Each State supplemental  
10 acute care benefits program shall designate any ap-  
11 propriate State agency to administer the program.

12               “(2) COORDINATION.—The State supplemental  
13 acute care benefits program shall specify how the  
14 program—

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

20                       “(B) will be coordinated with qualified  
21 health coverage.

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

1           “(1) such reports, and cooperate with such au-  
2           dits, as the Secretary determines are needed con-  
3           cerning the State’s administration of the program  
4           under this part, including the processing of any  
5           claims under the program, and

6           “(2) such data and information as the Sec-  
7           retary may require in order to carry out the Sec-  
8           retary’s responsibilities.

9   **“SEC. 2124. PAYMENTS TO STATES.**

10          “(a) IN GENERAL.—Subject to subsection (b), the  
11          Secretary shall provide for payment to each State operat-  
12          ing an approved State supplemental acute care benefits  
13          program for a quarter in an amount equal to the sum of—

14                 “(1) the Federal title XXI matching percentage  
15                 (specified under section 2107(a)) of the amount ex-  
16                 pended by the State under the program during the  
17                 quarter for supplemental acute care benefits for sup-  
18                 plemental benefit eligible individuals; and

19                 “(2) 50 percent of the amounts expended by  
20                 the State during the quarter as found necessary by  
21                 the Secretary for the proper and efficient adminis-  
22                 tration of such program in the State.

23          “(b) LIMITATION ON PAYMENTS FOR SUPPLE-  
24          MENTAL ACUTE CARE BENEFITS.—



1           “(1) IN GENERAL.—The total amount of pay-  
2           ments that may be made to a State under subsection  
3           (a)(1) for all quarters in a calendar year may not  
4           exceed the product of—

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

8                   “(B) the average monthly number of sup-  
9                   plemental benefit eligible individuals in the  
10                  State in the year.

11           “(2) ESTIMATIONS AND ADJUSTMENTS.—The  
12           Secretary shall—

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

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

20           “(c) PER CAPITA SUPPLEMENTAL ACUTE CARE  
21           BENEFIT FEDERAL PAYMENT LIMIT DEFINED.—

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

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

5 “(2) BASE PER CAPITA SUPPLEMENTAL ACUTE  
6 CARE FEDERAL PAYMENTS.—For purposes of para-  
7 graph (1), the ‘base per capita supplemental acute  
8 care Federal payments’ described in this paragraph,  
9 for a State, is—

10 “(A) the baseline Federal medicaid supple-  
11 mental acute care benefit expenditures (as de-  
12 fined in paragraph (3)) for the State, divided  
13 by

14 “(B) the number of AFDC recipients, SSI  
15 recipients, and non-cash medicaid beneficiaries  
16 (as described in section 1931(a)(2)) enrolled in  
17 the State plan under title XIX in 1995, as de-  
18 termined under paragraph (4).

19 “(3) DETERMINATION OF BASELINE FEDERAL  
20 MEDICAID SUPPLEMENTAL ACUTE CARE PAY-  
21 MENTS.—

22 “(A) IN GENERAL.—For purposes of para-  
23 graph (2)(A), the ‘baseline Federal medicaid  
24 supplemental acute care payments’ for a State  
25 is the amount of Federal payments made under

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

7 “(B) DISPROPORTIONATE SHARE PAY-  
8 MENTS NOT INCLUDED.—In applying subpara-  
9 graph (A), payments attributable to section  
10 1923 shall not be counted in the amount of  
11 payments.

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

16 “(4) APPLICATION TO PARTICULAR ITEMS AND  
17 SERVICES.—For purposes of this subsection, in de-  
18 termining the per capita supplemental medical bene-  
19 fit expenditure limit for a category of items and  
20 services (within the supplemental acute care bene-  
21 fits) furnished in a State, there shall be counted only  
22 that proportion of such expenditures (determined  
23 only with respect to medical assistance furnished to  
24 AFDC recipients, SSI recipients, and non-cash med-  
25 icaid beneficiaries) that were attributable to items

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

5 “(5) DETERMINATION OF NUMBER OF RECIPI-  
6 ENTS AND BENEFICIARIES.—For purposes of para-  
7 graph (2)(B), the number of AFDC recipients, SSI  
8 recipients, and non-cash medicaid beneficiaries for a  
9 State for 1995 shall be determined based on actual  
10 reports submitted by the State to the Secretary. In  
11 the case of individuals who were not recipients or  
12 beneficiaries for the entire fiscal year, the number  
13 shall take into account only the portion of the year  
14 in which they were such recipients. The Secretary  
15 may audit such reports.

16 “(d) SUPPLEMENTAL ACUTE CARE BENEFIT IN-  
17 CREASE FACTOR DESCRIBED.—For purposes of sub-  
18 section (b)(1)(C), the ‘supplemental medical benefit in-  
19 crease factor’ for a year for a State is equal to the  
20 FEHBP national rolling increase factor (as defined in sec-  
21 tion 2107(c)(1)) for the year.

22 “(e) FUNDING.—Payments to States under this sec-  
23 tion shall be made by the Secretary at such time and in  
24 such form as provided in regulations promulgated by the

1 Secretary, based on the form and manner in which pay-  
2 ments are made under section 1903.

3 “PART C—GENERAL PROVISIONS

4 “**SEC. 2141. NATURE OF PAYMENT OBLIGATION.**

5 “Sections 2106 and 2124 constitute budget authority  
6 in advance of appropriations Acts, and represent the obli-  
7 gation of the Federal Government to provide payments to  
8 States under such sections in accordance with the applica-  
9 ble provisions of this title.

10 “**SEC. 2142. AUDITS.**

11 “The Secretary shall conduct regular audits of the  
12 activities under the State programs conducted under this  
13 title.

14 “**SEC. 2143. DEMONSTRATION PROJECT AUTHORITY.**

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

22 “(b) RESTRICTION.—The Secretary may authorize a  
23 waiver under subsection (a) only if the Secretary deter-  
24 mines that under the waiver—

1           “(1) all individuals who would be premium as-  
2           sistance eligible individuals remain eligible for pre-  
3           mium assistance,

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

6           “(3) the amount of payments made by the Fed-  
7           eral Government do not exceed the amount of pay-  
8           ments otherwise provided.

9   **“SEC. 2144. DEFINITIONS AND DETERMINATIONS OF IN-**  
10                                   **COME.**

11           “For purposes of this title:

12           “(1) DETERMINATIONS OF INCOME.—

13                   “(A) FAMILY INCOME.—The term ‘family  
14                   income’ means, with respect to an individual  
15                   who—

16                           “(i) is not a dependent (as defined in  
17                           subparagraph (B)) of another individual,  
18                           the sum of the modified adjusted gross in-  
19                           comes (as defined in subparagraph (D))  
20                           for the individual, the individual’s spouse,  
21                           and dependents of the individual; or

22                           “(ii) is a dependent of another indi-  
23                           vidual, the sum of the modified adjusted  
24                           gross incomes for the other individual, the

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

3           “(B) DEPENDENT.—The term ‘dependent’  
4           shall have the meaning given such term under  
5           paragraphs (1) or (2) of section 152(a) of the  
6           Internal Revenue Code of 1986.

7           “(C) SPECIAL RULE FOR FOSTER CHIL-  
8           DREN.—For purposes of subparagraph (A), a  
9           child who is placed in foster care by a State  
10          agency shall not be considered a dependent of  
11          another individual.

12          “(D) MODIFIED ADJUSTED GROSS IN-  
13          COME.—The term ‘modified adjusted gross in-  
14          come’ means adjusted gross income (as defined  
15          in section 62(a) of the Internal Revenue Code  
16          of 1986)—

17                  “(i) determined without regard to sec-  
18                  tions 135, 162(l), 220, 911, 931, and 933  
19                  of such Code, and

20                  “(ii) increased by—

21                          “(I) the amount of interest re-  
22                          ceived or accrued by the individual  
23                          during the taxable year which is ex-  
24                          empt from tax,

1           “(II) the amount of the social se-  
2           curity benefits (as defined in section  
3           86(d) of such Code) received during  
4           the taxable year to the extent not in-  
5           cluded in gross income under section  
6           86 of such Code,

7           “(III) the amount of aid to fami-  
8           lies with dependent children received  
9           during the taxable year under part A  
10          of title IV to the extent not included  
11          in gross income under such Code, and

12          “(IV) the amount of any supple-  
13          mental security income benefits pro-  
14          vided under title XVI.

15          The determination under the preceding sen-  
16          tence shall be made without regard to any car-  
17          ryover or carryback.

18          “(E) ELECTION WITH RESPECT TO IN-  
19          COME DETERMINATION.—As elected by a family  
20          at the time of submission of an application for  
21          a premium or cost-sharing assistance under this  
22          part, family income shall be determined ei-  
23          ther—

24                  “(i) by multiplying by a factor of 4  
25                  the individual’s family income for the 3-



1 month period immediately preceding the  
2 month in which the application is made, or  
3 “(ii) based upon estimated income for  
4 the entire year in which the application is  
5 submitted.

6 “(2) APPLICABLE POVERTY LINE.—The term  
7 ‘applicable poverty line’ means the income official  
8 poverty line (as defined by the Office of Manage-  
9 ment and Budget, and revised annually in accord-  
10 ance with section 673(2) of the Omnibus Budget  
11 Reconciliation Act of 1981) that—

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

15 “(B) in the case of a family of more than  
16 four individuals, is applicable to a family of  
17 four persons.

18 “(3) PREGNANT WOMAN.—The term ‘pregnant  
19 woman’ includes a woman during the 60-day period  
20 beginning on the last day of the pregnancy.

21 “(4) PREMIUM.—Any reference to the term  
22 ‘premium’ includes a reference to premium equiva-  
23 lence for self-insured plans.”.

1 **SEC. 2102. DIVISION OF MEDICAID BENEFITS INTO CORE**  
2 **BENEFITS AND SUPPLEMENTAL BENEFITS**  
3 **FOR AFDC, SSI, AND NON-CASH BENE-**  
4 **FICIARIES; LIMITATION ON FEDERAL FINAN-**  
5 **CIAL PARTICIPATION FOR CORE AND SUP-**  
6 **PLEMENTAL BENEFITS.**

7 (a) IN GENERAL.—Title XIX of the Social Security  
8 Act is amended by redesignating section 1931 as section  
9 1932 and by inserting after section 1930 the following new  
10 section:

11 “MEDICAID REFORM RULES FOR BENEFITS FOR ACUTE  
12 MEDICAL AND SUPPLEMENTAL SERVICES FOR AFDC  
13 RECIPIENTS, SSI RECIPIENTS, AND NON-CASH MED-  
14 ICAID BENEFICIARIES

15 “SEC. 1931. (a) APPLICATION OF SECTION.—

16 “(1) IN GENERAL.—This section applies with  
17 respect to medical assistance for acute medical serv-  
18 ices (as defined in paragraph (2)) under State plans  
19 under this title for calendar quarters beginning on  
20 or after January 1, 1998, provided to AFDC recipi-  
21 ents, SSI recipients, and non-cash medicaid categor-  
22 ical beneficiaries. To the extent this section applies,  
23 it supersedes any contrary provision of this title or  
24 of other applicable law.

25 “(2) DEFINITIONS.—In this section:

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

5                   “(i) Nursing facility services (as de-  
6 fined in section 1905(f)).

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

10                   “(iii) Personal care services (as de-  
11 scribed in section 1905(a)(24)).

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

14                   “(v) Home or community-based serv-  
15 ices furnished under a waiver granted  
16 under subsection (c), (d), or (e) of section  
17 1915.

18                   “(vi) Home and community care fur-  
19 nished to functionally disabled elderly indi-  
20 viduals under section 1929.

21                   “(vii) Community supported living ar-  
22 rangements services under section 1930.

23                   “(viii) Case-management services (as  
24 described in section 1915(g)(2)).

1           “(ix) Home health care services (as  
2           referred to in section 1905(a)(7)), clinic  
3           services, and rehabilitation services that  
4           are furnished to an individual who has a  
5           condition or disability that qualifies the in-  
6           dividual to receive any of the services de-  
7           scribed in a previous clause.

8           “(x) Hospice care.

9           “(B) AFDC RECIPIENT.—The term  
10          ‘AFDC recipient’ means, for a month, an indi-  
11          vidual who is receiving aid or assistance under  
12          any plan of the State approved under title I, X,  
13          XIV, or XVI, or part A or part E of title IV  
14          for the month.

15          “(C) CORE BENEFITS.—The term ‘core  
16          benefits’ means benefits with respect to acute  
17          medical services which the Secretary identifies  
18          under subsection (b)(1) as typically included in  
19          the services covered under benchmark coverage  
20          (as defined in section 1903(1) of the Health  
21          Care Improvement Act of 1995).

22          “(D) NON-CASH MEDICAID BENE-  
23          FICIARY.—The term ‘non-cash medicaid bene-  
24          ficiary’ means an individual described in section

1 1902(a)(10)(A) who is not an AFDC recipient  
2 or a SSI recipient.

3 “(E) SSI RECIPIENT.—The term ‘SSI re-  
4 cipient’ means, for a month, an individual—

5 “(i) with respect to whom supple-  
6 mental security income benefits are being  
7 paid under title XVI for the month,

8 “(ii) who is receiving a supplementary  
9 payment under section 1616 or under sec-  
10 tion 212 of Public Law 93–66 for the  
11 month,

12 “(iii) who is receiving monthly bene-  
13 fits under section 1619(a) (whether or not  
14 pursuant to section 1616(c)(3)) for the  
15 month, or

16 “(iv) who is treated under section  
17 1619(b) as receiving supplemental security  
18 income benefits in a month for purposes of  
19 title XIX.

20 “(F) SUPPLEMENTAL ACUTE CARE BENE-  
21 FITS.—The term ‘supplemental acute care bene-  
22 fits’ means benefits for acute medical services  
23 which are not—

24 “(i) core benefits, and

1                   “(ii) benefits for items or services de-  
2                   scribed in clauses (i) through (x) of sub-  
3                   paragraph (A).

4           “(b) DIVISION OF ACUTE MEDICAL SERVICE BENE-  
5           FITS INTO CORE BENEFITS AND SUPPLEMENTAL ACUTE  
6           CARE BENEFITS.—The Secretary shall divide the class of  
7           benefits for acute medical services into the following bene-  
8           fit groups:

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

12                   “(2) SUPPLEMENTAL ACUTE CARE BENE-  
13           FITS.—A group of benefits consisting of supple-  
14           mental acute care benefits (as defined in subsection  
15           (a)(2)(F)).

16           “(c) LIMITATION ON AMOUNT OF FEDERAL FINAN-  
17           CIAL PARTICIPATION FOR BENEFITS FOR ACUTE MEDI-  
18           CAL SERVICES FOR AFDC RECIPIENTS, SSI RECIPIENTS,  
19           AND NON-CASH MEDICAID BENEFICIARIES.—With re-  
20           spect to expenditures for medical assistance for acute med-  
21           ical services benefits for AFDC recipients, SSI recipients,  
22           and non-cash medicaid beneficiaries who are not entitled  
23           to benefits under part A of title XVIII in a State for quar-  
24           ters in a calendar year after 1998—

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

3           “(2) such a recipient or beneficiary is not enti-  
4 tled to receive any medical assistance for such bene-  
5 fits under the State plan under this title.

6           “(d) ELIMINATION OF ENTITLEMENT FOR SUPPLE-  
7 MENTAL ACUTE CARE BENEFITS.—With respect to medi-  
8 cal assistance for supplemental acute care benefits for  
9 AFDC recipients and non-cash medicaid beneficiaries who  
10 are not entitled to benefits under part A of title XVIII  
11 in a State for quarters in 1998 or any succeeding year—

12           “(1) no Federal financial participation shall be  
13 payable under section 1903(a)(1),

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

17           “(3) such a recipient or beneficiary is not enti-  
18 tled to receive any medical assistance for such bene-  
19 fits under the State plan under this title.”.

20           (b) CONFORMING AMENDMENT.—Section 1903(i) of  
21 the Social Security Act (42 U.S.C. 1396b(i)) is amend-  
22 ed—

23           (1) by striking “or” at the end of paragraph  
24 (14),

1           (2) by striking the period at the end of para-  
2 graph (15) and inserting “; or”, and

3           (3) by inserting after paragraph (15) the fol-  
4 lowing:

5           “(16) in accordance with section 1931, with re-  
6 spect to amounts expended for medical assistance  
7 for core benefits for AFDC recipients, SSI recipi-  
8 ents, and non-cash medicaid beneficiaries who are  
9 not entitled to benefits under part A of title XVIII  
10 for calendar quarters beginning on or after January  
11 1, 1998.”.

12 **SEC. 2103. OPERATION OF PROGRAM AS STATE PLAN RE-**  
13 **QUIREMENT UNDER MEDICAID.**

14           (a) IN GENERAL.—Section 1902(a) of the Social Se-  
15 curity Act (42 U.S.C. 1396a(a)) is amended—

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

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

20           (3) by inserting after paragraph (62) the fol-  
21 lowing new paragraph:

22           “(63) provide for a State program furnishing  
23 premium subsidies for low-income individuals in ac-  
24 cordance with part A of title XXI.”.



1 (b) EFFECTIVE DATE.—The requirement of section  
2 1902(a)(63) of the Social Security Act (as added by sub-  
3 section (a)) shall apply to Federal financial participation  
4 for calendar quarters beginning on or after January 1,  
5 1998.

6 **SEC. 2104. APPLICATION OF MISCELLANEOUS PROVISIONS.**

7 (a) APPLICATION OF SAVE PROVISIONS.—Section  
8 1137(b) of the Social Security Act (42 U.S.C. 1320b-  
9 7(b)) is amended—

10 (1) by striking “and” at the end of paragraph  
11 (4),

12 (2) by striking the period at the end of para-  
13 graph (5) and inserting “; and”, and

14 (3) by adding at the end the following:

15 “(6) a State subsidy program under part A of  
16 title XXI.”.

17 (b) DISCLOSURE OF CERTAIN INFORMATION.

18 (1) IN GENERAL.—Subsection (l) of section  
19 6103 of the Internal Revenue Code of 1986 is  
20 amended by adding at the end the following new  
21 paragraph:

22 “(15) DISCLOSURE OF RETURN INFORMATION  
23 TO CARRY OUT HEALTH PREMIUM ASSISTANCE CER-  
24 TIFICATE PROGRAM.—The Secretary shall, upon  
25 written request from a State, disclose to officials of

1 the State return information for purposes of deter-  
2 mining or verifying whether any individual is enti-  
3 tled to a premium assistance certificate under part  
4 A of title XXI of the Social Security Act and the  
5 amount thereof. Return information disclosed under  
6 this paragraph may be used by such officers and em-  
7 ployees only for the purposes of, and to the extent  
8 necessary in, making such determination or verifica-  
9 tion.”.

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

14 (c) APPLICATION OF DEFINITION OF STATE.—Sec-  
15 tion 1001(a)(1) of the Social Security Act (42 U.S.C.  
16 1301(a)(1)) is amended by striking “title XX” and insert-  
17 ing “titles XX and XXI”.

18 (d) CONSTRUCTION.—Nothing in this title shall be  
19 construed as preventing the Secretary of Health and  
20 Human Services from continuing in effect waivers (in ef-  
21 fect as of the date of the enactment of this Act) of require-  
22 ments under title XIX of the Social Security Act.

1                   **TITLE III—ACCESS**  
2                   **IMPROVEMENTS**  
3           **Subtitle A—Improved Access in**  
4                   **Rural Areas**

5   **PART 1—GRANTS TO ENCOURAGE COMMUNITY**  
6                   **RURAL HEALTH NETWORKS**

7   **SEC. 3001. ASSISTANCE FOR DEVELOPMENT OF ACCESS**  
8                   **PLANS FOR CHRONICALLY UNDERSERVED**  
9                   **AREAS.**

10           (a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IM-  
11   PLEMENT ACTION PLANS TO INCREASE ACCESS.—

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

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

1 of a chronically underserved area to health care serv-  
2 ices that meets the requirements of subsection (c),  
3 together with such other information and assurances  
4 as the Secretary may require.

