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103D CONGRESS
2D SESSION

H. R. 3222

To contain health care costs and improve access to health care through accountable health plans and managed competition, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 6, 1993

Mr. COOPER (for himself, Mr. ANDREWS of Texas, Mr. GRANDY, Mr. KLUG, Mr. STENHOLM, Mrs. JOHNSON of Connecticut, Mr. PAYNE of Virginia, Mr. GUNDERSON, Mr. PETERSON of Florida, Mr. HOBSON, Mr. CARR of Michigan, Mr. HOUGHTON, Mr. MCCURDY, Mr. QUILLEN, Mr. BARCIA of Michigan, Mr. BOEHLERT, Mr. BROWDER, Mr. CLEMENT, Mr. CLINGER, Mr. DOOLEY, Mr. EDWARDS of Texas, Mr. EMERSON, Mrs. FOWLER, Mr. GILCHREST, Mr. GORDON, Mr. GOSS, Mr. HAYES, Mr. HORN, Mr. HUGHES, Mr. HUTTO, Mr. LAUGHLIN, Mrs. LLOYD, Ms. LONG, Mr. MCHALE, Mr. MCMILLAN, Mr. MACHTLEY, Mr. MILLER of Florida, Mr. MONTGOMERY, Mr. MORAN, Mr. NEAL of North Carolina, Mr. NUSSLE, Mr. ORTON, Mr. PARKER, Mr. PETRI, Mr. PORTER, Mr. SHAYS, Ms. SNOWE, Mr. TANNER, and Mr. TAUZIN) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, and the Judiciary

OCTOBER 27, 1993

Additional sponsor: Mr. SABO

JANUARY 27, 1994

Additional sponsors: Mr. SYNAR, Mr. KOLBE, Mr. MINGE, Mr. REGULA, Ms. ENGLISH of Arizona, Mr. CAMP, and Mr. WALSH

A BILL

To contain health care costs and improve access to health care through accountable health plans and managed competition, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Managed Competition Act of 1993''.

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

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) NEED FOR COST CONTAINMENT INCENTIVES.—The current health insurance marketplace is unable to provide efficient and effective health care coverage because—

(A) there is no organized method for price-based competition among health plans offering standardized benefits;

(B) there is no method by which health plans are held accountable for their performance in effectively and efficiently improving the health and well-being of their enrollees;

(C) the Internal Revenue Code not only provides no incentives for employees to select carefully among competing health plans on the basis of cost, but also provides incentives for employers and employees to select plans with greater expenses;

(D) health plans frequently manage costs through underwriting practices and favorable selection rather than through increased efficiencies in the provision of health care; and

(E) underwriting practices discriminate unfairly against individuals in need of health care.

(2) MANAGED COMPETITION.—

(A) The economy of the United States has been based on a model of competitive markets and the United States has successfully relied on this model in order to promote efficiencies and innovation in nearly every economic area.

(B) However, in order to provide for such a market in health care, there is a need to provide proper incentives to providers and purchasers in the market for health care.

(C) Only through such a reform will the country achieve the dual goals of maintaining high quality care, innovation, and consumer choice and of providing real incentives for cost containment.

(b) PURPOSE.—

(1) GENERAL OBJECTIVE.—It is the general objective of this Act to reform the health care market-

place to provide universal access to high quality, cost-effective care through competitive health plans.

(2) COST CONTAINMENT OBJECTIVE.—It is also a specific objective of this Act to bring the rate of increase in health care costs by the year 2000 down to the rate of increase in costs in the economy as a whole.

(3) SPECIFIC MEASURES TO ACHIEVE OBJECTIVES.—In order to—

(A) control costs through enhanced price competition, the Act extends tax benefits for employer contributions only to the lowest price of a qualifying plan in an area;

(B) promote competition based on cost-effective care instead of through risk selection, the Act standardizes benefits, prohibits experience rating, and adjusts premium payments to plans based on the risk characteristics of individuals enrolled in the plan;

(C) provide access to coverage, the Act makes available to all individuals competitively priced accountable health plans regardless of their employment status;

(D) to promote competition based on quality, the Act provides for the systematic report-

ing and public dissemination of information on the performance of plans in meeting the clinical health requirements, functional needs, well-being, and personal satisfaction of its enrollees; and

(E) improve health care coverage of low-income individuals, the Act offers financial assistance in purchasing accountable health plans and meeting cost-sharing requirements.

SEC. 3. GLOSSARY OF CERTAIN TERMS USED IN TITLES I AND II.