5 (3) AMOUNT OF ASSISTANCE.—

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

11 (i) for the first year of the period, an  
12 amount equal to 100 percent of the  
13 amounts expended by the State during the  
14 year to implement the plan described in  
15 paragraph (1) (as reported to the Sec-  
16 retary in accordance with such require-  
17 ments as the Secretary may impose);

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

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

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

7 (b) DESIGNATION OF AREAS.—

8 (1) DESIGNATION BY GOVERNOR.—In accord-  
9 ance with the guidelines developed under paragraph  
10 (2), the Governor of a State may designate an area  
11 in the State as a chronically underserved area for  
12 purposes of this section upon the request of a local  
13 official of the area or upon the Governor’s initiative.

14 (2) GUIDELINES FOR DESIGNATION.—

15 (A) DEVELOPMENT BY SECRETARY.—Not  
16 later than 1 year after the date of the enact-  
17 ment of this Act, the Secretary shall develop  
18 guidelines for the designation of areas as chron-  
19 ically underserved areas under this section.

20 (B) FACTORS CONSIDERED IN DEVELOP-  
21 MENT OF GUIDELINES.—In developing guide-  
22 lines under paragraph (1), the Secretary shall  
23 consider the following factors:

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

1 (I) is designated as a health pro-  
2 fessional shortage area (under section  
3 332(a) of the Public Health Service  
4 Act), or meets the criteria for des-  
5 ignation as such an area; or

6 (II) was previously designated as  
7 such an area or previously met such  
8 criteria for an extended period prior  
9 to the designation of the area under  
10 this section (in accordance with cri-  
11 teria established by the Secretary).

12 (ii) The availability and adequacy of  
13 health care providers and facilities for resi-  
14 dents of the area.

15 (iii) The extent to which the availabil-  
16 ity of assistance under other Federal and  
17 State programs has failed to alleviate the  
18 lack of access to health care services for  
19 residents of the area.

20 (iv) The percentage of residents of the  
21 area whose income is at or below the pov-  
22 erty level.

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

1                   (vi) The existence of cultural or geo-  
2                   graphic barriers to access to health care  
3                   services in the area, including weather con-  
4                   ditions.

5                   (3) REVIEW BY SECRETARY.—No designation  
6                   under paragraph (1) shall take effect under this sec-  
7                   tion unless the Secretary—

8                   (A) has been notified of the proposed des-  
9                   ignation; and

10                  (B) has not, within 60 days after the date  
11                  of receipt of the notice, disapproved the des-  
12                  ignation.

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

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

1 providers and facilities and residents of the area that is  
2 the subject of the plan, together with such other require-  
3 ments as the Secretary may impose.

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

10 **SEC. 3002. TECHNICAL ASSISTANCE GRANTS FOR NET-**  
11 **WORKS.**

12 (a) IN GENERAL.—The Secretary shall make funds  
13 available under this section to provide technical assistance  
14 (including information regarding eligibility for other Fed-  
15 eral programs) and advice for entities described in sub-  
16 section (b) seeking to establish or enhance a community  
17 rural health network in an underserved rural area.

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

21 (1) An entity receiving a grant under section  
22 3003.

23 (2) A State or unit of local government.



1           (3) An entity providing health care services (in-  
2           cluding health professional education services) in the  
3           area involved.

4           (c) USE OF FUNDS.—

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

7           (A) for planning a community health net-  
8           work and the submission of the plan for the  
9           network to the Secretary under section 3003(c)  
10          (subject to the limitation described in para-  
11          graph (2));

12          (B) to provide assistance in conducting  
13          community-based needs and prioritization, iden-  
14          tifying existing regional health resources, and  
15          developing networks, utilizing existing local pro-  
16          viders and facilities where appropriate;

17          (C) to provide advice on obtaining the  
18          proper balance of primary and secondary facili-  
19          ties for the population served by the network;

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

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

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

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

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

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

11 (2) LIMITATION ON AMOUNT AVAILABLE FOR  
12 DEVELOPMENT OF NETWORK.—The amount of fi-  
13 nancial assistance available for activities described in  
14 paragraph (1) may not exceed \$50,000 and may not  
15 be available for a period of time exceeding 1 year.

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

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

22 (2) State Offices of Rural Health, or any com-  
23 bination of such centers and Offices.

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

1 of fiscal years 1996 and 1997 and \$30,000,000 for each  
2 of fiscal years 1998 through 2000 to carry out this sec-  
3 tion. Amounts appropriated under this section shall be  
4 available until expended.

5 **SEC. 3003. DEVELOPMENT GRANTS FOR NETWORKS.**

6 (a) IN GENERAL.—The Secretary shall provide finan-  
7 cial assistance to eligible entities in order to provide for  
8 the development and implementation of community rural  
9 health networks.

10 (b) ELIGIBLE ENTITIES.—

11 (1) IN GENERAL.—An entity is eligible to re-  
12 ceive financial assistance under this section only if  
13 the entity—

14 (A) is (i) based in a rural area or (ii) is  
15 described in paragraph (2), (3), or (4) of sec-  
16 tion 3002(b),

17 (B) is undertaking to develop and imple-  
18 ment a community rural health network in an  
19 underserved rural area (or underserved rural  
20 areas) with the active participation of at least  
21 3 health care providers or facilities in the area,  
22 and

23 (C) has consulted with the local govern-  
24 ments of the area to be served by the network  
25 and with individuals who reside in the area.

1           (2) COORDINATION WITH PROVIDERS OUTSIDE  
2           OF AREA PERMITTED.—Nothing in this section shall  
3           be construed as preventing an entity that coordi-  
4           nates the delivery of services in an underserved rural  
5           area with an entity outside the area from qualifying  
6           for financial assistance under this section, or as pre-  
7           venting an entity consisting of a consortia of mem-  
8           bers located in adjoining States from qualifying for  
9           such assistance.

10           (3) PERMITTING ENTITIES NOT RECEIVING  
11           FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE  
12           FUNDING FOR IMPLEMENTATION.—An entity that is  
13           eligible to receive financial assistance under this sec-  
14           tion may receive assistance to carry out activities de-  
15           scribed in subsection (c)(1)(B) notwithstanding that  
16           the entity does not receive assistance to carry out  
17           activities described in subsection (c)(1)(A).

18           (c) USE OF FUNDS.—

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

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

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

4 (i) establishing information systems,  
5 including telecommunications,

6 (ii) recruiting health care providers,

7 (iii) providing services to enable indi-  
8 viduals to have access to health care serv-  
9 ices, including transportation and language  
10 interpretation services (including interpre-  
11 tation services for the hearing-impaired),  
12 and

13 (iv) establishing and operating a com-  
14 munity health advisor program described  
15 in paragraph (2).

16 (2) COMMUNITY HEALTH ADVISOR PROGRAM.—

17 (A) PROGRAM DESCRIBED.—In paragraph  
18 (1), a “community health advisor program” is  
19 a program under which community health advi-  
20 sors carry out the following activities:

21 (i) Collaborating efforts with health  
22 care providers and related entities to facili-  
23 tate the provision of health services and  
24 health-related social services.

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

6           (iii) Providing health-related counsel-  
7 ing.

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

11           (v) Improving the ability of individ-  
12 uals to use health services and health-relat-  
13 ed social services under Federal, State,  
14 and local programs through assisting indi-  
15 viduals in establishing eligibility under the  
16 programs.

17           (vi) Providing outreach services to in-  
18 form the community of the availability of  
19 the services provided under the program.

20           (B) COMMUNITY HEALTH ADVISOR DE-  
21 FINED.—In subparagraph (A), the term “com-  
22 munity health advisor” means, with respect to  
23 a community health advisor program, an indi-  
24 vidual—

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

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

7 (3) LIMITATIONS ON ACTIVITIES FUNDED.—Fi-  
8 nancial assistance made available under this section  
9 may not be used for any of the following:

10 (A) For a telecommunications system un-  
11 less such system is coordinated with, and does  
12 not duplicate, a system existing in the area.

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

15 (4) LIMITATION ON AMOUNT AVAILABLE FOR  
16 DEVELOPMENT OF NETWORK.—The amount of fi-  
17 nancial assistance available for activities described in  
18 paragraph (1)(A) may not exceed \$50,000 and may  
19 not be made available for a period of time exceeding  
20 1 year.

21 (d) APPLICATION.—

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

1 and manner specified by the Secretary, and had ap-  
2 proved by the Secretary an application.

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

5 (A) a description of the community rural  
6 health network, including service area and ca-  
7 pacity, and

8 (B) a description of how the proposed net-  
9 work will utilize existing health care facilities in  
10 a manner that avoids unnecessary duplication.

11 (e) AUTHORIZATION OF APPROPRIATIONS.—

12 (1) IN GENERAL.—There are authorized to be  
13 appropriated \$100,000,000 for each of fiscal years  
14 1996 and 1997, \$120,000,000 for fiscal year 1998,  
15 \$130,000,000 for fiscal year 1999, \$140,000,000 for  
16 fiscal year 2000, \$150,000,000 for fiscal year 2001,  
17 \$160,000,000 for fiscal year 2002, \$170,000,000 for  
18 fiscal year 2003, and \$180,000,000 for fiscal year  
19 2004, to carry out this section. Amounts appro-  
20 priated under this section shall be available until ex-  
21 pended.

22 (2) INTEGRATION OF OTHER AUTHORIZA-  
23 TIONS.—In order to provide for the authorization of  
24 appropriations under paragraph (1), notwithstanding  
25 any other provision of law, no funds are authorized



1 to be appropriated to carry out the following pro-  
2 grams in fiscal years after fiscal year 1996:

3 (A) The rural health transition grant pro-  
4 gram (under section 4005(e) of the Omnibus  
5 Budget Reconciliation Act of 1987).

6 (B) The rural health outreach program  
7 (for which appropriations were annually pro-  
8 vided under the Departments of Labor, Health  
9 and Human Services, and Education, and Re-  
10 lated Agencies Appropriation Acts).

11 (3) ANNUAL LIMIT ON ASSISTANCE TO GRANT-  
12 EE.—The amount of financial assistance provided to  
13 an entity under this section during a year may not  
14 exceed \$250,000.

15 **SEC. 3004. DEFINITIONS.**

16 For purposes of this part:

17 (1) COMMUNITY RURAL HEALTH NETWORK.—  
18 The term “community rural health network” means  
19 a formal cooperative arrangement between partici-  
20 pating hospitals, physicians, and other health care  
21 providers which—

22 (A) is located in an underserved rural  
23 area;

24 (B) furnishes health care services to indi-  
25 viduals residing in the area; and

1 (C) is governed by a board of directors se-  
2 lected by participating health care providers  
3 and residents of the area.

4 (2) RURAL AREA.—The term “rural area” has  
5 the meaning given such term in section  
6 1886(d)(2)(D) of the Social Security Act.

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

9 (4) STATE.—The term “State” means each of  
10 the several States, the District of Columbia, Puerto  
11 Rico, the Virgin Islands, Guam, the Northern Mari-  
12 ana Islands, and American Samoa.

13 (5) UNDERSERVED RURAL AREA.—The term  
14 “underserved rural area” means a rural area des-  
15 igned—

16 (A) as a health professional shortage area  
17 under section 332(a) of the Public Health Serv-  
18 ice Act; or

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

1 **PART 2—INCENTIVES FOR HEALTH PROFES-**  
2 **SIONALS TO PRACTICE IN RURAL AREAS**  
3 **THROUGH THE NATIONAL HEALTH SERVICE**  
4 **CORPS PROGRAM**

5 **SEC. 3011. NATIONAL HEALTH SERVICE CORPS LOAN RE-**  
6 **PAYMENTS EXCLUDED FROM GROSS INCOME.**

7 (a) IN GENERAL.—Part III of subchapter B of chap-  
8 ter 1 of the Internal Revenue Code of 1986 (relating to  
9 items specifically excluded from gross income) is amended  
10 by redesignating section 137 as section 138 and by insert-  
11 ing after section 136 the following new section:

12 **“SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN RE-**  
13 **PAYMENTS.**

14 “(a) GENERAL RULE.—Gross income shall not in-  
15 clude any qualified loan repayment.

16 “(b) QUALIFIED LOAN REPAYMENT.—For purposes  
17 of this section, the term ‘qualified loan repayment’ means  
18 any payment made on behalf of the taxpayer by the Na-  
19 tional Health Service Corps Loan Repayment Program  
20 under section 338B(g) of the Public Health Service Act.”.

21 (b) CONFORMING AMENDMENT.—Paragraph (3) of  
22 section 338B(g) of the Public Health Service Act is  
23 amended by striking “Federal, State, or local” and insert-  
24 ing “State or local”.

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

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

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

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to payments made under section  
5 338B(g) of the Public Health Service Act after the date  
6 of the enactment of this Act.

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

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

13 “(4) With respect to meeting the criteria under  
14 paragraph (1)(A) for an area to be designated as a  
15 health professional shortage area, the Secretary  
16 shall, in the case of a frontier area, make the deter-  
17 mination of whether the frontier area is a rational  
18 area for the delivery of health services without re-  
19 gard to—

20 “(A) the travel time between population  
21 centers in the frontier area; or

22 “(B) the travel time to contiguous area re-  
23 sources in the frontier area.”.

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

7 (c) AGENCY RECOMMENDATIONS FOR IMPROVE-  
8 MENTS.—Not later than July 1, 1996, the Secretary of  
9 Health and Human Services shall submit to the Congress  
10 a report specifying the recommendations of the Secretary  
11 for improving the manner of determining the extent to  
12 which a geographic area has a need for assignments of  
13 members of the National Health Service Corps, and for  
14 equitably allocating such assignments among the geo-  
15 graphic areas with a need for such assignments.

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

19 **SEC. 3013. OTHER PROVISIONS REGARDING NATIONAL**  
20 **HEALTH SERVICE CORPS.**

21 (a) SCHOLARSHIP AND LOAN REPAYMENT PRO-  
22 GRAMS.—

23 (1) AUTHORIZATION OF APPROPRIATIONS.—  
24 Section 338H(b)(1) of the Public Health Service Act  
25 (42 U.S.C. 254q(b)(1)) is amended—

1 (A) by striking “and” after “1991,”; and

2 (B) by striking “through 2000.” and in-  
3 sserting “through 2004.”.

4 (2) ALLOCATION FOR PARTICIPATION OF  
5 NURSES IN SCHOLARSHIP PROGRAM.—Section  
6 338H(b)(2) of the Public Health Service Act (42  
7 U.S.C. 254q(b)(2)) is amended by adding at the end  
8 the following subparagraph:

9 “(C) Of the amounts appropriated under  
10 paragraph (1) for fiscal year 1995 and subse-  
11 quent fiscal years, the Secretary shall reserve  
12 such amounts as may be necessary to ensure  
13 that, of the aggregate number of individuals  
14 who are participants in the Scholarship Pro-  
15 gram, the total number who are being educated  
16 as nurses or are serving as nurses, respectively,  
17 is increased to 20 percent.”.

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

20 (1) IN GENERAL.—Section 338H(b) of the Pub-  
21 lic Health Service Act (42 U.S.C. 254q(b)) is  
22 amended by adding at the end the following para-  
23 graph:

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

1 ships and loan repayments, the Secretary shall en-  
 2 sure that an appropriate number of mental health  
 3 professionals is assigned under section 333 for  
 4 health professional shortage areas.”.

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

11 **PART 3—ASSISTANCE FOR INSTITUTIONAL**  
 12 **PROVIDERS**

13 **Subpart A—Emergency Medical Systems**

14 **SEC. 3021. EMERGENCY MEDICAL SERVICES.**

15 (a) HEADINGS.—Title XII of the Public Health Serv-  
 16 ice Act (42 U.S.C. 300d et seq.) is amended—

17 (1) in the heading for the title, by striking  
 18 “**TRAUMA CARE**” and inserting “**EMER-**  
 19 **GENCY MEDICAL AND TRAUMA CARE**  
 20 **SERVICES**”; and

21 (2) in the heading for part A, by striking “Gen-  
 22 eral” and all that follows and inserting “General Au-  
 23 thorities and Duties”.

24 (b) STATE OFFICES OF EMERGENCY MEDICAL SERV-  
 25 ICES; DEMONSTRATION PROGRAM REGARDING TELE-

1 COMMUNICATIONS.—Part A of title XII of the Public  
2 Health Service Act (42 U.S.C. 300d et seq.), as amended  
3 by section 601(b) of Public Law 103-183 (107 Stat.  
4 2238), is amended—

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

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

9 **“SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL**  
10 **SERVICES.**

11 “(a) PROGRAM OF GRANTS.—The Secretary may  
12 make grants to States for the purpose of improving the  
13 availability and quality of emergency medical services  
14 through the operation of State offices of emergency medi-  
15 cal services.

16 “(b) REQUIREMENT OF MATCHING FUNDS.—

17 “(1) IN GENERAL.—The Secretary may not  
18 make a grant under subsection (a) unless the State  
19 involved agrees, with respect to the costs to be in-  
20 curred by the State in carrying out the purpose de-  
21 scribed in such subsection, to provide non-Federal  
22 contributions toward such costs in an amount that—

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



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

4           “(C) for any third fiscal year of such pay-  
5 ments, is not less than \$3 for each \$1 of Fed-  
6 eral funds provided in the grant.

7           “(2) DETERMINATION OF AMOUNT OF NON-  
8 FEDERAL CONTRIBUTION.—

9           “(A) Subject to subparagraph (B), non-  
10 Federal contributions required in paragraph (1)  
11 may be in cash or in kind, fairly evaluated, in-  
12 cluding plant, equipment, or services. Amounts  
13 provided by the Federal Government, or serv-  
14 ices assisted or subsidized to any significant ex-  
15 tent by the Federal Government, may not be in-  
16 cluded in determining the amount of such non-  
17 Federal contributions.

18           “(B) The Secretary may not make a grant  
19 under subsection (a) unless the State involved  
20 agrees that—

21           “(i) for the first fiscal year of pay-  
22 ments under the grant, 100 percent or less  
23 of the non-Federal contributions required  
24 in paragraph (1) will be provided in the  
25 form of in-kind contributions;

1           “(ii) for any second fiscal year of such  
2           payments, not more than 50 percent of  
3           such non-Federal contributions will be pro-  
4           vided in the form of in-kind contributions;  
5           and

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

9           “(c) CERTAIN REQUIRED ACTIVITIES.—The Sec-  
10          retary may not make a grant under subsection (a) unless  
11          the State involved agrees that activities carried out by an  
12          office operated pursuant to such subsection will include—

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

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

17           “(3) identifying Federal and State programs re-  
18          garding emergency medical services and providing  
19          technical assistance to public and nonprofit private  
20          entities regarding participation in such programs.

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

1 be provided with an annual budget of not less than  
2 \$50,000.

3 “(e) CERTAIN USES OF FUNDS.—

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

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

11 “(B) the grant will not be expended to pro-  
12 vide emergency medical services (including pro-  
13 viding cash payments regarding such services).

14 “(2) ESTABLISHMENT OF OFFICE.—Activities  
15 for which a State may expend a grant under sub-  
16 section (a) include paying the costs of establishing  
17 an office of emergency medical services for purposes  
18 of such subsection.

19 “(f) REPORTS.—The Secretary may not make a  
20 grant under subsection (a) unless the State involved  
21 agrees to submit to the Secretary reports containing such  
22 information as the Secretary may require regarding activi-  
23 ties carried out under this section by the State.

24 “(g) REQUIREMENT OF APPLICATION.—The Sec-  
25 retary may not make a grant under subsection (a) unless

1 an application for the grant is submitted to the Secretary  
2 and the application is in such form, is made in such man-  
3 ner, and contains such agreements, assurances, and infor-  
4 mation as the Secretary determines to be necessary to  
5 carry out this section.”; and

6 (3) in section 1204 (as redesignated by para-  
7 graph (1) of this subsection)—

8 (A) by redesignating subsection (c) as sub-  
9 section (d); and

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

12 “(c) DEMONSTRATION PROGRAM REGARDING TELE-  
13 COMMUNICATIONS.—

14 “(1) LINKAGES FOR RURAL FACILITIES.—  
15 Projects under subsection (a)(1) shall include dem-  
16 onstration projects to establish telecommunications  
17 between rural medical facilities and medical facilities  
18 that have expertise or equipment that can be utilized  
19 by the rural facilities through the telecommuni-  
20 cations.

21 “(2) MODES OF COMMUNICATION.—The Sec-  
22 retary shall ensure that the telecommunications  
23 technologies demonstrated under paragraph (1) in-  
24 clude interactive video telecommunications, static  
25 video imaging transmitted through the telephone

1 system, and facsimiles transmitted through such sys-  
2 tem.”.

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

6 “(a) EMERGENCY MEDICAL SERVICES GEN-  
7 ERALLY.—For the purpose of carrying out section 1201  
8 other than with respect to trauma care, and for the pur-  
9 pose of carrying out section 1204(c), there are authorized  
10 to be appropriated \$2,000,000 for each of the fiscal years  
11 1997, 1998, and 1999.

12 “(b) STATE OFFICES.—For the purpose of carrying  
13 out section 1202, there are authorized to be appropriated  
14 \$3,000,000 for each of the fiscal years 1997, 1998, and  
15 1999.”.

16 **SEC. 3022. GRANTS TO STATES REGARDING AIRCRAFT FOR**  
17 **TRANSPORTING RURAL VICTIMS OF MEDICAL**  
18 **EMERGENCIES.**

19 Part E of title XII of the Public Health Service Act  
20 (42 U.S.C. 300d–51 et seq.) is amended by adding at the  
21 end the following new section:

22 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**  
23 **VICTIMS OF MEDICAL EMERGENCIES.**

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

1 ment of air medical transport systems that provide victims  
2 of medical emergencies in rural areas with access to treat-  
3 ments for the injuries or other conditions resulting from  
4 such emergencies.

5 “(b) APPLICATION AND PLAN.—

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

14 “(2) STATE PLAN.—An application submitted  
15 under paragraph (1) shall contain a State plan that  
16 shall—

17 “(A) describe the intended uses of the  
18 grant proceeds and the geographic areas to be  
19 served;

20 “(B) demonstrate that the geographic  
21 areas to be served, as described under subpara-  
22 graph (A), are rural in nature;

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

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

3 “(D) demonstrate that in utilizing the  
4 grant proceeds for the establishment or en-  
5 hancement of air medical services the State  
6 would be making a cost-effective improvement  
7 to existing ground-based or air emergency medi-  
8 cal service systems;

9 “(E) demonstrate that the State will not  
10 utilize the grant proceeds to duplicate the capa-  
11 bilities of existing air medical systems that are  
12 effectively meeting the emergency medical needs  
13 of the populations they serve;

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

19 “(G) demonstrate that the State, in utiliz-  
20 ing the grant proceeds, will—

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

1 the fiscal year for which the grant is re-  
2 ceived; and

3 “(ii) ensure that recipients of direct  
4 financial assistance from the State under  
5 such grant will maintain expenditures of  
6 such recipients for such systems at a level  
7 at least equal to the level of such expendi-  
8 tures maintained by such recipients for the  
9 fiscal year preceding the fiscal year for  
10 which the financial assistance is received;

11 “(H) demonstrate that persons experienced  
12 in the field of air medical service delivery were  
13 consulted in the preparation of the State plan;  
14 and

15 “(I) contain such other information as the  
16 Secretary may determine appropriate.

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

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

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



1 posed air medical transport systems into a com-  
2 prehensive network or plan for regional or statewide  
3 emergency medical service delivery.

4 “(d) STATE ADMINISTRATION AND USE OF  
5 GRANT.—

6 “(1) IN GENERAL.—The Secretary may not  
7 make a grant to a State under subsection (a) unless  
8 the State agrees that such grant will be adminis-  
9 tered by the State agency with principal responsibil-  
10 ity for carrying out programs regarding the provi-  
11 sion of medical services to victims of medical emer-  
12 gencies or trauma.

13 “(2) PERMITTED USES.—A State may use  
14 amounts received under a grant awarded under this  
15 section to award subgrants to public and private en-  
16 tities operating within the State.

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

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

3       “(f) REPORTS.—

4           “(1) REQUIREMENT.—A State that receives a  
5 grant under this section shall annually (during each  
6 year in which the grant proceeds are used) prepare  
7 and submit to the Secretary a report that shall con-  
8 tain—

9           “(A) a description of the manner in which  
10 the grant proceeds were utilized;

11           “(B) a description of the effectiveness of  
12 the air medical transport programs assisted  
13 with grant proceeds; and

14           “(C) such other information as the Sec-  
15 retary may require.

16       “(2) TERMINATION OF FUNDING.—In reviewing  
17 reports submitted under paragraph (1), if the Sec-  
18 retary determines that a State is not using amounts  
19 provided under a grant awarded under this section  
20 in accordance with the State plan submitted by the  
21 State under subsection (b), the Secretary may termi-  
22 nate the payment of amounts under such grant to  
23 the State until such time as the Secretary deter-  
24 mines that the State comes into compliance with  
25 such plan.

1       “(g) DEFINITION.—As used in this section, the term  
2 ‘rural areas’ means geographic areas that are located out-  
3 side of standard metropolitan statistical areas, as identi-  
4 fied by the Secretary.

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

9       **Subpart B—Demonstration Projects to En-**  
10       **courage Primary Care and Rural-Based**  
11       **Graduate Medical Education**

12       **SEC. 3031. STATE AND CONSORTIUM DEMONSTRATION**  
13       **PROJECTS.**

14       (a) IN GENERAL.—

15               (1) PARTICIPATION OF STATES AND CONSOR-  
16       TIA.—The Secretary shall establish and conduct a  
17       demonstration project to increase the number and  
18       percentage of medical students entering primary  
19       care practice relative to those entering nonprimary  
20       care practice under which the Secretary shall make  
21       payments in accordance with subsection (d)—

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

1 (B) to not more than 10 health care train-  
2 ing consortia for the purpose of testing and  
3 evaluating mechanisms to meet such goals.

4 (2) EXCLUSION OF CONSORTIA IN PARTICIPAT-  
5 ING STATES.—A consortia may not receive payments  
6 under the demonstration project under paragraph  
7 (1)(B) if any of its members is located in a State  
8 receiving payments under the project under para-  
9 graph (1)(A).

10 (b) APPLICATIONS.—

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

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

1           (B) an assurance that no hospital conduct-  
2           ing an approved medical residency training pro-  
3           gram in the State will lose more than 10 per-  
4           cent of such hospital's approved medical resi-  
5           dency positions in any year as a result of the  
6           project; and

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

9           (2) APPROVAL OF APPLICATIONS.—A State or  
10          consortium that submits an application under para-  
11          graph (1) may begin a demonstration project under  
12          this subsection—

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

15               (B) at the end of the 60-day period begin-  
16               ning on the date such application is submitted,  
17               unless the Secretary denies the application dur-  
18               ing such period.

19          (3) NOTICE AND COMMENT.—A State or con-  
20          sortium shall issue a public notice on the date it  
21          submits an application under paragraph (1) which  
22          contains a general description of the proposed dem-  
23          onstration project. Any interested party may com-  
24          ment on the proposed demonstration project to the  
25          State or consortium or the Secretary during the 30-

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

3 (c) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

4 (1) REQUIREMENTS FOR STATES.—Each State  
5 participating in the demonstration project under this  
6 subtitle shall use the payments provided under sub-  
7 section (d) to test and evaluate either of the follow-  
8 ing mechanisms to increase the number and percent-  
9 age of medical students entering primary care prac-  
10 tice relative to those entering nonprimary care prac-  
11 tice:

12 (A) USE OF ALTERNATIVE WEIGHTING  
13 FACTORS.—

14 (i) IN GENERAL.—The State may  
15 make payments to hospitals in the State  
16 for direct graduate medical education costs  
17 in amounts determined under the meth-  
18 odology provided under section 1886(h) of  
19 the Social Security Act, except that the  
20 State shall apply weighting factors that are  
21 different than the weighting factors other-  
22 wise set forth in section 1886(h)(4)(C) of  
23 the Social Security Act.

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

1           weighting factors under clause (i), the  
2           State shall ensure that the amount of pay-  
3           ment made to hospitals for costs attrib-  
4           utable to primary care residents shall be  
5           greater than the amount that would have  
6           been paid to hospitals for costs attributable  
7           to such residents if the State had applied  
8           the weighting factors otherwise set forth in  
9           section 1886(h)(4)(C) of the Social Secu-  
10          rity Act.

11           (B) PAYMENTS FOR MEDICAL EDUCATION  
12          THROUGH CONSORTIUM.—The State may make  
13          payments for graduate medical education costs  
14          through payments to a health care training con-  
15          sortium (or through any entity identified by  
16          such a consortium as appropriate for receiving  
17          payments on behalf of the consortium) that is  
18          established in the State but that is not other-  
19          wise participating in the demonstration project.

20          (2) REQUIREMENTS FOR CONSORTIUM.—

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

1 whose members provide medical residency train-  
2 ing (or through any entity identified by such a  
3 consortium as appropriate for receiving pay-  
4 ments on behalf of the consortium).

5 (B) USE OF PAYMENTS.—

6 (i) IN GENERAL.—Each consortium  
7 receiving payments under subparagraph  
8 (A) shall use such funds to conduct activi-  
9 ties which test and evaluate mechanisms to  
10 increase the number and percentage of  
11 medical students entering primary care  
12 practice relative to those entering  
13 nonprimary care practice, and may use  
14 such funds for the operation of the consor-  
15 tium.

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



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

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

13               (1) In the case of a State—

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

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

1 (2) In the case of a consortium—

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

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

15 (e) ADDITIONAL GRANT FOR PLANNING AND EVAL-  
16 UATION.—

17 (1) IN GENERAL.—The Secretary may award  
18 grants to States and consortia participating in the  
19 demonstration project under this section for the pur-  
20 pose of developing and evaluating such projects. A  
21 State or consortia may conduct such an evaluation  
22 or contract with a private entity to conduct the eval-  
23 uation. Each State and consortia desiring to receive  
24 a grant under this paragraph shall prepare and sub-  
25 mit to the Secretary an application, at such time, in

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

3 (2) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated such sums  
5 as may be necessary for grants under this paragraph  
6 for fiscal years 1997 through 2001.

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

13 (g) EVALUATIONS AND REPORTS.—

14 (1) EVALUATIONS.—Each State or consortium  
15 participating in the demonstration project shall sub-  
16 mit to the Secretary a final evaluation within 360  
17 days of the termination of the State or consortium's  
18 participation and such interim evaluations as the  
19 Secretary may require.

20 (2) REPORTS TO CONGRESS.—Not later than  
21 360 days after the first demonstration project under  
22 this subtitle begins, and annually thereafter for each  
23 year in which such a project is conducted, the Sec-  
24 retary shall submit a report to Congress which eval-  
25 uates the effectiveness of the State and consortium

1 activities conducted under such projects and includes  
2 any legislative recommendations determined appro-  
3 priate by the Secretary.

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

9 **SEC. 3032. GOALS FOR PROJECTS.**

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

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

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

18 (3) The allocation of not less than 50 percent  
19 of the training spent in a graduate medical residency  
20 training program at sites at which acute care inpa-  
21 tient hospital services are not furnished.

22 (4) The rotation of residents in approved medi-  
23 cal residency training programs among practices  
24 that serve residents of rural areas.

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

6 **SEC. 3033. DEFINITIONS.**

7           In this subpart:

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

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

16                   (A) A hospital operating an approved med-  
17                   ical residency training program at which resi-  
18                   dents receive training at ambulatory training  
19                   sites located in rural areas.

20                   (B) A school of medicine or osteopathic  
21                   medicine.

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

1 (D) A school of nursing (as defined in sec-  
2 tion 853 of the Public Health Service Act).

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

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

9 (5) RURAL AREA.—The term “rural area” has  
10 the meaning given such term in section  
11 1886(d)(2)(D) of the Social Security Act.

## 12 **Subpart C—Medicare Demonstration**

### 13 **Regarding Consortia of Hospitals**

#### 14 **SEC. 3041. MEDICARE DEMONSTRATION REGARDING CON-** 15 **SORTIA OF HOSPITALS.**

16 (a) IN GENERAL.—The Secretary shall establish and  
17 conduct not more than 10 demonstration projects to in-  
18 crease the number and percentage of medical students en-  
19 tering primary care practice relative to those entering  
20 nonprimary care practice under which the Secretary shall  
21 make payments in accordance with subsection (c) to par-  
22 ticipating health care training consortia.

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

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

3 (1) an explanation of a plan with the goal of  
4 training at least 50 percent of all residents partici-  
5 pating in approved residency training programs con-  
6 ducted by members of the consortium as primary  
7 care residents (as defined in subsection (f)(4)); and

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

10 (c) PAYMENTS TO PARTICIPANTS.—

11 (1) IN GENERAL.—Notwithstanding any provi-  
12 sion of title XVIII of the Social Security Act—

13 (A) in the case of a consortium participat-  
14 ing in a demonstration project under this sub-  
15 title, the Secretary shall make payments under  
16 such title for the direct and indirect costs of  
17 graduate medical education of members of the  
18 consortium to the consortium (or through any  
19 entity identified by such a consortium as appro-  
20 priate for receiving payments on behalf of the  
21 consortium), except that the amount paid to the  
22 consortium shall be based on the designations  
23 described in paragraph (2); and

24 (B) the Secretary may not make any pay-  
25 ment under such title to a member of a consor-

1           tium for the direct and indirect costs of grad-  
2           uate medical education during the period of the  
3           consortium's participation in the demonstration  
4           project.

5           (2) DESIGNATION OF RESIDENTS BY CONSOR-  
6           TIUM.—Each consortium participating in a dem-  
7           onstration project shall designate for each resident  
8           assigned to the consortium a hospital operating an  
9           approved medical residency training program for  
10          purposes of enabling the Secretary to calculate the  
11          amount paid to the consortium under paragraph  
12          (1)(A). Such hospital shall be the hospital where the  
13          resident receives the majority of the resident's hos-  
14          pital-based, nonambulatory training experience.

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

22                  (A) the number of full-time-equivalent resi-  
23                  dents in approved medical residency training  
24                  programs of the member calculated under sec-  
25                  tion 1886(h)(4) of the Social Security Act dur-



1           ing the academic year beginning July 1, 1994;  
2           and

3                   (B) the ratio of the member's full-time  
4           equivalent interns and residents to beds applica-  
5           ble under section 1886(d)(5)(B)(ii) of such Act  
6           for discharges occurring during the 12-month  
7           cost reporting period beginning or after July 1,  
8           1994.

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

15          (e) EVALUATIONS AND REPORTS.—

16                   (1) EVALUATIONS.—Each consortium partici-  
17          pating in a demonstration project shall submit to the  
18          Secretary a final evaluation within 360 days of the  
19          termination of the consortium's participation and  
20          such interim evaluations as the Secretary may re-  
21          quire.

22                   (2) REPORTS TO CONGRESS.—Not later than  
23          360 days after the first demonstration project under  
24          this section begins, and annually thereafter for each  
25          year in which such a project is conducted, the Sec-

1       retary shall submit a report to Congress which eval-  
2       uates the effectiveness of the consortium activities  
3       conducted under such projects and includes any leg-  
4       islative recommendations determined appropriate by  
5       the Secretary.

6       (f) DEFINITIONS.—In this section:

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

11          (2) HEALTH CARE TRAINING CONSORTIUM.—  
12      The term “health care training consortium” means  
13      a State, regional, or local entity consisting of at  
14      least 2 hospitals operating approved medical resi-  
15      dency training programs.

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

19          (4) PRIMARY CARE RESIDENT.—The term “pri-  
20      mary care resident” means a resident enrolled in an  
21      approved medical residency training program in fam-  
22      ily medicine, general internal medicine, general pedi-  
23      atrics, preventive medicine, geriatric medicine, osteo-  
24      pathic general practice, or obstetrics and gynecology.

1     **Subtitle B—Public Health Grants**

2     **SEC. 3101. GRANTS TO STATES FOR PUBLIC HEALTH PRO-**  
3                     **GRAMS.**

4             Part B of title III of the Public Health Service Act  
5 (42 U.S.C. 243 et seq.), as amended by section 703 of  
6 Public Law 103–183 (107 Stat. 2240), is amended by in-  
7 serting after section 317F the following section:

8             “GRANTS TO STATES FOR PUBLIC HEALTH PROGRAMS

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

11                 “(1) Education and training of public health  
12 professionals.

13                 “(2) Prevention and control of poisoning.

14                 “(3) Prevention and control of infectious dis-  
15 eases.

16                 “(4) Laboratory services regarding public  
17 health.

18                 “(5) Community and school-based health edu-  
19 cation.

20                 “(6) Prevention programs regarding public  
21 health.

22                 “(7) Community and school-based public-health  
23 services.

24                 “(8) Collection and reporting of data regarding  
25 public health.

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

5 **SEC. 3102. SCHOLARSHIP AND LOAN REPAYMENT PRO-**  
6 **GRAMS REGARDING SERVICE IN PUBLIC**  
7 **HEALTH POSITIONS.**

8 Part D of title VII of the Public Health Service Act  
9 (42 U.S.C. 294 et seq.) is amended—

10 (1) by redesignating subparts II and III as sub-  
11 parts III and IV, respectively; and

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

14 **“Subpart II—Scholarship and Loan Repayment Pro-**  
15 **grams Regarding Service in Public Health Posi-**  
16 **tions**

17 **“SEC. 765A. SCHOLARSHIP AND LOAN REPAYMENT PRO-**  
18 **GRAMS.**

19 “(a) SCHOLARSHIP PROGRAM.

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

1 uals described in paragraph (2) for the purpose of  
2 assisting the individuals with the costs of attending  
3 public and nonprofit private schools of public health  
4 (or other public or nonprofit private institutions pro-  
5 viding graduate or specialized training in public  
6 health).

7 “(2) ELIGIBLE INDIVIDUALS.—An individual  
8 referred to in paragraph (1) is any individual meet-  
9 ing the following conditions:

10 “(A) The individual is enrolled (or accept-  
11 ed for enrollment) at a school or other institu-  
12 tion referred to in paragraph (1) as a full-time  
13 or part-time student in a program providing  
14 training in a health profession in a field of pub-  
15 lic health (including the fields of epidemiology,  
16 biostatistics, environmental health, health ad-  
17 ministration and planning, behavioral sciences,  
18 maternal and child health, occupational safety,  
19 public health nursing, nutrition, and toxi-  
20 cology).

21 “(B) The individual enters into the con-  
22 tract required pursuant to subsection (c) as a  
23 condition of receiving the scholarship (relating  
24 to an agreement to provide services in approved

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

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

7 “(A) the school or other institution with  
8 respect to which the award is to be provided  
9 has coordinated the activities of the school or  
10 institution with relevant activities of the Health  
11 Resources and Services Administration and the  
12 Centers for Disease Control and Prevention;  
13 and

14 “(B) not fewer than 60 percent of the  
15 graduates of the school or institution are in  
16 public health positions determined by the Sec-  
17 retary to be consistent with the needs of the  
18 United States regarding such professionals.

19 “(4) APPLICABILITY OF CERTAIN PROVI-  
20 SIONS.—Except as inconsistent with this subsection  
21 or subsection (c), the provisions of subpart III of  
22 part D of title III (relating to the Scholarship and  
23 Loan Repayment Programs of the National Health  
24 Service Corps) apply to an award of a scholarship  
25 under paragraph (1) to the same extent and in the

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

3 “(b) LOAN REPAYMENT PROGRAM.—

4 “(1) IN GENERAL.—The Secretary, acting  
5 through the Administrator of the Health Resources  
6 and Services Administration and in consultation  
7 with the Director of the Centers for Disease Control  
8 and Prevention, shall carry out a program under  
9 which the Federal Government enters into agree-  
10 ments to repay all or part of the educational loans  
11 of individuals meeting the following conditions:

12 “(A) The individual involved is a graduate  
13 of a school or other institution described in sub-  
14 section (a)(1).

15 “(B) The individual meets the applicable  
16 legal requirements to provide services as a pub-  
17 lic health professional (including a professional  
18 in any of the fields specified in subsection  
19 (a)(2)(A)).

20 “(C) The individual enters into the con-  
21 tract required pursuant to subsection (c) as a  
22 condition of the Federal Government repaying  
23 such loans (relating to an agreement to provide  
24 services in approved public health positions, as  
25 defined in subsection (c)).

1           “(2) APPLICABILITY OF CERTAIN PROVI-  
2           SIONS.—Except as inconsistent with this subsection  
3           or subsection (c), the provisions of subpart III of  
4           part D of title III (relating to the Scholarship and  
5           Loan Repayment Programs of the National Health  
6           Service Corps) apply to an agreement regarding re-  
7           payment under paragraph (1) to the same extent  
8           and in the same manner as such provisions apply to  
9           an agreement regarding repayment under section  
10          338B.