The following specialized, defined terms are used in titles I and II of this Act:

ACCOUNTABLE HEALTH PLAN; AHP.—The terms ''accountable health plan'' and ''AHP'' are defined in section 1701(b)(1).

APPLICABLE FEDERAL ASSISTANCE AMOUNT.—The term ''applicable Federal assistance amount'' is defined in section 2009(c)(1).

APPLICABLE LOW-INCOME PREMIUM AMOUNT.—The term ''applicable low-income premium amount'' is defined in section 2009(c)(2).

BASE FEDERAL PREMIUM AMOUNT.—The ''base Federal premium amount'' is defined in section 2005(a)(1).

BASE INDIVIDUAL PREMIUM.—The term ''base individual premium'' is defined in section 2009(c)(3).

BENEFITS, EVALUATIONS, AND DATA STANDARDS BOARD.—The term ''Benefits, Evaluations, and Data Standards Board'' refers to the Board established under section 1303.

CLOSED AND OPEN PLANS.—The terms ''closed'' and ''open'' are defined, with respect to a health plan, under section 1701(b)(4).

COMMISSION.—The term ''Commission'' is defined in section 1701(b)(2).

ELIGIBLE EMPLOYEE.—The term ''eligible employee'' is defined in section 1701(a)(2).

ELIGIBLE FAMILY MEMBER.—The term ''eligible family member'' is defined in section 1701(a)(3).

ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' is defined in section 1701(a)(1).

ELIGIBLE RESIDENT.—The term ''eligible resident'' is defined in section 1701(a)(4).

ENROLLEE UNIT.—The term ''enrollee unit'' is defined in section 1701(a)(5).

FAMILY ADJUSTED TOTAL INCOME.—The term ''family adjusted total income'' is defined in section 2009(b)(1).

HEALTH CARE JOINT VENTURE.—The term ''health care joint venture'' is defined in section 1232(i)(3).

HEALTH OUTCOME.—The term ''health outcome'' is defined in section 1302(b)(5)(B).

HEALTH PLAN STANDARDS BOARD.—The term ''Health Plan Standards Board'' refers to the Board established under section 1304.

HEALTH PLAN.—The term ''health plan'' is defined in section 1701(c)(1).

HPPC; HEALTH PLAN PURCHASING COOPERATIVE.—The terms ''health plan purchasing cooperative'' and ''HPPC'' are defined in section 1701(b)(3).

INDIVIDUAL RESPONSIBILITY PERCENTAGE.—The term ''individual responsibility percentage'' is defined in section 2009(c)(5).

INVESTIGATIONAL TREATMENT.—The term ''investigational treatment'' is defined in section 1302(b)(4)(B).

LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' is defined in section 2009(a)(1).

MEDICALLY APPROPRIATE.—The term ''medically appropriate'' is defined in section 1302(b)(1).

MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' is defined in section 1701(a)(6).

MEDICARE-ELIGIBLE INDIVIDUAL.—The term ''medicare-eligible individual'' is defined in section 1701(a)(6).

MODERATELY LOW-INCOME INDIVIDUAL.—The term ''moderately low-income individual'' is defined in section 2009(a)(2).

MODIFIED FAMILY INCOME.—The term ''modified family income'' is defined in section 2009(b)(2).

NETWORK PLAN.—The term ''network plan'' is defined in section 1208(b)(3)(D) and in section 1222(b)(1).

PARTICIPATING PROVIDER.—The term ''participating provider'' is defined in section 1222(b)(2).

PHYSICIAN INCENTIVE PLAN.—The term ''physician incentive plan'' is defined in section 1207(b)(2).

POVERTY LINE.—The term ''poverty line'' is defined in section 2009(c)(4).

PRE-EXISTING CONDITION.—The term ''pre-existing condition'' is defined in section 1204(b)(2)(B)(ii).

PREMIUM CLASS.—The term ''premium class'' is defined in section 1701(c)(3).

REFERENCE PREMIUM RATE.—The term ''reference premium rate'' is defined in section 2009(c)(4).

SECRETARY.—The term ''Secretary'' is defined in section 1701(c)(4).

SMALL EMPLOYER; LARGE EMPLOYER.—The terms ''small employer'' and ''large employer'' are defined in section 1701(c)(2).

SPECIALIZED CENTER OF CARE.—The term ''specialized center of care'' is defined in section 1308(d).

STATE-ADJUSTED POVERTY LEVEL DEFINED.—The term ''State-adjusted poverty level'' is defined in section 2009(b)(3)(A).