11          “(3) AMOUNT OF REPAYMENTS.—For each year  
12          for which an individual contracts to serve in an ap-  
13          proved public health position pursuant to paragraph  
14          (2), the Secretary may repay not more than \$20,000  
15          of the principal and interest of the educational loans  
16          of the individual.

17          “(c) APPROVED PUBLIC HEALTH POSITIONS.—

18                 “(1) POSITION REGARDING POPULATIONS WITH  
19                 SIGNIFICANT NEED FOR SERVICES.—

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



1           ices as a public health professional to a popu-  
2           lation determined by the Secretary to have a  
3           significant unmet need for the services of such  
4           a professional.

5           “(B) For purposes of subsection (a)(4) and  
6           (b)(2), the period of obligated service is the fol-  
7           lowing, as applicable to the program participant  
8           involved:

9                   “(i) In the case of scholarships under  
10                  subsection (a) for full-time students, the  
11                  greater of—

12                           “(I) 1 year for each year for  
13                           which such a scholarship is provided;  
14                           or

15                           “(II) 2 years.

16                   “(ii) In the case of scholarships under  
17                  subsection (a) for part-time students, a pe-  
18                  riod determined by the Secretary on the  
19                  basis of the number of hours of education  
20                  or training received under the scholarship,  
21                  considering the percentage constituted by  
22                  the ratio of such number to the number of  
23                  hours for a full-time student in the pro-  
24                  gram involved.

1           “(iii) In the case of the loan repay-  
2           ments under subsection (b), such period as  
3           the Secretary and the participant may  
4           agree, except that the period may not be  
5           less than 2 years.

6           “(2) APPROVAL OF ENTITIES FOR ASSIGNMENT  
7           OF PROGRAM PARTICIPANTS.—The entities referred  
8           to in paragraph (1)(A) are public and nonprofit pri-  
9           vate entities approved by the Secretary as meeting  
10          such requirements for the assignment of a program  
11          participant as the Secretary may establish. The enti-  
12          ties that the Secretary may so approve include State  
13          and local departments of health, public hospitals,  
14          community and neighborhood health clinics, migrant  
15          health clinics, community-based health-related orga-  
16          nizations, certified regional poison control centers,  
17          purchasing cooperatives regarding health insurance,  
18          and any other public or nonprofit private entity.

19          “(3) DEFINITIONS.—For purposes of this sec-  
20          tion:

21                 “(1) The term ‘approved public health position’,  
22                 with respect to a program participant, means a posi-  
23                 tion to which the participant is assigned pursuant to  
24                 paragraph (1).

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

5           “(d) CERTAIN CONSIDERATIONS.—

6           “(1) SPECIAL CONSIDERATION FOR CERTAIN  
7           INDIVIDUALS.—In making awards of scholarships  
8           under subsection (a) and making repayments under  
9           subsection (b), the Secretary shall give special con-  
10          sideration to individuals who are in the armed forces  
11          of the United States or who are veterans of the  
12          armed forces.

13          “(2) SCHOOL HEALTH EDUCATION PRO-  
14          GRAMS.—The Secretary shall ensure that the ap-  
15          proved public health positions to which the Secretary  
16          assigns program participants under this part include  
17          positions in programs that provide education on the  
18          promotion of health and the prevention of diseases  
19          and that are carried out on the premises of public  
20          or nonprofit private elementary and secondary  
21          schools.

22          “(e) FUNDING.—

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

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

3 “(2) ALLOCATIONS.—Of the amounts appro-  
4 priated under subsection (a) for a fiscal year, the  
5 Secretary shall obligate not less than 30 percent for  
6 the purpose of providing awards for scholarships  
7 under subsection (a) to individuals who have not  
8 previously received such scholarships.”.

9 **Subtitle C—Academic Health**  
10 **Centers**

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

13 (a) STUDY.—The Secretary of Health and Human  
14 Services shall conduct a study of the feasibility and desir-  
15 ability of making payments to facilities that are not hos-  
16 pitals for the direct and indirect costs of graduate medical  
17 education attributable to residents trained at such facili-  
18 ties. In conducting the study, the Secretary shall evaluate  
19 new payment methodologies—

20 (1) under which each entity which incurs costs  
21 of graduate medical education shall receive reim-  
22 bursement for such costs; and

23 (2) which would encourage the training of pri-  
24 mary care physicians.

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

6 **SEC. 3202. STUDY OF FUNDING NEEDS OF HEALTH PROFES-**  
7 **SIONS SCHOOLS.**

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

13 (b) CONSIDERATION OF CERTAIN COSTS.—In con-  
14 ducting the study under subsection (a), the Secretary shall  
15 also consider the following costs regarding the funding  
16 needs of health professions schools:

17 (1) Uncompensated costs incurred in providing  
18 health care.

19 (2) Costs resulting from reduced productivity  
20 due to teaching responsibilities.

21 (3) Increased costs of caring for the health  
22 needs of patients with severe medical complications.

23 (4) Uncompensated costs incurred by faculty,  
24 residents, and students in providing consultations  
25 for hospitalized patients.

1           (5) Uncompensated costs incurred in conduct-  
2           ing clinical research.

3           (c) CONSIDERATIONS REGARDING ADDITIONAL  
4 FUNDING.—In conducting the study under subsection (a),  
5 the Secretary shall determine the following:

6           (1) Whether the health professions schools in-  
7           volved have a significant need for an increase in the  
8           amount of funds available to the schools.

9           (2) If there is such a need—

10           (A) recommendations regarding the  
11           sources of funds to provide the increase; and

12           (B) recommendations for a methodology  
13           for determining the amount that should be pro-  
14           vided to the schools involved.

15           (d) REPORT TO CONGRESS.—Not later than 18  
16 months after the date of the enactment of this Act, the  
17 Secretary shall submit to the Congress a report describing  
18 the findings and recommendations made in the study.

19           **TITLE IV—MALPRACTICE**  
20           **REFORM**  
21           **Subtitle A—Findings; Purpose;**  
22           **Definitions**

23           **SEC. 4001. FINDINGS; PURPOSE.**

24           (a) FINDINGS.—Congress finds that—

1           (1) the health care and insurance industries are  
2 industries affecting interstate commerce and the  
3 medical malpractice litigation systems existing  
4 throughout the United States affect interstate com-  
5 merce by contributing to the high cost of health care  
6 and premiums for malpractice insurance purchased  
7 by health care providers; and

8           (2) the Federal Government has a major inter-  
9 est in health care as a direct provider of health care  
10 and as a source of payment for health care, and has  
11 a demonstrated interest in assessing the quality of  
12 care, access to care, and the costs of care through  
13 the evaluative activities of several Federal agencies.

14 (b) PURPOSE.—It is the purpose of this title to—

15           (1) provide grants to States to develop alter-  
16 native dispute resolution procedures to attain a more  
17 efficient, expeditious, and equitable resolution of  
18 health care malpractice disputes;

19           (2) enhance general knowledge concerning the  
20 benefits of different forms of alternative dispute res-  
21 olution mechanisms; and

22           (3) establish uniformity and curb excesses in  
23 the State-based medical liability systems through  
24 Federally-mandated reforms.

1 **SEC. 4002. DEFINITIONS.**

2 As used in this title:

3 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
4 TEM.—The term “alternative dispute resolution sys-  
5 tem” means a system that is enacted or adopted by  
6 a State to resolve medical malpractice claims other  
7 than through a medical malpractice liability action.

8 (2) CLAIMANT.—The term “claimant” means  
9 any person who brings a health care liability action  
10 and, in the case of an individual who is deceased, in-  
11 competent, or a minor, the person on whose behalf  
12 such an action is brought.

13 (3) CLEAR AND CONVINCING EVIDENCE.—The  
14 term “clear and convincing evidence” is that meas-  
15 ure or degree of proof that will produce in the mind  
16 of the trier of fact a firm belief or conviction as to  
17 the truth of the allegations sought to be established,  
18 except that such measure or degree of proof is more  
19 than that required under a preponderance of the evi-  
20 dence, but less than that required for proof beyond  
21 a reasonable doubt.

22 (4) ECONOMIC DAMAGES.—The term “economic  
23 damages” means damages paid to compensate an in-  
24 dividual for losses for hospital and other medical ex-  
25 penses, lost wages, lost employment, and other pecu-  
26 niary losses.



1           (5) HEALTH CARE PROFESSIONAL.—The term  
2           “health care professional” means any individual who  
3           provides health care services in a State and who is  
4           required by State law or regulation to be licensed or  
5           certified by the State to provide such services in the  
6           State.

7           (6) HEALTH CARE PROVIDER.—The term  
8           “health care provider” means any organization or  
9           institution that is engaged in the delivery of health  
10          care services in a State that is required by State law  
11          or regulation to be licensed or certified by the State  
12          to engage in the delivery of such services in the  
13          State.

14          (7) INJURY.—The term “injury” means any ill-  
15          ness, disease, or other harm that is the subject of  
16          a medical malpractice claim.

17          (8) MEDICAL MALPRACTICE LIABILITY AC-  
18          TION.—The term “medical malpractice liability ac-  
19          tion” means any civil action brought pursuant to  
20          State law in which a plaintiff alleges a medical mal-  
21          practice claim against a health care provider or  
22          health care professional, but does not include any  
23          action in which the plaintiff’s sole allegation is an al-  
24          legation of an intentional tort.

1           (9) MEDICAL MALPRACTICE CLAIM.—The term  
2           “medical malpractice claim” means any claim relat-  
3           ing to the provision of (or the failure to provide)  
4           health care services or the use of a medical product,  
5           without regard to the theory of liability asserted,  
6           and includes any third-party claim, cross-claim,  
7           counterclaim, or contribution claim in a medical  
8           malpractice liability action.

9           (10) MEDICAL PRODUCT.—

10           (A) IN GENERAL.—The term “medical  
11           product” means, with respect to the allegation  
12           of a claimant, a drug (as defined in section  
13           201(g)(1) of the Federal Food, Drug, and Cos-  
14           metic Act (21 U.S.C. 321(g)(1)) or a medical  
15           device (as defined in section 201(h) of the Fed-  
16           eral Food, Drug, and Cosmetic Act (21 U.S.C.  
17           321(h)) if—

18                   (i) such drug or device was subject to  
19                   premarket approval under section 505,  
20                   507, or 515 of the Federal Food, Drug,  
21                   and Cosmetic Act (21 U.S.C. 355, 357, or  
22                   360e) or section 351 of the Public Health  
23                   Service Act (42 U.S.C. 262) with respect  
24                   to the safety of the formulation or per-  
25                   formance of the aspect of such drug or de-

1 vice which is the subject of the claimant's  
2 allegation or the adequacy of the packag-  
3 ing or labeling of such drug or device, and  
4 such drug or device is approved by the  
5 Food and Drug Administration; or

6 (ii) the drug or device is generally rec-  
7 ognized as safe and effective under regula-  
8 tions issued by the Secretary of Health  
9 and Human Services under section 201(p)  
10 of the Federal Food, Drug, and Cosmetic  
11 Act (21 U.S.C. 321(p)).

12 (B) EXCEPTION IN CASE OF MISREPRE-  
13 SENTATION OR FRAUD.—Notwithstanding sub-  
14 paragraph (A), the term “medical product”  
15 shall not include any product described in such  
16 subparagraph if the claimant shows that the  
17 product is approved by the Food and Drug Ad-  
18 ministration for marketing as a result of with-  
19 held information, misrepresentation, or an ille-  
20 gal payment by manufacturer of the product.

21 (11) NONECONOMIC DAMAGES.—The term  
22 “noneconomic damages” means damages paid to  
23 compensate an individual for losses for physical and  
24 emotional pain, suffering, inconvenience, physical  
25 impairment, mental anguish, disfigurement, loss of

1 enjoyment of life, loss of consortium, and other  
2 nonpecuniary losses, but does not include punitive  
3 damages.

4 (12) PUNITIVE DAMAGES.—The term “punitive  
5 damages” means compensation, in addition to com-  
6 pensation for actual harm suffered, that is awarded  
7 for the purpose of punishing a person for conduct  
8 deemed to be malicious, wanton, willful, or exces-  
9 sively reckless.

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

12 (14) STATE.—The term “State” means each of  
13 the several States, the District of Columbia, the  
14 Commonwealth of Puerto Rico, the Virgin Islands,  
15 and Guam.

16 **Subtitle B—Uniform Standards for**  
17 **Malpractice Claims**

18 **SEC. 4101. APPLICABILITY.**

19 Except as provided in section 4110, this subtitle shall  
20 apply to any medical malpractice liability action brought  
21 in a Federal or State court, and to any medical mal-  
22 practice claim subject to an alternative dispute resolution  
23 system, that is initiated on or after January 1, 1996.

1 **SEC. 4102. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**  
2 **TION THROUGH ALTERNATIVE DISPUTE RES-**  
3 **OLUTION.**

4 (a) IN GENERAL.—

5 (1) STATE CASES.—A medical malpractice li-  
6 ability action may not be brought in any State court  
7 during a calendar year unless the medical mal-  
8 practice liability claim that is the subject of the ac-  
9 tion has been initially resolved under an alternative  
10 dispute resolution system certified for the year by  
11 the Secretary under section 4202(a), or, in the case  
12 of a State in which such a system is not in effect  
13 for the year, under the alternative Federal system  
14 established under section 4202(b).

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

24 (3) CLAIMS AGAINST UNITED STATES.—

25 (A) ESTABLISHMENT OF PROCESS FOR  
26 CLAIMS.—The Attorney General shall establish

1 an alternative dispute resolution process for the  
2 resolution of tort claims consisting of medical  
3 malpractice liability claims brought against the  
4 United States under chapter 171 of title 28,  
5 United States Code. Under such process, the  
6 resolution of a claim shall occur after the com-  
7 pletion of the administrative claim process ap-  
8 plicable to the claim under section 2675 of such  
9 title.

10 (B) REQUIREMENT FOR INITIAL RESOLU-  
11 TION UNDER PROCESS.—A medical malpractice  
12 liability action based on a medical malpractice  
13 liability claim described in subparagraph (A)  
14 may not be brought in any Federal court unless  
15 the claim has been initially resolved under the  
16 alternative dispute resolution process estab-  
17 lished by the Attorney General under such sub-  
18 paragraph.

19 (b) INITIAL RESOLUTION OF CLAIMS UNDER  
20 ADR.—For purposes of subsection (a), an action is “ini-  
21 tially resolved” under an alternative dispute resolution  
22 system if—

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

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

4           (c) PROCEDURES FOR FILING ACTIONS.—

5           (1) NOTICE OF INTENT TO CONTEST DECI-  
6 SION.—Not later than 60 days after a decision is is-  
7 sued with respect to a medical malpractice liability  
8 claim under an alternative dispute resolution system,  
9 each party affected by the decision shall submit a  
10 sealed statement to a court of competent jurisdiction  
11 indicating whether or not the party intends to con-  
12 test the decision.

13           (2) DEADLINE FOR FILING ACTION.—A medical  
14 malpractice liability action may not be brought by a  
15 party unless—

16                   (A) the party has filed the notice of intent  
17 required by paragraph (1); and

18                   (B) the party files the action in a court of  
19 competent jurisdiction not later than 90 days  
20 after the decision resolving the medical mal-  
21 practice liability claim that is the subject of the  
22 action is issued under the applicable alternative  
23 dispute resolution system.

1           (3) COURT OF COMPETENT JURISDICTION.—  
2       For purposes of this subsection, the term “court of  
3       competent jurisdiction” means—

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

6           (B) with respect to actions filed in a Fed-  
7       eral court, the appropriate United States dis-  
8       trict court.

9       (d) LEGAL EFFECT OF UNCONTESTED ADR DECI-  
10      SION.—The decision reached under an alternative dispute  
11     resolution system shall, for purposes of enforcement by a  
12     court of competent jurisdiction, have the same status in  
13     the court as the verdict of a medical malpractice liability  
14     action adjudicated in a State or Federal trial court. The  
15     previous sentence shall not apply to a decision that is con-  
16     tested by a party affected by the decision pursuant to sub-  
17     section (c)(1).

18     **SEC. 4103. PROCEDURAL REQUIREMENTS FOR FILING OF**  
19                 **ACTIONS.**

20       (a) CERTIFICATE OF MERIT.—

21           (1) IN GENERAL.—Each individual who files a  
22     medical malpractice liability action shall, not later  
23     than 90 days after filing the action—

24           (A) submit a certificate of merit described  
25     in subsection (b); or



1 (B) post a surety (or equivalent security)  
2 bond of \$4,000 (or, during the 45-day period  
3 that begins on the date the action is filed, a  
4 cost bond of \$2,000) with the court.

5 (2) EXTENSION OF DEADLINE.—On the motion  
6 of any party to the action or upon a written agree-  
7 ment of the parties filed with the court, the court  
8 may extend the deadline specified in paragraph (1)  
9 for a period not to exceed 30 days.

10 (3) DISMISSAL FOR FAILURE TO MEET RE-  
11 QUIREMENT.—If an individual filing a medical mal-  
12 practice liability action fails to meet the require-  
13 ments of paragraph (1)—

14 (A) the court shall dismiss the action with-  
15 out prejudice to the refiling of the action by the  
16 individual; and

17 (B) require the individual to pay any court  
18 costs incurred by the defendants as a result of  
19 the filing of the action.

20 (4) WAIVER FOR GOOD CAUSE.—The court may  
21 waive the application of paragraph (1) to a plaintiff  
22 if the plaintiff shows good cause that such para-  
23 graph should not apply.

24 (5) CERTIFICATE OF MERIT DESCRIBED.—In  
25 paragraph (1), a “certificate of merit” is, with re-

1 spect to an individual filing a medical malpractice li-  
2 ability action, an affidavit declaring that the individ-  
3 ual (or the individual's attorney) has obtained a  
4 written opinion from a medical expert who is knowl-  
5 edgeable of the relevant medical issues involved in  
6 the action that the defendant was negligent and the  
7 defendant's conduct was a proximate cause of the al-  
8 leged injury that is the subject of the action.

9 (b) RESPONSE TO STANDARD INTERROGATORIES  
10 AND REQUESTS FOR DOCUMENTS.—

11 (1) DEADLINE.—Each party to a medical mal-  
12 practice liability action shall respond to the standard  
13 set of interrogatories and requests for production of  
14 documents developed pursuant to paragraph (4) as  
15 follows:

16 (A) In the case of a plaintiff, the party  
17 shall provide the defendant (or the defendant's  
18 attorney) with full and complete responses not  
19 later than 45 days after filing the action.

20 (B) In the case of a defendant, the party  
21 shall provide the plaintiff (or the plaintiff's at-  
22 torney) with full and complete responses not  
23 later than 45 days after receiving the plaintiff's  
24 responses under subparagraph (A).

1           (C) In the case of a party who is added to  
2           the action after the action is filed, the party  
3           shall provide all other parties (or such parties'  
4           attorneys) with full and complete responses not  
5           later than 45 days after the date of the filing  
6           of the pleading by which the party is added to  
7           the action.

8           (2) EXTENSION OF DEADLINE.—On the motion  
9           of any party to the action that is supported by good  
10          cause, or upon a written agreement of the parties  
11          filed with the court, the court shall extend the dead-  
12          line specified in paragraph (1) for a period not to  
13          exceed 30 days.

14          (3) IMPOSITION OF SANCTIONS FOR FAILURE  
15          TO RESPOND.—If a party to a medical malpractice  
16          liability action fails to respond to the standard set  
17          of interrogatories and requests for production of  
18          documents as required under paragraph (1), the  
19          party shall be subject to sanctions by the court  
20          under any applicable laws, rules, and regulations  
21          governing the imposition of sanctions by the court.

22          (4) DEVELOPMENT OF STANDARD INTERROG-  
23          ATORIES AND REQUESTS.—

24                  (A) APPOINTMENT OF EXPERT PANELS.—

25                  The Governor of each State shall appoint a

1 panel to develop the standard set of interrog-  
2 atories and requests for production of docu-  
3 ments that will be used for purposes of this  
4 subsection in the courts of the State. The set  
5 shall be comprehensive and designed to expedite  
6 the discovery process in the courts. The Attor-  
7 ney General shall appoint a panel to develop  
8 such set that will be used for purposes of this  
9 subsection in the Federal courts.

10 (B) COMPOSITION.—Each panel appointed  
11 pursuant to subparagraph (A) shall consist of  
12 not less than 6 and not more than 12 members,  
13 of whom an equal number shall be attorneys  
14 who customarily represent plaintiffs in medical  
15 malpractice liability actions and attorneys who  
16 customarily represent defendants in such ac-  
17 tions.

18 (C) DEADLINES.—Not later than October  
19 1, 1996, each panel appointed pursuant to sub-  
20 paragraph (A) shall complete and publish the  
21 standard set of interrogatories and requests for  
22 production of documents.

1 **SEC. 4104. TREATMENT OF NONECONOMIC AND PUNITIVE**  
2 **DAMAGES.**

3 (a) **LIMITATION ON NONECONOMIC DAMAGES.**—The  
4 total amount of noneconomic damages that may be award-  
5 ed to a claimant and the members of the claimant’s family  
6 for losses resulting from the injury which is the subject  
7 of a medical malpractice liability action may not exceed  
8 \$250,000, regardless of the number of parties against  
9 whom the action is brought or the number of actions  
10 brought with respect to the injury.

11 (b) **NO AWARD OF PUNITIVE DAMAGES AGAINST**  
12 **MANUFACTURER OF MEDICAL PRODUCT.**—In the case of  
13 a medical malpractice liability action in which the plaintiff  
14 alleges a claim against the manufacturer of a medical  
15 product, no punitive or exemplary damages may be award-  
16 ed against such manufacturer.

17 (c) **SEVERAL LIABILITY FOR NONECONOMIC DAM-**  
18 **AGES.**—The liability of each defendant for noneconomic  
19 damages shall be several only and shall not be joint, and  
20 each defendant shall be liable only for the amount of non-  
21 economic damages allocated to the defendant in direct pro-  
22 portion to the defendant’s percentage of responsibility (as  
23 determined by the trier of fact). The previous sentence  
24 shall not apply if the defendant has been found to be liable  
25 as a result of gross negligence or fraud.

1 (d) ALLOCATION OF PUNITIVE DAMAGE AWARDS  
2 FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVI-  
3 TIES.—

4 (1) IN GENERAL.—The total amount of any pu-  
5 nitive damages awarded in a medical malpractice li-  
6 ability action shall be paid to the State in which the  
7 action is brought (or, in a case brought in Federal  
8 court, in the State in which the health care services  
9 that caused the injury that is the subject of the ac-  
10 tion were provided) for the purposes of carrying out  
11 the activities described in paragraph (2).

12 (2) ACTIVITIES DESCRIBED.—A State shall use  
13 amounts paid pursuant to paragraph (1) to carry  
14 out activities to assure the safety and quality of  
15 health care services provided in the State, including  
16 (but not limited to)—

17 (A) licensing or certifying health care pro-  
18 fessionals and health care providers in the  
19 State;

20 (B) implementing health care quality as-  
21 surance programs;

22 (C) carrying out public education programs  
23 to increase awareness of the availability of com-  
24 parative quality information on accountable  
25 health plans;

1 (D) carrying out programs to reduce mal-  
2 practice-related costs for providers volunteering  
3 to provide services in medically underserved  
4 areas; and

5 (E) implementing and operating a State  
6 alternative dispute resolution system certified  
7 by the Secretary under section 4202.

8 (3) MAINTENANCE OF EFFORT.—A State shall  
9 use any amounts paid pursuant to paragraph (1) to  
10 supplement and not to replace amounts spent by the  
11 State for the activities described in paragraph (2).

12 (e) DEVELOPMENT OF ALTERNATIVE LIMITS ON  
13 NONECONOMIC DAMAGES.—

14 (1) IN GENERAL.—Not later than 1 year after  
15 the date of the enactment of this Act, the Secretary  
16 in consultation with the Attorney General shall de-  
17 velop and transmit to Congress alternative limits on  
18 the amount of noneconomic damages that may be  
19 awarded with respect to medical malpractice liability  
20 claims, together with legislative specifications nec-  
21 essary to replace the limit imposed under subsection  
22 (a) on the amount of such damages with such alter-  
23 native limits. The purpose of the development of the  
24 limits is to provide certainty and fairness in mal-  
25 practice awards and to avoid unwarranted disparities

1 among health care providers and health care profes-  
2 sionals who have engaged in similar conduct.

3 (2) ESTABLISHMENT OF SEPARATE LIMITS FOR  
4 CATEGORIES OF INJURIES.—In developing limits  
5 under paragraph (1), the Secretary shall establish  
6 separate limits for noneconomic damages resulting  
7 from each of the following categories of injuries:

8 (A) Non-physical injuries.

9 (B) Insignificant physical injuries.

10 (C) Temporary minor physical injuries.

11 (D) Temporary major physical injuries.

12 (E) Permanent minor physical injuries.

13 (F) Permanent substantial physical inju-  
14 ries.

15 (G) Permanent major physical injuries.

16 (H) Permanent grave physical injuries.

17 (I) Death.

18 (3) FACTORS CONSIDERED.—In developing lim-  
19 its under paragraph (1) for each of the categories  
20 described in paragraph (2), the Secretary shall—

21 (A) examine the most recent available data  
22 on the amount of damages awarded with re-  
23 spect to such claims; and

24 (B) set specific limits that reasonably com-  
25 pensate most injured parties at the level of



1 compensation currently provided, excluding  
2 those levels of compensation that the Secretary  
3 finds unreasonably large.

4 (4) CONSULTATION.—In developing limits  
5 under this subsection, the Secretary shall consult  
6 with representatives of each of the following:

7 (A) Attorneys who represent plaintiffs in  
8 medical malpractice liability actions.

9 (B) Attorneys who represent health care  
10 professionals and health care providers in medi-  
11 cal malpractice liability actions.

12 (C) Physicians and other health care pro-  
13 fessionals and providers.

14 (D) Individuals who have suffered injury  
15 as a result of medical malpractice.

16 (E) Judges who preside over medical mal-  
17 practice liability actions.

18 (F) Medical ethicists.

19 (G) Health care economists.

20 (H) Liability insurers.

21 (5) GUIDANCE TO ENTITIES RESOLVING  
22 CLAIMS.—If Congress enacts legislation that imposes  
23 the limits developed by the Secretary under this sub-  
24 section on the amount of noneconomic damages that  
25 may be awarded with respect to medical malpractice

1 liability claims, the Secretary shall prepare and dis-  
2 seminate guidelines to assist courts and other enti-  
3 ties resolving such claims in the determination of the  
4 particular category of injury specified in paragraph  
5 (2) to which a claimant's injury shall be assigned for  
6 purposes of applying the appropriate limit on such  
7 damages.

8 **SEC. 4105. PERIODIC PAYMENTS FOR FUTURE LOSSES.**

9 (a) **IN GENERAL.**—In any medical malpractice liabil-  
10 ity action in which the damages awarded for future eco-  
11 nomic loss exceeds \$100,000, a defendant may not be re-  
12 quired to pay such damages in a single, lump-sum pay-  
13 ment, but may be permitted to make such payments on  
14 a periodic basis. The periods for such payments shall be  
15 determined by the court, based upon projections of when  
16 such expenses are likely to be incurred.

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

21 **SEC. 4106. UNIFORM STATUTE OF LIMITATIONS.**

22 (a) **IN GENERAL.**—No medical malpractice claim  
23 may be initiated after the expiration of the 2-year period  
24 that begins on the date on which the alleged injury that  
25 is the subject of such claim was discovered or the date

1 on which the alleged injury that is the subject of such  
2 claim was discovered or the date on which such injury  
3 should reasonably have been discovered, whichever is ear-  
4 lier.

5 (b) EXCEPTION FOR MINORS.—In the case of an al-  
6 leged injury suffered by a minor who has not attained 6  
7 years of age, a medical malpractice claim may be initiated  
8 after the expiration of the period described in subsection  
9 (a) if the claim is initiated before the minor attains 8  
10 years of age.

11 **SEC. 4107. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
12 **SERVICES.**

13 (a) IN GENERAL.—In the case of a medical mal-  
14 practice claim relating to services provided during labor  
15 or the delivery of a baby, if the health care professional  
16 or health care provider against whom the claim is brought  
17 did not previously treat the claimant for the pregnancy,  
18 the trier of fact may not find that such professional or  
19 provider committed malpractice and may not assess dam-  
20 ages against such professional or provider unless the mal-  
21 practice is proven by clear and convincing evidence.

22 (b) APPLICABILITY TO GROUP PRACTICES OR  
23 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-  
24 section (a), a health care professional shall be considered  
25 to have previously treated an individual for a pregnancy

1 if the professional is a member of a group practice whose  
2 members previously treated the individual for the preg-  
3 nancy or is providing services to the individual during  
4 labor or the delivery of a baby pursuant to an agreement  
5 with another professional.

6 **SEC. 4108. UNIFORM STANDARD FOR DETERMINING LIABIL-**  
7 **ITY IN ACTIONS BASED ON NEGLIGENCE.**

8 (a) STANDARD OF REASONABLENESS.—Except as  
9 provided in subsection (b), a defendant in a medical mal-  
10 practice liability action may not be found to have commit-  
11 ted malpractice unless the defendant's conduct at the time  
12 of providing the health care services that are the subject  
13 of the action was not reasonable.

14 (b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—  
15 Subsection (a) shall not apply with respect to a medical  
16 malpractice action if (in accordance with applicable State  
17 law) the theory of liability upon which the action is based  
18 is a theory of strict liability.

19 **SEC. 4109. JURISDICTION OF FEDERAL COURTS.**

20 Nothing in this subtitle shall be construed to estab-  
21 lish jurisdiction over any medical malpractice liability ac-  
22 tion in the district courts of the United States on the basis  
23 of sections 1331 or 1337 of title 28, United States Code.

1 **SEC. 4110. PREEMPTION.**

2 (a) IN GENERAL.—This subtitle supersedes any State  
3 law only to the extent that the State law permits the recov-  
4 ery by a claimant or the assessment against a defendant  
5 of a greater amount of damages or establishes a less strict  
6 standard of proof for determining whether a defendant has  
7 committed malpractice, than the provisions of this sub-  
8 title.

9 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
10 OF LAW OR VENUE.—Nothing in this subtitle shall be con-  
11 strued to—

12 (1) waive or affect any defense of sovereign im-  
13 munity asserted by any State under any provision of  
14 law;

15 (2) waive or affect any defense of sovereign im-  
16 munity asserted by the United States;

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

19 (4) preempt State choice-of-law rules with re-  
20 spect to claims brought by a foreign nation or a citi-  
21 zen of a foreign nation; or

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

1 **Subtitle C—Requirements for State**  
2 **Alternative Dispute Resolution**  
3 **Systems (ADR)**

4 **SEC. 4201. BASIC REQUIREMENTS.**

5 (a) IN GENERAL.—A State’s alternative dispute reso-  
6 lution system meets the requirements of this section if the  
7 system—

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

11 (2) requires that a written opinion resolving the  
12 dispute be issued not later than 6 months after the  
13 date by which each party against whom the claim is  
14 filed has received notice of the claim (other than in  
15 exceptional cases for which a longer period is re-  
16 quired for the issuance of such an opinion), and that  
17 the opinion contain—

18 (A) findings of fact relating to the dispute,  
19 and

20 (B) a description of the costs incurred in  
21 resolving the dispute under the system (includ-  
22 ing any fees paid to the individuals hearing and  
23 resolving the claim), together with an appro-  
24 priate assessment of the costs against any of  
25 the parties;

1           (3) requires individuals who hear and resolve  
2 claims under the system to meet such qualifications  
3 as the State may require (in accordance with regula-  
4 tions of the Secretary);

5           (4) is approved by the State or by local govern-  
6 ments in the State;

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

9                 (A) permits the parties to a dispute to se-  
10 lect the procedure to be used for the resolution  
11 of the dispute under the system, and

12                 (B) if the parties do not agree on the pro-  
13 cedure to be used for the resolution of the dis-  
14 pute, assigns a particular procedure to the par-  
15 ties;

16           (6) provides for the transmittal to the State  
17 agency responsible for monitoring or disciplining  
18 health care professionals and health care providers  
19 of any findings made under the system that such a  
20 professional or provider committed malpractice, un-  
21 less, during the 90-day period beginning on the date  
22 the system resolves the claim against the profes-  
23 sional or provider, the professional or provider  
24 brings an action contesting the decision made under  
25 the system; and

1           (7) provides for the regular transmittal to the  
2 Administrator for Health Care Policy and Research  
3 of information on disputes resolved under the sys-  
4 tem, in a manner that assures that the identity of  
5 the parties to a dispute shall not be revealed.

6           (b) APPLICATION OF MALPRACTICE LIABILITY  
7 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—  
8 The provisions of subtitle B (other than sections 4102 and  
9 4103) shall apply with respect to claims brought under  
10 a State alternative dispute resolution system or the alter-  
11 native Federal system in the same manner as such provi-  
12 sions apply with respect to medical malpractice liability  
13 actions brought in the State.

14 **SEC. 4202. CERTIFICATION OF STATE SYSTEMS; APPLICA-**  
15 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

16           (a) CERTIFICATION.—

17           (1) IN GENERAL.—Not later than October 1 of  
18 each year (beginning with 1996), the Secretary, in  
19 consultation with the Attorney General, shall deter-  
20 mine whether a State's alternative dispute resolution  
21 system meets the requirements of this part for the  
22 following calendar year.

23           (2) BASIS FOR CERTIFICATION.—The Secretary  
24 shall certify a State's alternative dispute resolution  
25 system under this subsection for a calendar year if



1 the Secretary determines under paragraph (1) that  
2 the system meets the requirements of section 4201.

3 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-  
4 TEM.—

5 (1) ESTABLISHMENT AND APPLICABILITY.—

6 Not later than October 1, 1996, the Secretary, in  
7 consultation with the Attorney General, shall estab-  
8 lish by rule an alternative Federal ADR system for  
9 the resolution of medical malpractice liability claims  
10 during a calendar year in States that do not have  
11 in effect an alternative dispute resolution system  
12 certified under subsection (a) for the year.

13 (2) REQUIREMENTS FOR SYSTEM.—Under the  
14 alternative Federal ADR system established under  
15 paragraph (1)—

16 (A) paragraphs (1), (2), (6), and (7) of  
17 section 4201(a) shall apply to claims brought  
18 under the system;

19 (B) if the system provides for the resolu-  
20 tion of claims through arbitration, the claims  
21 brought under the system shall be heard and  
22 resolved by arbitrators appointed by the Sec-  
23 retary in consultation with the Attorney Gen-  
24 eral; and

1 (C) with respect to a State in which the  
2 system is in effect, the Secretary may (at the  
3 State's request) modify the system to take into  
4 account the existence of dispute resolution pro-  
5 cedures in the State that affect the resolution  
6 of medical malpractice liability claims.

7 (3) TREATMENT OF STATES WITH ALTER-  
8 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-  
9 eral ADR system established under this subsection is  
10 applied with respect to a State for a calendar year,  
11 the State shall make a payment to the United States  
12 (at such time and in such manner as the Secretary  
13 may require) in an amount equal to 110 percent of  
14 the costs incurred by the United States during the  
15 year as a result of the application of the system with  
16 respect to the State.

17 **SEC. 4203. GRANTS TO STATES.**

18 (a) IN GENERAL.—The Secretary shall make grants  
19 to States for a 2-year period to assist States in implement-  
20 ing and operating alternative dispute resolution systems  
21 that meet the requirements of section 4201.

22 (b) ELIGIBILITY.—A State is eligible to receive a  
23 grant under this section if the Secretary has certified the  
24 State's alternative dispute resolution system under section  
25 4202(b).

1 (c) LIMITATION ON AMOUNT OF GRANT.—The  
2 amount of funds provided to a State under a grant under  
3 this section may not exceed \$5,000,000 during the 2-year  
4 period of the grant.

5 **SEC. 4204. REPORTS ON IMPLEMENTATION AND EFFEC-**  
6 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**  
7 **LUTION SYSTEMS.**

8 (a) IN GENERAL.—Not later than 5 years after the  
9 date of the enactment of this Act, the Secretary shall pre-  
10 pare and submit to the Congress a report describing and  
11 evaluating State alternative dispute resolution systems op-  
12 erated pursuant to this subtitle and the alternative Fed-  
13 eral system established under section 4202(b).

14 (b) CONTENTS OF REPORT.—The Secretary shall in-  
15 clude in the report prepared and submitted under sub-  
16 section (a)—

17 (1) information on—

18 (A) the effect of the alternative dispute  
19 resolution systems on the cost of health care  
20 within each State,

21 (B) the impact of such systems on the ac-  
22 cess of individuals to health care within the  
23 State, and

24 (C) the effect of such systems on the qual-  
25 ity of health care provided within the State; and

1           (2) to the extent that such report does not pro-  
2           vide information on no-fault systems operated by  
3           States as alternative dispute resolution systems pur-  
4           suant to this part, an analysis of the feasibility and  
5           desirability of establishing a system under which  
6           medical malpractice liability claims shall be resolved  
7           on a no-fault basis.

8           **Subtitle D—Grants to States for**  
9           **Development of Practice Guide-**  
10          **lines**

11          **SEC. 4301. GRANTS TO STATES.**

12           (a) **IN GENERAL.**—The Secretary shall make grants  
13           to States for a 2-year period for the development of medi-  
14           cal practice guidelines for health care professionals (in-  
15           cluding mid-level practitioners) that may be applied to re-  
16           solve medical malpractice liability claims and actions in  
17           the State.

18           (b) **ELIGIBILITY.**—A State is eligible to receive a  
19           grant under this section if the State submits to the Sec-  
20           retary an application at such time, in such form, and con-  
21           taining such information and assurances as the Secretary  
22           may require, including assurances that the State will sub-  
23           mit such periodic reports on the development and applica-  
24           tion of the State’s medical practice guidelines as the Sec-  
25           retary may require.

1 (c) NUMBER OF GRANTS.—

2 (1) IN GENERAL.—Except as provided in para-  
3 graph (2), the Secretary shall award not less than  
4 10 grants under this section.

5 (2) EXCEPTION.—Notwithstanding paragraph  
6 (1), the Secretary may award less than 10 grants  
7 under this section if the Secretary determines that  
8 there are an inadequate number of applications sub-  
9 mitted that meet the eligibility and approval require-  
10 ments of this section.

11 (d) LIMITATION ON AMOUNT OF GRANT.—The  
12 amount of funds provided to a State under a grant under  
13 this section may not exceed \$5,000,000 during the 2-year  
14 period of the grant.

15 **TITLE V—MARKET INCENTIVES**  
16 **TO CONTAINING COSTS**  
17 **Subtitle A—Administrative**  
18 **Simplification**

19 **SEC. 5000. PURPOSE.**

20 It is the purpose of this subtitle to improve the effi-  
21 ciency and effectiveness of the health care system, includ-  
22 ing the medicare program under title XVIII of the Social  
23 Security Act and the medicaid program under title XIX  
24 of such Act, by encouraging the development of a health  
25 information network through the adoption of standards

1 and the establishment of requirements for the electronic  
2 transmission of certain health information.

3 **SEC. 5001. DEFINITIONS.**

4 For purposes of this subtitle:

5 (1) **CODE SET.**—The term “code set” means  
6 any set of codes used for encoding data elements,  
7 such as tables of terms, medical concepts, medical  
8 diagnostic codes, or medical procedure codes.

9 (2) **COORDINATION OF BENEFITS.**—The term  
10 “coordination of benefits” means determining and  
11 coordinating the financial obligations of plan spon-  
12 sors when health care benefits are payable by more  
13 than one such sponsor.

14 (3) **HEALTH INFORMATION.**—The term “health  
15 information” means any information that relates to  
16 the past, present, or future physical or mental health  
17 or condition or functional status of an individual,  
18 the provision of health care to an individual, or pay-  
19 ment for the provision of health care to an individ-  
20 ual.

21 (4) **HEALTH INFORMATION NETWORK.**—The  
22 term “health information network” means the health  
23 information system that is formed through the appli-  
24 cation of the requirements and standards established  
25 under this subtitle.