STATE.—The term ''State'' is defined in section 1701(c)(5).

TREATMENT.—The term ''treatment'' is defined in section 1302(b)(5)(A).

TYPE OF ENROLLMENT.—The term ''type of enrollment'' is defined in section 1701(c)(6).

UNIFORM SET OF EFFECTIVE BENEFITS.—The term ''uniform set of effective benefits'' is defined in section 1701(c)(7).

UTILIZATION REVIEW PROGRAM.—The term ''utilization review program'' is defined in section 1223(b).

VERY LOW-INCOME INDIVIDUAL.—The term ''very low-income individual'' is defined in section 2009(a)(3).

TITLE I—MANAGED COMPETITION IN EMPLOYER-BASED HEALTH PLANS: INCENTIVES TO CONTROL COSTS

Subtitle A—Use of Tax Incentives to Purchase Cost-Effective Plans

SEC. 1001. UNIFORM TAX DISINCENTIVE TO EFFECTIVELY LIMIT DEDUCTIBILITY OF EXCESS EMPLOYER HEALTH PLAN EXPENSES.

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

''SEC. 4980C. EMPLOYER HEALTH PLAN EXPENSES IN EXCESS OF ACCOUNTABLE HEALTH PLAN COSTS.

''(a) GENERAL RULE.—There is hereby imposed a tax equal to the product of the rate of tax specified in

section 11(b)(1)(C) and the amount of the excess health plan expenses of any employer.

''(b) EXCESS HEALTH PLAN EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'excess health plan expenses' means health plan expenses paid or incurred by the employer for any month with respect to any covered individual to the extent such expenses do not meet the requirements of paragraphs (2), (3), and (4).

''(2) LIMIT TO ACCOUNTABLE HEALTH PLANS.—Health plan expenses meet the requirements of this paragraph only if—

''(A) the expenses are attributable to coverage of the covered individual under an accountable health plan, and

''(B) in the case of a small employer, the expenses are attributable to payment to a health plan purchasing cooperative for coverage under an accountable health plan.

''(3) LIMIT ON PER INDIVIDUAL CONTRIBUTION.—

''(A) IN GENERAL.—Health plan expenses with respect to any covered individual meet the requirements of this paragraph for any month

only to the extent that the amount of such expenses does not exceed the reference premium rate (as defined in section 2009(c)(4) of the Managed Competition Act of 1993) for the month.

''(B) USE OF COMMUNITY RATE WITHIN TYPE OF ENROLLMENT OR ACROSS HPPC AREAS IN PLACE OF REFERENCE PREMIUM RATE FOR LARGE EMPLOYERS.—In the case of an employer that is not a small employer and which maintains a closed AHP (as defined in section 1701(b)(4)(A)) that elects certain rules to apply under section 1205(b)(3) of the Managed Competition Act of 1993, the reference premium rate amount for a covered individual shall be computed based on the weighted average of such amounts within the type of enrollment or across HPPC areas, as elected under such section.

''(C) TREATMENT OF HEALTH PLANS OUTSIDE THE UNITED STATES.—For purposes of subparagraph (A), in the case of a covered individual residing outside the United States, there shall be substituted for the reference premium rate such reasonable amounts as the Health

Care Standards Commission determines to be comparable to the limit imposed under subparagraph (A) or subparagraph (B) (if applicable).

''(4) REQUIREMENT OF LEVEL CONTRIBUTION.—Health plan expenses meet the requirements of this paragraph for any month only if the amount of the employer contribution (for a premium class) does not vary based on the accountable health plan selected.

''(c) EXCEPTION FOR MEDICARE-ELIGIBLE RETIREES.—Subsections (a) and (b) shall not apply to health plan expenses with respect to an individual who is eligible for benefits under part A of title XVIII of the Social Security Act if such expenses are for a health plan that is not a primary payor under section 1862(b) of such Act.

''(d) SPECIAL RULES.—

''(1) TREATMENT OF SELF-INSURED PLANS.—In the case of a self-insured health plan, the amount of contributions per employee shall be determined for purposes of subsection (b)(3) in accordance with rules established by the Health Care Standards Commission which are based on the principles of section 4980B(f)(4)(B) (as in effect before the date of the enactment of this Act).

''(2) CONTRIBUTIONS TO CAFETERIA PLANS.—Contributions under a cafeteria plan on behalf of an employee that are used for a group health plan coverage shall be treated for purposes of this section as health plan expenses paid or incurred by the employer.