1           (5) HEALTH INFORMATION NETWORK SERV-  
2           ICE.—The term “health information network serv-  
3           ice”—

4                   (A) means a private entity or an entity op-  
5                   erated by a State that enters into contracts—

6                           (i) to process or facilitate the process-  
7                           ing of nonstandard data elements of health  
8                           information into standard data elements;

9                           (ii) to provide the means by which  
10                           persons are connected to the health infor-  
11                           mation network for purposes of meeting  
12                           the requirements of this subtitle, including  
13                           the holding of standard data elements of  
14                           health information;

15                           (iii) to provide authorized access to  
16                           health information through the health in-  
17                           formation network; or

18                           (iv) to provide specific information  
19                           processing services, such as automated co-  
20                           ordination of benefits and claims trans-  
21                           action routing; and

22                   (B) includes a health information security  
23                   organization.

24           (6) HEALTH INFORMATION SECURITY ORGANI-  
25           ZATION.—The term “health information security or-

1       ganization” means a private entity or an entity oper-  
2       ated by a State that accesses standard data elements  
3       of health information through the health information  
4       network, processes such information into non-identi-  
5       fiable health information, and may store such infor-  
6       mation.

7               (7) HEALTH PROVIDER.—The term “health  
8       provider” includes a provider of services (as defined  
9       in section 1861(u) of the Social Security Act), a pro-  
10      vider of medical or other health services (as defined  
11      in section 1861(s) of such Act), and any other per-  
12      son (other than a plan sponsor) furnishing health  
13      care items or services.

14              (8) INDIVIDUALLY IDENTIFIABLE HEALTH IN-  
15      FORMATION.—The term “individually identifiable  
16      health information” means health information in the  
17      health information network—

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

20                      (B) with respect to which there is a rea-  
21                      sonable basis to believe that the information  
22                      can be used to identify such an individual.

23              (9) NON-IDENTIFIABLE HEALTH INFORMA-  
24      TION.—The term “non-identifiable health informa-



1       tion” means health information that is not individ-  
2       ually identifiable health information.

3           (10) PLAN SPONSOR.—The term “plan spon-  
4       sor” means—

5           (A) a carrier (as defined in section  
6       1903(2)) providing health insurance coverage  
7       (as defined in section 1903(7));

8           (B) a group health plan;

9           (C) an association or other entity which es-  
10       tablishes or maintains a multiple employer wel-  
11       fare arrangement (as defined in section  
12       1903(12)) providing benefits consisting of medi-  
13       cal care described in section 607(1) of the Em-  
14       ployee Retirement Income Security Act of 1974;  
15       and

16          (D) a State, or the Federal Government,  
17       acting in a capacity as a provider of health ben-  
18       efits to eligible individuals that is equivalent to  
19       that of a carrier.

20          (11) STANDARD.—The term “standard”, when  
21       used with reference to a transaction or to data ele-  
22       ments of health information, means that the trans-  
23       action or data elements meet any standard adopted  
24       by the Secretary under part 1 that applies to the  
25       transaction or data elements.

1 **PART 1—STANDARDS FOR DATA ELEMENTS AND**  
2 **TRANSACTIONS**

3 **SEC. 5011. GENERAL REQUIREMENTS ON SECRETARY.**

4 (a) IN GENERAL.—The Secretary shall adopt stand-  
5 ards and modifications to standards under this part that  
6 are—

7 (1) consistent with the objective of reducing the  
8 costs of providing and paying for health care; and

9 (2) in use and generally accepted, developed, or  
10 modified by the standard-setting organizations ac-  
11 credited by the American National Standard Insti-  
12 tute.

13 (b) INITIAL STANDARDS.—The Secretary may de-  
14 velop an expedited process for the adoption of initial  
15 standards under this part.

16 (c) PROTECTION OF COMMERCIAL INFORMATION.—  
17 In adopting standards under this part, the Secretary may  
18 not require disclosure of trade secrets or confidential com-  
19 mercial information by any person.

20 **SEC. 5012. STANDARDS FOR DATA ELEMENTS OF HEALTH**  
21 **INFORMATION.**

22 (a) IN GENERAL.—The Secretary shall adopt stand-  
23 ards necessary to make uniform and compatible for elec-  
24 tronic transmission through the health information net-  
25 work the data elements of any health information that the

1 Secretary determines is appropriate for transmission in  
2 connection with a transaction described in section 5021.

3 (b) ADDITIONS.—The Secretary may make additions  
4 to any set of data elements adopted under subsection (a)  
5 as the Secretary determines appropriate in a manner that  
6 minimizes the disruption and cost of compliance with such  
7 additions.

8 (c) CERTAIN DATA ELEMENTS.—

9 (1) UNIQUE HEALTH IDENTIFIERS.—The Sec-  
10 retary shall establish a system to provide for a  
11 standard unique health identifier for each individual,  
12 employer, plan sponsor, and health provider for use  
13 in the health care system.

14 (2) CODE SETS.—

15 (A) IN GENERAL.—The Secretary, in con-  
16 sultation with experts from the private sector  
17 and Federal agencies, shall—

18 (i) select code sets for appropriate  
19 data elements from among the code sets  
20 that have been developed by private and  
21 public entities; or

22 (ii) establish code sets for such data  
23 elements if no code sets for the data ele-  
24 ments have been developed.

1           (B) DISTRIBUTION.—The Secretary shall  
2           establish efficient and low-cost procedures for  
3           distribution of code sets and modifications to  
4           code sets.

5 **SEC. 5013. INFORMATION TRANSACTION STANDARDS.**

6           (a) IN GENERAL.—The Secretary shall adopt tech-  
7           nical standards that are consistent with the health infor-  
8           mation network privacy standards adopted under section  
9           5014 relating to the method by which standard data ele-  
10          ments of health information may be transmitted electroni-  
11          cally, including standards with respect to the format in  
12          which such data elements may be transmitted.

13          (b) SPECIAL RULE FOR COORDINATION OF BENE-  
14          FITS.—Any standard adopted by the Secretary under  
15          paragraph (1) that relates to coordination of benefits shall  
16          provide that a claim for reimbursement for health services  
17          furnished shall be tested, by an algorithm specified by the  
18          Secretary, against all records of enrollment and eligibility  
19          for the individual who received such services that are avail-  
20          able to the recipient of the claim through the health infor-  
21          mation network to determine any primary and secondary  
22          obligors for payment.

23          (c) ELECTRONIC SIGNATURE.—The Secretary, in co-  
24          ordination with the Secretary of Commerce, shall promul-  
25          gate regulations specifying procedures for the electronic

1 transmission and authentication of signatures, compliance  
2 with which shall be deemed to satisfy State and Federal  
3 statutory requirements for written signatures with respect  
4 to transactions described in section 5021 and written sig-  
5 natures on health records and prescriptions.

6 (d) STANDARDS FOR CLAIMS FOR CLINICAL LABORA-  
7 TORY TESTS.—The standards under this section shall pro-  
8 vide that claims for clinical laboratory tests for which ben-  
9 efits are payable by a plan sponsor shall be submitted di-  
10 rectly by the person or entity that performed (or super-  
11 vised the performance of) the tests to the sponsor in a  
12 manner consistent with (and subject to such exceptions  
13 as are provided under) the requirement for direct submis-  
14 sion of such claims under the medicare program.

15 **SEC. 5014. HEALTH INFORMATION NETWORK PRIVACY**  
16 **STANDARDS.**

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

21 (1) The rights of an individual who is the sub-  
22 ject of such information.

23 (2) The procedures to be established for the ex-  
24 ercise of such rights.

1           (3) The uses and disclosures of such informa-  
2           tion that are authorized or required.

3           (4) Safeguards for the security of such informa-  
4           tion and adequate security practices.

5 **SEC. 5015. TIMETABLES FOR ADOPTION OF STANDARDS.**

6           (a) INITIAL STANDARDS FOR DATA ELEMENTS.—

7 The Secretary shall adopt standards relating to—

8           (1) the data elements for the information de-  
9           scribed in section 5012(a) not later than 9 months  
10          after the date of the enactment of this Act (except  
11          in the case of standards with respect to data ele-  
12          ments for claims attachments, which shall be adopt-  
13          ed not later than 24 months after the date of the  
14          enactment of this Act); and

15          (2) any addition to a set of data elements, in  
16          conjunction with making such an addition.

17          (b) INITIAL PRIVACY STANDARDS.—The Secretary  
18 shall adopt standards relating to the privacy of individ-  
19 ually identifiable health information in the health informa-  
20 tion network under section 5014 not later than 12 months  
21 after the date of the enactment of this Act.

22          (c) INITIAL STANDARDS FOR INFORMATION TRANS-  
23 ACTIONS.—The Secretary shall adopt standards relating  
24 to information transactions under section 5013 not later  
25 than 18 months after the date of the enactment of this

1 Act (except in the case of standards for claims attach-  
2 ments, which shall be adopted not later than 24 months  
3 after the date of the enactment of this Act).

4 (d) MODIFICATIONS TO STANDARDS.—

5 (1) IN GENERAL.—Except as provided in para-  
6 graph (2), the Secretary shall review the standards  
7 adopted under this part and shall adopt modified  
8 standards as determined appropriate, but not more  
9 frequently than once every 6 months. Any modifica-  
10 tion to standards shall be completed in a manner  
11 which minimizes the disruption to, and costs of com-  
12 pliance incurred by, a plan sponsor, health provider,  
13 or health plan purchasing organization that is re-  
14 quired to comply with part 2.

15 (2) SPECIAL RULES.—

16 (A) MODIFICATIONS DURING FIRST 12-  
17 MONTH PERIOD.—Except with respect to addi-  
18 tions and modifications to code sets under sub-  
19 paragraph (B), the Secretary may not adopt  
20 any modification to a standard adopted under  
21 this part during the 12-month period beginning  
22 on the date the standard is adopted, unless the  
23 Secretary determines that the modification is  
24 necessary in order to permit a plan sponsor, a

1 health provider, or a health plan purchasing or-  
2 ganization to comply with part 2.

3 (B) ADDITIONS AND MODIFICATIONS TO  
4 CODE SETS.—

5 (i) IN GENERAL.—The Secretary shall  
6 ensure that procedures exist for the rou-  
7 tine maintenance, testing, enhancement,  
8 and expansion of code sets.

9 (ii) ADDITIONAL RULES.—If a code  
10 set is modified under this subsection, the  
11 modified code set shall include instructions  
12 on how data elements that were encoded  
13 prior to the modification are to be con-  
14 verted or translated so as to preserve the  
15 value of the data elements. Any modifica-  
16 tion to a code set under this subsection  
17 shall be implemented in a manner that  
18 minimizes the disruption to, and costs of  
19 compliance incurred by, a plan sponsor,  
20 health provider, or health plan purchasing  
21 organization that is required to comply  
22 with part 2.

23 (e) EVALUATION OF STANDARDS.—The Secretary  
24 may establish a process to measure or verify the consist-  
25 ency of standards adopted or modified under this part.



1 Such process may include demonstration projects and  
2 analyses of the cost of implementing such standards and  
3 modifications.

4 **PART 2—REQUIREMENTS WITH RESPECT TO**  
5 **CERTAIN TRANSACTIONS AND INFORMATION**

6 **SEC. 5021. STANDARD TRANSACTIONS AND INFORMATION.**

7 (a) TRANSACTIONS BY SPONSORS.—

8 (1) TRANSACTIONS WITH PROVIDERS.—If a  
9 plan sponsor conducts any of the transactions de-  
10 scribed in paragraph (3) with a health provider—

11 (A) the transaction shall be a standard  
12 transaction; and

13 (B) the health information transmitted by  
14 the sponsor to the provider or by the provider  
15 to the sponsor in connection with the trans-  
16 action shall be in the form of standard data ele-  
17 ments.

18 (2) TRANSACTIONS WITH SPONSORS.—If a plan  
19 sponsor conducts any of the transactions described  
20 in paragraph (3) with another plan sponsor—

21 (A) the transaction shall be a standard  
22 transaction; and

23 (B) the health information transmitted by  
24 either sponsor in connection with the trans-

1           action shall be in the form of standard data ele-  
2           ments.

3           (3) TRANSACTIONS.—The transactions referred  
4           to in paragraphs (1) and (2) are the following:

5                   (A) Verification of eligibility for benefits.

6                   (B) Coordination of benefits.

7                   (C) Claim submission.

8                   (D) Claim attachment submission.

9                   (E) Claim status notification.

10                  (F) Claim status verification.

11                  (G) Claim adjudication.

12                  (H) Payment and remittance advice.

13                  (I) Certification or authorization of a re-  
14                  ferral to a health provider who is not part of a  
15                  provider network.

16           (b) USE OF HEALTH INFORMATION NETWORK SERV-  
17           ICES.—A plan sponsor, a health provider, or a health plan  
18           purchasing organization may comply with any provision  
19           of this section by entering into an agreement or other ar-  
20           rangement with a health information network service cer-  
21           tified under section 5031 pursuant to which the service  
22           undertakes the duties applicable to the sponsor, provider,  
23           or organization under the provision.

1 **SEC. 5022. ACCESSING HEALTH INFORMATION FOR AU-**  
2 **THORIZED PURPOSES.**

3 (a) **PROCUREMENT RULE FOR GOVERNMENT AGEN-**  
4 **CIES.—**

5 (1) **IN GENERAL.—**A health information secu-  
6 rity organization that is certified under section 5031  
7 shall make available to a Federal or State agency,  
8 pursuant to a cost-type contract (as defined under  
9 the Federal Acquisition Regulation), any non-identi-  
10 fiable health information, including non-identifiable  
11 health information that is derived from individually  
12 identifiable health information, that—

13 (A) is held by the service or may be ob-  
14 tained by the service under paragraph (2) or  
15 subsection (b);

16 (B) consists of data elements that are sub-  
17 ject to a standard under part 1; and

18 (C) is requested by the agency to fulfill a  
19 requirement under this Act.

20 (2) **CERTAIN INFORMATION AVAILABLE AT LOW**  
21 **COST.—**If a health information security organization  
22 requires health information consisting of data ele-  
23 ments that are subject to a standard under part 1  
24 from a plan sponsor or a health provider in order to  
25 comply with a request made by a Federal or State  
26 agency under paragraph (1), the sponsor or provider

1 shall make such information available to such orga-  
2 nization for a charge that does not exceed the rea-  
3 sonable cost of transmitting the information.

4 (b) **PROCUREMENT RULE FOR INFORMATION SECUR-**  
5 **RITY ORGANIZATIONS.**—A health information security or-  
6 ganization that makes non-identifiable health information  
7 available to a Federal or State agency under subsection  
8 (a) shall make such non-identifiable information available,  
9 for a charge that does not exceed the reasonable cost of  
10 transmitting the information, to any other health informa-  
11 tion security organization that—

12 (A) is certified under section 5031; and

13 (B) requests the information.

14 **SEC. 5023. ENSURING AVAILABILITY OF INFORMATION.**

15 The Secretary shall establish a procedure under  
16 which a plan sponsor or health provider that does not have  
17 the ability to transmit standard data elements directly,  
18 and does not have access to a health information network  
19 service certified under section 5031, may comply with the  
20 provisions of this part.

21 **SEC. 5024. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**  
22 **MENTS.**

23 (a) **INITIAL COMPLIANCE.**—

24 (1) **IN GENERAL.**—Not later than 12 months  
25 after the date on which standards are adopted under

1 part 1 with respect to a type of transaction, or data  
2 elements for a type of health information, a plan  
3 sponsor, health provider, or health plan purchasing  
4 organization shall comply with the requirements of  
5 this part with respect to such transaction or infor-  
6 mation.

7 (2) ADDITIONAL DATA ELEMENTS.—Not later  
8 than 12 months after the date on which the Sec-  
9 retary adopts an addition to a set of data elements  
10 for health information under section 5012, a plan  
11 sponsor, health provider, or health plan purchasing  
12 organization shall comply with the requirements of  
13 this part using such data elements.

14 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

15 (1) IN GENERAL.—If the Secretary adopts a  
16 modified standard under section 5015(c), a plan  
17 sponsor, health provider, or health plan purchasing  
18 organization shall comply with the modified standard  
19 at such time as the Secretary determines appro-  
20 priate, taking into account the time needed to com-  
21 ply due to the nature and extent of the modification.

22 (2) SPECIAL RULE.—In the case of a modifica-  
23 tion to a standard that does not occur within the 12-  
24 month period beginning on the date the standard is

1 adopted, the time determined appropriate by the  
2 Secretary under paragraph (1) may not be—

3 (A) earlier than the last day of the 90-day  
4 period beginning on the date the modified  
5 standard is adopted; or

6 (B) later than the last day of the 12-  
7 month period beginning on the date the modi-  
8 fied standard is adopted.

9 **PART 3—MISCELLANEOUS PROVISIONS**

10 **SEC. 5031. STANDARDS AND CERTIFICATION FOR HEALTH**  
11 **INFORMATION NETWORK SERVICES.**

12 (a) STANDARDS FOR OPERATION.—The Secretary  
13 shall establish standards with respect to the operation of  
14 health information network services, including standards  
15 ensuring that such services—

16 (1) develop, operate, and cooperate with one an-  
17 other to form the health information network;

18 (2) meet all of the standards adopted under  
19 part 1 that are applicable to the services;

20 (3) make public information concerning their  
21 performance, as measured by uniform indicators  
22 such as accessibility, transaction responsiveness, ad-  
23 ministrative efficiency, reliability, dependability, and  
24 any other indicator determined appropriate by the  
25 Secretary; and

1           (4) if they are part of a larger organization,  
2           have policies and procedures in place which isolate  
3           their activities with respect to processing informa-  
4           tion in a manner that prevents access to such infor-  
5           mation by such larger organization.

6           (b) CERTIFICATION BY THE SECRETARY.—

7           (1) ESTABLISHMENT.—Not later than 18  
8           months after the date of the enactment of this Act,  
9           the Secretary shall establish a certification proce-  
10          dure for health information network services which  
11          ensures that certified services are qualified to meet  
12          the requirements of this subtitle and the standards  
13          established by the Secretary under this section. Such  
14          certification procedure shall be implemented in a  
15          manner that minimizes the costs and delays of oper-  
16          ations for such services.

17          (2) APPLICATION.—Each entity desiring to be  
18          certified as a health information network service  
19          shall apply to the Secretary for certification in a  
20          form and manner determined appropriate by the  
21          Secretary.

22          (3) AUDITS AND REPORTS.—The procedure es-  
23          tablished under paragraph (1) shall provide for au-  
24          dits by the Secretary and reports by an entity cer-  
25          tified under this section as the Secretary determines

1 appropriate in order to monitor such entity's compli-  
2 ance with the requirements of this subtitle and the  
3 standards established by the Secretary under this  
4 section.

5 (4) RECERTIFICATION.—A health information  
6 network service shall be recertified under this sub-  
7 section at least every 3 years.

8 (c) LOSS OF CERTIFICATION.—

9 (1) MANDATORY TERMINATION.—Except as  
10 provided in paragraph (2), if a health information  
11 network service violates a health information net-  
12 work privacy standard adopted under section 5014  
13 that is applicable to the service, its certification  
14 under this section shall be terminated unless the  
15 Secretary determines that appropriate corrective ac-  
16 tion has been taken.

17 (2) CONDITIONAL CERTIFICATION—The Sec-  
18 retary may establish a procedure under which a  
19 health information network service may remain cer-  
20 tified on a conditional basis if the service is operat-  
21 ing consistently with a plan intended to correct any  
22 violations described in paragraph (1). Such proce-  
23 dure may provide for the appointment of a trustee  
24 to continue operation of the service until the require-  
25 ments for full certification are met.



1 (d) CERTIFICATION BY PRIVATE ENTITIES.—The  
2 Secretary may designate private entities to conduct the  
3 certification procedures established by the Secretary under  
4 this section. A health information network service certified  
5 by such an entity in accordance with such designation  
6 shall be considered to be certified by the Secretary.

7 (e) INFORMATION HELD BY HEALTH INFORMATION  
8 NETWORK SERVICES.—If a health information network  
9 service certified under this section loses its certified status  
10 or takes any action that would threaten the continued  
11 availability of the standard data elements of health infor-  
12 mation held by such service, such data elements shall be  
13 transferred to another health information network service  
14 certified under this section that has been designated by  
15 the Secretary.

16 **SEC. 5032. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

17 (a) IN GENERAL.—Except as provided in subsection  
18 (c), after the Secretary has established standards under  
19 section 5012 that are necessary to make uniform and com-  
20 patible for electronic transmission the data elements that  
21 the Secretary determines are appropriate for transmission  
22 in connection with a transaction described in part 2, an  
23 individual or entity may not require an individual or en-  
24 tity, to provide in any manner any additional data element  
25 in connection with—

1 (1) the transaction; or

2 (2) an inquiry with respect to the transaction.

3 (b) TRANSMISSION METHOD.—Except as provided in  
4 subsection (c), after the Secretary has established stand-  
5 ards under section 5013 relating to the method by which  
6 data elements that the Secretary determines are appro-  
7 priate for transmission in connection with a transaction  
8 described in part 2 may be transmitted electronically, an  
9 individual or entity may not require an individual or entity  
10 to transmit any data element in a manner inconsistent  
11 with the standards in connection with—

12 (1) the transaction; or

13 (2) an inquiry with respect to the transaction.

14 (c) EXCEPTION.—Subsections (a) and (b) do not  
15 apply if—

16 (1) an individual or entity voluntarily agrees to  
17 provide the additional data element; or

18 (2) a waiver is granted under subsection (d) to  
19 permit the requirement to be imposed.

20 (d) CONDITIONS FOR WAIVERS.—

21 (1) IN GENERAL.—An individual or entity may  
22 request a waiver from the Secretary in order to im-  
23 pose on an individual or entity a requirement other-  
24 wise prohibited under subsection (a) or (b). Subject

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

3 (2) CONSIDERATION OF WAIVER REQUESTS.—A  
4 waiver may not be granted under this subsection to  
5 impose an otherwise prohibited requirement unless  
6 the Secretary determines that the value of any addi-  
7 tional information to be provided under the require-  
8 ment for research or other purposes significantly  
9 outweighs the administrative cost of the imposition  
10 of the requirement, taking into account the burden  
11 of the timing of the imposition of the requirement.

12 (e) ANONYMOUS REPORTING.—If an individual or en-  
13 tity attempts to impose on an individual or entity a re-  
14 quirement prohibited under subsection (a) or (b), the indi-  
15 vidual or entity on whom the requirement is being imposed  
16 may contact the Secretary. The Secretary shall develop a  
17 procedure under which an individual or entity that con-  
18 tacts the Secretary under the preceding sentence shall re-  
19 main anonymous. The Secretary shall notify the individual  
20 or entity imposing the requirement that the requirement  
21 may not be imposed unless the other individual or entity  
22 voluntarily agrees to such requirement or a waiver is ob-  
23 tained under subsection (d).

1 **SEC. 5033. EFFECT ON STATE LAW.**

2 (a) **IN GENERAL.**—Except as otherwise provided in  
3 this section, a provision, requirement, or standard under  
4 this subtitle shall supersede any contrary provision of  
5 State law.

6 (b) **STATE “QUILL AND PEN” LAWS.**—A State may  
7 not establish, continue in effect, or enforce any provision  
8 of State law that requires medical or health plan records  
9 (including billing information) to be maintained or trans-  
10 mitted in written rather than electronic form, except  
11 where the Secretary determines that the provision is nec-  
12 essary to prevent fraud and abuse, with respect to con-  
13 trolled substances, or for other purposes.

14 (c) **PUBLIC HEALTH REPORTING.**—Nothing in this  
15 subtitle shall be construed to invalidate or limit the au-  
16 thority, power, or procedures established under any law  
17 providing for the reporting of disease or injury, child  
18 abuse, birth, or death, public health surveillance, or public  
19 health investigation or intervention.

20 (d) **PUBLIC USE FUNCTIONS.**—Nothing in this sub-  
21 title shall be construed to limit the authority of a Federal  
22 or State agency to make non-identifiable health informa-  
23 tion available for public use.

24 (e) **PAYMENT FOR HEALTH CARE SERVICES OR PRE-**  
25 **MIUMS.**—Nothing in this subtitle shall be construed to  
26 prohibit a consumer from paying for health care items or

1 services, or plan or health insurance coverage premiums,  
2 by debit, credit, or other payment cards or numbers or  
3 other electronic payment means.

## 4 **Subtitle B—Antitrust**

### 5 **SEC. 5101. PUBLICATION OF ANTITRUST GUIDELINES ON** 6 **ACTIVITIES OF HEALTH PLANS.**

7 (a) IN GENERAL.—The Attorney General shall pro-  
8 vide for the development and publication of explicit guide-  
9 lines on the application of antitrust laws to the activities  
10 of health plans. The guidelines shall be designed to facili-  
11 tate development and operation of plans, consistent with  
12 the antitrust laws.

13 (b) REVIEW PROCESS.—The Attorney General shall  
14 establish a review process under which the administrator  
15 or sponsor of a health plan (or organization that proposes  
16 to administer or sponsor a health plan) may submit a re-  
17 quest to the Attorney General to obtain a prompt opinion  
18 (but in no event later than 90 days after the Attorney  
19 General receives the request) from the Department of Jus-  
20 tice on the plan’s conformity with the Federal antitrust  
21 laws.

22 (c) DEFINITIONS.—In this section—

23 (1) the term “antitrust laws”—

24 (A) has the meaning given it in subsection

25 (a) of the first section of the Clayton Act (15

1 U.S.C. 12(a)), except that such term includes  
2 section 5 of the Federal Trade Commission Act  
3 (15 U.S.C. 45) to the extent such section ap-  
4 plies to unfair methods of competition, and

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

7 (2) the term “health plan” means any contract  
8 or arrangement under which an entity bears all or  
9 part of the cost of providing health care items and  
10 services, including a hospital or medical expense in-  
11 curred policy or certificate, hospital or medical serv-  
12 ice plan contract, or health maintenance subscriber  
13 contract, but does not include—

14 (A) coverage only for accident, dental, vi-  
15 sion, disability, or long term care, medicare  
16 supplemental health insurance, or any combina-  
17 tion thereof,

18 (B) coverage issued as a supplement to li-  
19 ability insurance,

20 (C) workers’ compensation or similar in-  
21 surance, or

22 (D) automobile medical-payment insur-  
23 ance.

1 **SEC. 5102. ISSUANCE OF HEALTH CARE CERTIFICATES OF**  
2 **PUBLIC ADVANTAGE.**

3 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The  
4 Attorney General, after consultation with the Secretary,  
5 shall issue in accordance with this section a certificate of  
6 public advantage to each eligible health care collaborative  
7 activity that complies with the requirements in effect  
8 under this section on or after the expiration of the 1-year  
9 period that begins on the date of the enactment of this  
10 Act (without regard to whether or not the Attorney Gen-  
11 eral has promulgated regulations to carry out this section  
12 by such date). Such activity, and the parties to such activ-  
13 ity, shall not be liable under any of the antitrust laws for  
14 conduct described in such certificate and engaged in by  
15 such activity if such conduct occurs while such certificate  
16 is in effect.

17 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF  
18 CERTIFICATES.—

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

23 (A) the benefits that are likely to result  
24 from carrying out the activity outweigh the re-  
25 duction in competition (if any) that is likely to  
26 result from the activity, and

1 (B) such reduction in competition is nec-  
2 essary to obtain such benefits.

3 (2) FACTORS TO BE CONSIDERED.—

4 (A) WEIGHING OF BENEFITS AGAINST RE-  
5 DUCION IN COMPETITION.—For purposes of  
6 making the finding described in paragraph  
7 (1)(A), the Attorney General shall consider  
8 whether the activity is likely—

9 (i) to maintain or to increase the  
10 quality of health care by providing new  
11 services not currently offered in the rel-  
12 evant market,

13 (ii) to increase access to health care,

14 (iii) to achieve cost efficiencies that  
15 will be passed on to health care consumers,  
16 such as economies of scale, reduced trans-  
17 action costs, and reduced administrative  
18 costs, that cannot be achieved by the provi-  
19 sion of available services and facilities in  
20 the relevant market,

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

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



1 (vi) to reduce inefficient health care  
2 resource duplication.

3 (B) NECESSITY OF REDUCTION IN COM-  
4 PETITION.—For purposes of making the finding  
5 described in paragraph (1)(B), the Attorney  
6 General shall consider—

7 (i) the ability of the providers of  
8 health care services that are (or likely to  
9 be) affected by the health care collabo-  
10 rative activity and the entities responsible  
11 for making payments to such providers to  
12 negotiate societally optimal payment and  
13 service arrangements,

14 (ii) the effects of the health care col-  
15 laborative activity on premiums and other  
16 charges imposed by the entities described  
17 in clause (i), and

18 (iii) the availability of equally effi-  
19 cient, less restrictive alternatives to achieve  
20 the benefits that are intended to be  
21 achieved by carrying out the activity.

22 (C) ESTABLISHMENT OF CRITERIA AND PROCE-  
23 DURES.—Subject to subsections (d) and (e), not later than  
24 1 year after the date of the enactment of this Act, the  
25 Attorney General and the Secretary shall establish jointly

1 by rule the criteria and procedures applicable to the issu-  
2 ance of certificates under subsection (a). The rules shall  
3 specify the form and content of the application to be sub-  
4 mitted to the Attorney General to request a certificate,  
5 the information required to be submitted in support of  
6 such application, the procedures applicable to denying and  
7 to revoking a certificate, and the procedures applicable to  
8 the administrative appeal (if such appeal is authorized by  
9 rule) of the denial and the revocation of a certificate. Such  
10 information may include the terms of the health care col-  
11 laborative activity (in the case of an activity in existence  
12 as of the time of the application) and implementation plan  
13 for the collaborative activity.

14 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-  
15 TIVITY.—To be an eligible health care collaborative activ-  
16 ity for purposes of this section, a health care collaborative  
17 activity shall submit to the Attorney General an applica-  
18 tion that complies with the rules in effect under subsection  
19 (c) and that includes—

20 (1) an agreement by the parties to the activity  
21 that the activity will not foreclose competition by en-  
22 tering into contracts that prevent health care provid-  
23 ers from providing health care in competition with  
24 the activity,

1           (2) an agreement that the activity will submit  
2           to the Attorney General annually a report that de-  
3           scribes the operations of the activity and information  
4           regarding the impact of the activity on health care  
5           and on competition in health care, and

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

10          (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—

11         Not later than 90 days after an eligible health care col-  
12         laborative activity submits to the Attorney General an ap-  
13         plication that complies with the rules in effect under sub-  
14         section (c) and with subsection (d), the Attorney General  
15         shall issue or deny the issuance of such certificate. If, be-  
16         fore the expiration of such 90-day period, the Attorney  
17         General may extend the time for issuance for good cause.

18          (f) REVOCATION OF CERTIFICATE.—Whenever the  
19         Attorney General finds that a health care collaborative ac-  
20         tivity with respect to which a certificate is in effect does  
21         not meet the standards specified in subsection (b), the At-  
22         torney General shall revoke such certificate.

23          (g) WRITTEN REASONS; JUDICIAL REVIEW.—

24                 (1) DENIAL AND REVOCATION OF CERTIFI-  
25                 CATES.—If the Attorney General denies an applica-

1       tion for a certificate or revokes a certificate, the At-  
2       torney General shall include in the notice of denial  
3       or revocation a statement of the reasons relied upon  
4       for the denial or revocation of such certificate.

5               (2) JUDICIAL REVIEW.—

6               (A) AFTER ADMINISTRATIVE PROCEED-  
7       ING.—(i) If the Attorney General denies an ap-  
8       plication submitted or revokes a certificate is-  
9       sued under this section after an opportunity for  
10      hearing on the record, then any party to the  
11      health care collaborative activity involved may  
12      commence a civil action, not later than 60 days  
13      after receiving notice of the denial or revoca-  
14      tion, in an appropriate district court of the  
15      United States for review of the record of such  
16      denial or revocation.

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

24              (B) DENIAL OR REVOCATION WITHOUT AD-  
25      MINISTRATIVE PROCEEDING.—If the Attorney

1           General denies an application submitted or re-  
2           vokes a certificate issued under this section  
3           without an opportunity for hearing on the  
4           record, then any party to the health care col-  
5           laborative activity involved may commence a  
6           civil action, not later than 60 days after receiv-  
7           ing notice of the denial or revocation, in an ap-  
8           propriate district court of the United States for  
9           de novo review of such denial or revocation.

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

12           (1) to prepare, agree to prepare, or attempt to  
13           agree to prepare an application to request a certifi-  
14           cate under this section, or

15           (2) to attempt to enter into any health care col-  
16           laborative activity with respect to which such a cer-  
17           tificate is in effect.

18          (i) DEFINITIONS.—In this section:

19           (1) The term “antitrust laws” has the meaning  
20           given it in section 5101(c)(1).

21           (2) The term “certificate” means a certificate  
22           of public advantage authorized to be issued under  
23           subsection (a).

24           (3) The term “health care collaborative activ-  
25           ity” means an agreement (whether existing or pro-

1 posed) between 2 or more providers of health care  
2 services that is entered into solely for the purpose of  
3 sharing in the provision and coordination of health  
4 care services and that involves substantial integra-  
5 tion and financial risk-sharing between the parties,  
6 but does not include the exchanging of information,  
7 the entering into of any agreement, or the engage-  
8 ment in any other conduct that is not reasonably re-  
9 quired to carry out such agreement.

10 (4) The term “health care services” includes  
11 services related to the delivery or administration of  
12 health care services.

13 (5) The term “liable” means liable for any civil  
14 or criminal violation of the antitrust laws.

15 (6) The term “provider of health care services”  
16 means any individual or entity that is engaged in the  
17 delivery of health care services in a State and that  
18 is required by State law or regulation to be licensed  
19 or certified by the State to engage in the delivery of  
20 such services in the State.

21 **SEC. 5103. STUDY OF IMPACT ON COMPETITION.**

22 The Attorney General, in consultation with the Chair-  
23 man of the Federal Trade Commission, annually shall sub-  
24 mit to the Congress a report as part of the annual budget  
25 oversight proceedings concerning the Antitrust Division of

1 the Department of Justice. The report shall enable the  
2 Congress to determine how enforcement of antitrust laws  
3 is affecting the formation of efficient, cost-saving joint  
4 ventures and if the certificate of public advantage proce-  
5 dure set forth in section 5102 has resulted in undesirable  
6 reduction in competition in the health care marketplace.  
7 The report shall include an evaluation of the factors set  
8 forth in paragraphs (2)(A) and (2)(B) of section 5102(b).

## 9 **TITLE VI—MEDICARE**

### 10 **Subtitle A—Increased Beneficiary** 11 **Choice; Improved Program Effi-** 12 **ciency**

#### 13 **PART 1—INCREASED BENEFICIARY CHOICE**

#### 14 **SEC. 6001. REQUIREMENTS FOR HEALTH MAINTENANCE** 15 **ORGANIZATIONS UNDER MEDICARE.**

16 (a) USE OF METROPOLITAN STATISTICAL AREAS TO  
17 DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—  
18 Section 1876(a)(4) of the Social Security Act (42 U.S.C.  
19 1395mm(a)(4)) is amended by striking “in a geographic  
20 area served by an eligible organization or in a similar  
21 area” and inserting “in the metropolitan statistical area  
22 (as defined by the Office of Management and Budget) in  
23 which the individual resides, or in the entire portion of  
24 the State in which the individual resides which is not lo-  
25 cated in a metropolitan statistical area in the case of an

1 individual who does not reside in a metropolitan statistical  
2 area”.

3 (b) DETERMINATION OF MODEL ADDITIONAL  
4 HEALTH BENEFIT PACKAGES.—Section 1876(g) of such  
5 Act (42 U.S.C. 1395mm(g)) is amended by inserting after  
6 paragraph (3) the following new paragraph:

7 “(4) The Secretary shall develop the following model  
8 packages of additional health benefits (referred to in para-  
9 graph (3)(B)) which an eligible organization may provide  
10 (at its option) under paragraph (2):

11 “(A) Coverage for catastrophic illness (subject  
12 to a limit on out-of-pocket expenditures).

13 “(B) Coverage for prescription drugs.

14 “(C) Coverage for preventive services.”.

15 (c) REVISION OF MEMBERSHIP LIMITATION.—Sec-  
16 tion 1876(f) of such Act (42 U.S.C. 1395mm(f)) is  
17 amended—

18 (1) in paragraph (1), by striking “one-half”  
19 and inserting “25 percent”; and

20 (2) in paragraph (2)(A), by striking “50 per-  
21 cent” and inserting “75 percent”.

22 (d) ENROLLMENT PERIODS FOR MEDICARE HEALTH  
23 MAINTENANCE ORGANIZATIONS.—

24 (1) UNIFORM OPEN ENROLLMENT PERIOD.—

25 Section 1876(c)(3)(A)(i) of such Act (42 U.S.C.



1 1395mm(c)(3)(A)(i) is amended by striking “must  
2 have” and all that follows through “and including”  
3 and inserting the following: “shall have open enroll-  
4 ment during an annual uniform open enrollment pe-  
5 riod established by the Secretary for all eligible orga-  
6 nizations, together with”.

7 (2) OPEN ENROLLMENT FOR CERTAIN  
8 DISENROLLED INDIVIDUALS.—Section  
9 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C.  
10 1395mm(c)(3)(A)(ii)(I)) is amended by adding at  
11 the end the following: “Each eligible organization  
12 with a risk-sharing contract under this section shall  
13 have an open enrollment period for individuals resid-  
14 ing in the organization’s service area who disenroll  
15 from another eligible organization with a risk-shar-  
16 ing contract under this section on the grounds that  
17 the individual’s primary care physician is no longer  
18 a member of the organization’s provider network or  
19 for cause (in accordance with such standards, and as  
20 demonstrated through an appeals process that meets  
21 such requirements, as the Secretary may establish).

22 (e) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to contracts entered into on or  
24 after the date of the enactment of this Act.

1 **SEC. 6002. EXPANSION AND REVISION OF MEDICARE SE-**  
2 **LECT POLICIES.**

3 (a) PERMITTING MEDICARE SELECT POLICIES IN  
4 ALL STATES.—

5 (1) IN GENERAL.—Subsection (c) of section  
6 4358 of the Omnibus Budget Reconciliation Act of  
7 1990 (hereafter referred to as “OBRA–1990”) is  
8 hereby repealed.

9 (2) CONFORMING AMENDMENT.—Section 4358  
10 of OBRA–1990 is amended by redesignating sub-  
11 section (d) as subsection (c).

12 (b) REQUIREMENTS OF MEDICARE SELECT POLI-  
13 CIES.—Section 1882(t)(1) of the Social Security Act (42  
14 U.S.C. 1395ss(t)(1)) is amended to read as follows:

15 “(1)(A) If a medicare supplemental policy meets the  
16 1991 NAIC Model Regulation or 1991 Federal Regulation  
17 and otherwise complies with the requirements of this sec-  
18 tion except that—

19 “(i) the benefits under such policy are re-  
20 stricted to items and services furnished by certain  
21 entities (or reduced benefits are provided when items  
22 or services are furnished by other entities), and

23 “(ii) in the case of a policy described in sub-  
24 paragraph (C)(i)—

1           “(I) the benefits under such policy are not  
2           one of the groups or packages of benefits de-  
3           scribed in subsection (p)(2)(A),

4           “(II) except for nominal copayments im-  
5           posed for services covered under part B of this  
6           title, such benefits include at least the core  
7           group of basic benefits described in subsection  
8           (p)(2)(B), and

9           “(III) an enrollee’s liability under such pol-  
10          icy for physician’s services covered under part  
11          B of this title is limited to the nominal  
12          copayments described in subclause (II),

13 the policy shall nevertheless be treated as meeting those  
14 standards if the policy meets the requirements of subpara-  
15 graph (B).

16          “(B) A policy meets the requirements of this sub-  
17 paragraph if—

18           “(i) full benefits are provided for items and  
19           services furnished through a network of entities  
20           which have entered into contracts or agreements  
21           with the issuer of the policy,

22           “(ii) full benefits are provided for items and  
23           services furnished by other entities if the services are  
24           medically necessary and immediately required be-  
25           cause of an unforeseen illness, injury, or condition

1 and it is not reasonable given the circumstances to  
2 obtain the services through the network,

3 “(iii) the network offers sufficient access,

4 “(iv) the issuer of the policy has arrangements  
5 for an ongoing quality assurance program for items  
6 and services furnished through the network,

7 “(v)(I) the issuer of the policy provides to each  
8 enrollee at the time of enrollment an explanation  
9 of—

10 “(aa) the restrictions on payment under  
11 the policy for services furnished other than by  
12 or through the network,

13 “(bb) out of area coverage under the pol-  
14 icy,

15 “(cc) the policy’s coverage of emergency  
16 services and urgently needed care, and

17 “(dd) the availability of a policy through  
18 the entity that meets the 1991 Model NAIC  
19 Regulation or 1991 Federal Regulation without  
20 regard to this subsection and the premium  
21 charged for such policy, and

22 “(II) each enrollee prior to enrollment acknowl-  
23 edges receipt of the explanation provided under  
24 subclause (I), and

1           “(vi) the issuer of the policy makes available to  
2 individuals, in addition to the policy described in this  
3 subsection, any policy (otherwise offered by the is-  
4 suer to individuals in the State) that meets the 1991  
5 Model NAIC Regulation or 1991 Federal Regulation  
6 and other requirements of this section without re-  
7 gard to this subsection.

8           “(C)(i) A policy described in this subparagraph—

9           “(I) is offered by an eligible organization (as  
10 defined in section 1876(b)),

11           “(II) is not a policy or plan providing benefits  
12 pursuant to a contract under section 1876 or an ap-  
13 proved demonstration project described in section  
14 603(c) of the Social Security Amendments of 1983,  
15 section 2355 of the Deficit Reduction Act of 1984,  
16 or section 9412(b) of the Omnibus Budget Reconcili-  
17 ation Act of 1986, and

18           “(III) provides benefits which, when combined  
19 with benefits which are available under this title, are  
20 substantially similar to benefits under policies of-  
21 fered to individuals who are not entitled to benefits  
22 under this title.

23           “(ii) In making a determination under subclause (III)  
24 of clause (i) as to whether certain benefits are substan-  
25 tially similar, there shall not be taken into account, except

1 in the case of preventive services, benefits provided under  
2 policies offered to individuals who are not entitled to bene-  
3 fits under this title which are in addition to the benefits  
4 covered by this title and which are benefits an entity must  
5 provide in order to meet the definition of an eligible orga-  
6 nization under section 1876(b)(1).”.

7 (c) RENEWABILITY OF MEDICARE SELECT POLI-  
8 CIES.—Section 1882(q)(1) of the Social Security Act (42  
9 U.S.C. 1395ss(q)(1)) is amended—

10 (1) by striking “(1) Each” and inserting  
11 “(1)(A) Except as provided in subparagraph (B),  
12 each”;

13 (2) by redesignating subparagraphs (A) and  
14 (B) as clauses (i) and (ii), respectively; and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(B)(i) Except as provided in clause (ii), in the  
18 case of a policy that meets the requirements of sub-  
19 section (t), an issuer may cancel or nonrenew such  
20 policy with respect to an individual who leaves the  
21 service area of such policy.

22 “(ii) If an individual described in clause (i)  
23 moves to a geographic area where an issuer de-  
24 scribed in clause (i), or where an affiliate of such is-  
25 suer, is issuing medicare supplemental policies, such

1 individual must be permitted to enroll in any medi-  
2 care supplemental policy offered by such issuer or  
3 affiliate that provides benefits comparable to or less  
4 than the benefits provided in the policy being can-  
5 celed or nonrenewed. An individual whose coverage  
6 is canceled or nonrenewed under this subparagraph  
7 shall, as part of the notice of termination or  
8 nonrenewal, be notified of the right to enroll in other  
9 medicare supplemental policies offered by the issuer  
10 or its affiliates.

11 “(iii) For purposes of this subparagraph, the  
12 term ‘affiliate’ shall have the meaning given such  
13 term by the 1991 NAIC Model Regulation.”.

14 (d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of  
15 the Social Security Act (42 U.S.C. 1395ss(t)(2)) is  
16 amended—

17 (1) by striking “(2)” and inserting “(2)(A)”;

18 (2) by redesignating subparagraphs (A), (B),  
19 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-  
20 spectively;

21 (3) in clause (iv), as so redesignated—

22 (A) by striking “paragraph (1)(E)(i)” and  
23 inserting “paragraph (1)(B)(v)(I), and

24 (B) by striking “paragraph (1)(E)(ii)” and  
25 inserting “paragraph (1)(B)(v)(II)”;

1           (4) by striking “the previous sentence” and in-  
2           serting “this subparagraph”; and

3           (5) by adding at the end the following new sub-  
4           paragraph:

5           “(B) If the Secretary determines that an issuer of  
6 a policy approved under paragraph (1) has made a mis-  
7 representation to the Secretary or has provided the Sec-  
8 retary with false information regarding such policy, the  
9 issuer is subject to a civil money penalty in an amount  
10 not to exceed \$100,000 for each such determination. The  
11 provisions of section 1128A (other than the first sentence  
12 of subsection (a) and other than subsection (b)) shall  
13 apply to a civil money penalty under this subparagraph  
14 in the same manner as such provisions apply to a penalty  
15 or proceeding under section 1128A(a).”.

16           (e) EFFECTIVE DATES.—

17           (1) NAIC STANDARDS.—If, within 6 months  
18 after the date of the enactment of this Act, the Na-  
19 tional Association of Insurance Commissioners  
20 (hereafter in this subsection referred to as the  
21 “NAIC”) makes changes in the 1991 NAIC Model  
22 Regulation (as defined in section 1882(p)(1)(A) of  
23 the Social Security Act) to incorporate the additional  
24 requirements imposed by the amendments made by  
25 this section, section 1882(g)(2)(A) of such Act shall



1 be applied in each State, effective for policies issued  
2 to policyholders on and after the date specified in  
3 paragraph (3), as if the reference to the Model Reg-  
4 ulation adopted on June 6, 1979, were a reference  
5 to the 1991 NAIC Model Regulation (as so defined)  
6 as changed under this paragraph (such changed  
7 Regulation referred to in this subsection as the  
8 “1994 NAIC Model Regulation”).

9 (2) SECRETARY STANDARDS.—If the NAIC  
10 does not make changes in the 1991 NAIC Model  
11 Regulation (as so defined) within the 6-month period  
12 specified in paragraph (1), the Secretary of Health  
13 and Human Services (in this subsection as the “Sec-  
14 retary”) shall promulgate a regulation and section  
15 1882(g)(2)(A) of the Social Security Act shall be ap-  
16 plied in each State, effective for policies issued to  
17 policyholders on and after the date specified in para-  
18 graph (3), as if the reference to the Model Regula-  
19 tion adopted in June 6, 1979, were a reference to  
20 the 1991 NAIC Model Regulation (as so defined) as  
21 changed by the Secretary under this paragraph  
22 (such changed Regulation referred to in this sub-  
23 section as the “1994 Federal Regulation”).

24 (3) DATE SPECIFIED.—

1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), the date specified in this paragraph  
3 for a State is the earlier of—

4 (i) the date the State adopts the 1994  
5 NAIC Model Regulation or the 1994 Fed-  
6 eral Regulation; or

7 (ii) 1 year after the date the NAIC or  
8 the Secretary first adopts such regulations.

9 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
10 QUIRED.—In the case of a State which the Sec-  
11 retary identifies, in consultation with the NAIC,  
12 as—

13 (i) requiring State legislation (other  
14 than legislation appropriating funds) in  
15 order for medicare supplemental policies to  
16 meet the 1994 NAIC Model Regulation or  
17 the 1994 Federal Regulation, but

18 (ii) having a legislature which is not  
19 scheduled to meet in 1995 in a legislative  
20 session in which such legislation may be  
21 considered,

22 the date specified in this paragraph is the first  
23 day of the first calendar quarter beginning after  
24 the close of the first legislative session of the  
25 State legislature that begins on or after Janu-

1           ary 1, 1995. For purposes of the previous sen-  
2           tence, in the case of a State that has a 2-year  
3           legislative session, each year of such session  
4           shall be deemed to be a separate regular session  
5           of the State legislature.

6 **SEC. 6003. INCLUDING NOTICE OF AVAILABLE HEALTH**  
7                   **MAINTENANCE ORGANIZATIONS IN ANNUAL**  
8                   **NOTICE TO BENEFICIARIES.**

9           Section 1804 of the Social Security Act (42 U.S.C.  
10 1395b-2) is amended—

11           (1) by striking “and” at the end of paragraph  
12           (2);

13           (2) by striking the period at the end of para-  
14           graph (3) and inserting “, and”; and

15           (3) by inserting after paragraph (3) the follow-  
16           ing new paragraph:

17           “(4) with respect to the area in which the indi-  
18           vidual receiving the notice resides, a description of  
19           the eligible organizations under section 1833(a)(1)  
20           or section 1876 and the carriers offering a medicare  
21           supplemental policy described in section 1882(t)(1)  
22           which serve the area in which the individual receiv-  
23           ing the notice resides.”.

1 **SEC. 6004. LEGISLATIVE PROPOSAL ON ENROLLING MEDI-**  
2 **CARE BENEFICIARIES IN QUALIFIED HEALTH**  
3 **PLANS.**

4 (a) IN GENERAL.—

5 (1) LEGISLATIVE PROPOSAL.—Not later than 1  
6 year after the date of the enactment of this Act, the  
7 Secretary shall develop and submit to Congress a  
8 proposal for legislation which provides for the vol-  
9 untary enrollment of medicare beneficiaries in pri-  
10 vate health insurance plans.

11 (2) MEDICARE BENEFICIARY.—For purposes of  
12 this section, the term “medicare beneficiary” means  
13 an individual who is eligible for benefits under part  
14 A of title XVIII of the Social Security Act and is en-  
15 rolled under part B of such title.

16 (b) CONTENTS OF THE PROPOSAL.—A proposal for  
17 legislation submitted under subsection (a) shall—

18 (1) provide for an appropriate methodology by  
19 which the Secretary shall make payment to private  
20 health insurance plans for the enrollment of medi-  
21 care beneficiaries;

22 (2) provide individuals the opportunity to re-  
23 main enrolled in such a plan without an interruption  
24 in coverage upon becoming medicare beneficiaries;  
25 and

1           (3) provide medicare beneficiaries with the op-  
2           portunity to enroll in a private health insurance  
3           plan.

4 **SEC. 6005. OPTIONAL INTERIM ENROLLMENT OF MEDICARE**  
5 **BENEFICIARIES IN PRIVATE HEALTH PLANS.**

6           (a) INTERIM ENROLLMENT OF MEDICARE BENE-  
7           FICIARIES IN QUALIFIED HEALTH PLANS.—

8           (1) IN GENERAL.—Notwithstanding title XVIII  
9           of the Social Security Act, the Secretary shall pro-  
10          vide for a monthly payment as provided under sub-  
11          section (b)(1) to a private health insurance plan on  
12          behalf of enrolled medicare beneficiaries who choose  
13          to enroll in such a plan.

14          (2) MEDICARE BENEFICIARY.—For purposes of  
15          this section, the term “medicare beneficiary” means  
16          an individual who is eligible for benefits under part  
17          A of title XVIII of the Social Security Act and is en-  
18          rolled under part B of such title.

19          (b) PAYMENT SPECIFIED.—

20               (1) FEDERAL PAYMENT.—

21                   (A) IN GENERAL.—The amount of pay-  
22                   ment specified in this paragraph for an individ-  
23                   ual who is enrolled in a private health insurance  
24                   plan is the lesser of—

1 (i) the applicable rate specified in sec-  
2 tion 1876(a)(1)(C) of the Social Security  
3 Act; or

4 (ii) the monthly premium charged the  
5 individual for coverage under the private  
6 health insurance plan.

7 (B) SOURCE OF PAYMENT.—The payment  
8 to a private health insurance plan under this  
9 paragraph for individuals entitled to benefits  
10 under part A and enrolled under part B of title  
11 XVIII of the Social Security Act shall be made  
12 from the Federal Hospital Insurance Trust  
13 Fund and the Federal Supplementary Medical  
14 Insurance Trust Fund, with the allocation to be  
15 determined by the Secretary.

16 (2) INDIVIDUAL'S SHARE.—If the monthly pre-  
17 mium for the private plan in which the individual is  
18 enrolled is greater than the amount specified under  
19 paragraph (1)(A)(i), the individual shall be respon-  
20 sible for paying to the plan the difference between  
21 the monthly premium charged the individual for cov-  
22 erage under the plan and the amount specified in  
23 paragraph (1)(A)(i).

24 (3) BUDGET-NEUTRALITY.—The total amount  
25 of payments made by the Secretary under this sec-

1       tion with respect to a beneficiary for a year may not  
2       exceed the amount of payment that would have been  
3       made under title XVIII of the Social Security Act  
4       during the year if the beneficiary did not choose to  
5       enroll in a private health insurance plan during the  
6       year.

7       (c) PAYMENTS UNDER THIS SECTION AS SOLE MED-  
8       ICARE BENEFITS.—Payments made under this section  
9       shall be instead of the amounts that would otherwise be  
10      payable, pursuant to sections 1814(b) and 1833(a) of the  
11      Social Security Act, for services furnished to medicare  
12      beneficiaries.

13      (d) INCLUSION IN ANNUAL NOTICE TO BENE-  
14      FICIARIES.—Section 1804 of the Social Security Act (42  
15      U.S.C. 1395b–2), as amended by section 6003, is amend-  
16      ed—

17           (1) by striking “and” at the end of paragraph  
18           (3);

19           (2) by striking the period at the end of para-  
20           graph (4) and inserting “, and”; and

21           (3) by inserting after paragraph (4) the follow-  
22           ing new paragraph:

23           “(5) a description of the option provided pursu-  
24           ant to section 6005 of the Health Care Improvement  
25           Act of 1995 for payment to be made by the Sec-

1       retary on the individual's behalf for enrollment in a  
2       private health insurance plan.".

3       **PART 2—IMPROVED PROGRAM EFFICIENCY**

4       **SEC. 6011. IMPROVED EFFICIENCY THROUGH CONSOLIDA-**  
5                   **TION OF ADMINISTRATION OF PARTS A AND**  
6                   **B.**

7       (a) IN GENERAL.—The Secretary of Health and  
8       Human Services shall take such steps as may be necessary  
9       to consolidate the administration (including processing  
10       systems) of parts A and B of the medicare program (under  
11       title XVIII of the Social Security Act) over a 4-year pe-  
12       riod.

13       (b) COMBINATION OF INTERMEDIARY AND CARRIER  
14       FUNCTIONS.—In taking such steps, the Secretary shall  
15       contract with a single entity that combines the fiscal  
16       intermediary and carrier functions in each area except  
17       where the Secretary finds that special regional or national  
18       contracts are appropriate.

19       (c) SUPERSEDING CONFLICTING REQUIREMENTS.—  
20       The provisions of sections 1816 and 1842 of the Social  
21       Security Act (including provider nominating provisions in  
22       such section 1816) are superseded to the extent required  
23       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

1           least \$6,300,000,000 from the amount of  
2           aggregate payments for such services that  
3           would otherwise have been made during  
4           the period.”.

5 **SEC. 6102. REDUCTION IN HOSPITAL OUTPATIENT SERV-**  
6                   **ICES THROUGH ESTABLISHMENT OF PRO-**  
7                   **SPECTIVE PAYMENT SYSTEM.**

8           (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-  
9           cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended  
10          by striking “section 1886)—” and all that follows and in-  
11          serting the following: “section 1886), an amount equal to  
12          a prospectively determined payment rate established by  
13          the Secretary that provides for payments for such items  
14          and services to be based upon a national rate adjusted  
15          to take into account the relative costs of furnishing such  
16          items and services in various geographic areas, except that  
17          for items and services furnished during cost reporting pe-  
18          riods (or portions thereof) in years beginning with 1997,  
19          such amount shall be equal to 90 percent of the amount  
20          that would otherwise have been determined;”.

21          (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
22          SYSTEM.—Not later than July 1, 1996, the Secretary of  
23          Health and Human Services shall establish the prospective  
24          payment system for hospital outpatient services necessary

1 to carry out section 1833(a)(2)(B) of the Social Security  
2 Act (as amended by subsection (a)).

3 (c) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to items and services furnished  
5 on or after January 1, 1997.

6 **SEC. 6103. INCREASE IN MEDICARE PART B PREMIUM FOR**  
7 **INDIVIDUALS WITH HIGH INCOME.**

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

11 **“PART VIII—MEDICARE PART B PREMIUMS FOR**  
12 **HIGH-INCOME INDIVIDUALS**

“Sec. 49B. Medicare part B premium tax.

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

14 “(a) IMPOSITION OF TAX.—In the case of an individ-  
15 ual to whom this section applies for the taxable year, there  
16 is hereby imposed (in addition to any other tax imposed  
17 by this subtitle) a tax for such taxable year equal to the  
18 aggregate of the Medicare part B premium taxes for each  
19 of the months during such year that such individual is  
20 covered by Medicare part B.

21 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—  
22 This section shall apply to any individual for any taxable  
23 year if—

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

3           “(2) the modified adjusted gross income of the  
4 taxpayer for such taxable year exceeds the threshold  
5 amount.

6           “(c) MEDICARE PART B PREMIUM TAX FOR  
7 MONTH.—

8           “(1) IN GENERAL.—The Medicare part B pre-  
9 mium tax for any month is the applicable percentage  
10 (as defined in paragraph (2)) of the amount equal  
11 to the excess of—

12                   “(A) 150 percent of the monthly actuarial  
13 rate for enrollees age 65 and over determined  
14 for that calendar year under section 1839(b) of  
15 the Social Security Act, over

16                   “(B) the total monthly premium under sec-  
17 tion 1839 of the Social Security Act (deter-  
18 mined without regard to subsections (b) and (f)  
19 of section 1839 of such Act).

20           “(2) PHASE-IN OF TAX.—If the modified ad-  
21 justed gross income of the taxpayer for any taxable  
22 years exceeds the threshold amount by—

23                   “(A) less than \$25,000, the applicable per-  
24 centage under this paragraph is 33 percent;

1           “(B) at least \$25,000, but less than  
2           \$50,000, the applicable percentage under this  
3           paragraph is 66 percent,

4           “(C) at least \$50,000, but less than  
5           \$75,000, the applicable percentage under this  
6           paragraph is 75 percent, or

7           “(D) at least \$75,000, the applicable per-  
8           centage under this paragraph is 100 percent.

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

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

13           “(A) except as otherwise provided in this  
14          paragraph, \$75,000,

15           “(B) \$100,000 in the case of a joint re-  
16          turn, and

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

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

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

23           “(2) MODIFIED ADJUSTED GROSS INCOME.—  
24          The term ‘modified adjusted gross income’ means  
25          adjusted gross income—

1           “(A) determined without regard to sections  
2           135, 911, 931, and 933, and

3           “(B) increased by the amount of interest  
4           received or accrued by the taxpayer during the  
5           taxable year which is exempt from tax.

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

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

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

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

18          (c) EFFECTIVE DATE.—The amendments made by  
19          this section shall apply to months after December 1995  
20          in taxable years ending after December 31, 1995.

1 **SEC. 6104. PHASED-IN ELIMINATION OF MEDICARE HOS-**  
2 **PITAL DISPROPORTIONATE SHARE ADJUST-**  
3 **MENT PAYMENTS.**

4 Section 1886(d)(5)(F) of the Social Security Act (42  
5 U.S.C. 1395ww(d)(5)(F)) is amended—

6 (1) in clause (i), by inserting “and before Sep-  
7 tember 30, 2000,” after “1986,”;

8 (2) in clause (ii), by striking “The amount of  
9 such payment” and inserting “Subject to clause (ix),  
10 the amount of such payment”; and

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

13 “(ix) The amount of the additional payment made  
14 under this paragraph for a discharge shall be equal to—

15 “(I) for discharges occurring during fiscal year  
16 1997, 80 percent of the amount otherwise deter-  
17 mined for the discharge under clause (ii);

18 “(II) for discharges occurring during fiscal year  
19 1998, 60 percent of the amount otherwise deter-  
20 mined for the discharge under clause (ii);

21 “(III) for discharges occurring during fiscal  
22 year 1999, 40 percent of the amount otherwise de-  
23 termined for the discharge under clause (ii); and

24 “(IV) for discharges occurring during fiscal  
25 year 2000, 20 percent of the amount otherwise de-  
26 termined for the discharge under clause (ii).”.



1 **SEC. 6105. IMPOSITION OF COINSURANCE ON LABORATORY**  
2 **SERVICES.**

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

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

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

11 (b) EFFECTIVE DATE.—The amendments made by  
12 subsection (a) shall apply to tests furnished on or after  
13 January 1, 1996.



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