''(e) EMPLOYEES HELD HARMLESS.—Nothing in this section shall be construed as affecting the exclusion from gross income of an employee under section 106.

''(f) OTHER DEFINITIONS.—For purposes of this section—

''(1) COVERED INDIVIDUAL.—The term 'covered individual' means any beneficiary of a group health plan.

''(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1), but does not include, as defined by the Health Care Standards Commission, health coverage under a disability or accident policy or under a workers' compensation plan.

''(3) HEALTH PLAN EXPENSES.—

''(A) IN GENERAL.—The term 'health plan expenses' means employer expenses for any group health plan, including expenses for pre-

miums as well as payment of deductibles and coinsurance that would otherwise be applicable.

''(B) EXCLUSION OF CERTAIN DIRECT EXPENSES.—Such term does not include expenses for direct services which are determined by the Health Care Standards Commission to be primarily aimed at workplace health care and health promotion or related population-based preventive health activities.

''(4) SMALL EMPLOYER.—The term 'small employer' means, for a taxable year, an employer that is a small employer (within the meaning of section 1701(c)(2) of the Managed Competition Act of 1993) for the most recent calendar year ending before the end of the taxable year.

''(5) TYPE OF ENROLLMENT.—The term 'type of enrollment' is described in section 1701(c)(6) of the Managed Competition Act of 1993.''

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

''Sec. 4980C. Employer health plan expenses in excess of accountable health plan costs.''

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by

this section shall apply to expenses incurred for the provision of health services for periods after December 31, 1994.

(2) TRANSITION FOR COLLECTIVE BARGAINING AGREEMENTS.—The amendments made by this section shall not apply to employers with respect to their employees, insofar as such employees are covered under a collective bargaining agreement ratified before the date of the enactment of this Act, earlier than the date of termination of such agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or January 1, 1997, whichever is earlier.

SEC. 1002. INCREASE IN DEDUCTION FOR HEALTH PLAN PREMIUM EXPENSES OF SELF-EMPLOYED INDIVIDUALS.

(a) INCREASING DEDUCTION TO 100 PERCENT.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended by striking ''25 percent of''.

(b) MAKING PROVISION PERMANENT.—Subsection (l) of section 162 of such Code (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(c) LIMITATION TO ACCOUNTABLE HEALTH PLANS.—Paragraph (2) of section 162(l) of such Code is

amended by adding at the end thereof the following new paragraph:

''(3) DEDUCTION LIMITED TO ACCOUNTABLE HEALTH PLAN COSTS.—No deduction shall be allowed under this section for any amount which would be excess health plan expenses (as defined in section 4980C(b), determined without regard to paragraph (4) thereof) if the taxpayer were a small employer.''

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1994.

(2) EXCEPTION.—The amendment made by subsection (c) shall apply to expenses for periods of coverage beginning on or after January 1, 1995.

SEC. 1003. DEDUCTION FOR HEALTH PLAN PREMIUM EXPENSES OF INDIVIDUALS.

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

''(g) SPECIAL RULES FOR HEALTH PLAN PREMIUM EXPENSES.—

''(1) IN GENERAL.—The deduction under subsection (a) shall be determined without regard to the limitation based on adjusted gross income with respect to amounts paid for premiums for coverage under an accountable health plan.

''(2) LIMITS.—

''(A) LIMIT IN AMOUNT.—The amount allowed as a deduction under paragraph (1) with respect to the cost of providing coverage for any individual shall not exceed the applicable limit specified in section 4980C(b)(3) reduced by the aggregate amount paid by all other entities (including any employer or any level of government) for coverage of such individual under any health plan.

''(B) LIMIT TO HPPC PLANS.—

''(i) IN GENERAL.—The deduction under this subsection shall be allowed only in the case of an individual who obtains coverage under an accountable health plan through a health plan purchasing cooperative.

''(ii) EXCEPTION FOR EMPLOYEES OF LARGE EMPLOYERS.—Clause (i) shall not apply to an individual who obtains cov-

erage in an accountable health plan by virtue of the individual's (or other person's) employment by a large employer.

''(3) DEDUCTION ALLOWED AGAINST GROSS INCOME.—The deduction under this subsection shall be taken into account in determining adjusted gross income under section 62(a).

''(4) TREATMENT OF MEDICARE PROGRAM.—Coverage under part A or part B of title XVIII of the Social Security Act shall not be considered for purposes of this subsection to be coverage under an accountable health plan.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994, and taxable years ending after such date.

SEC. 1004. EXCLUSION FROM GROSS INCOME FOR CONTRIBUTIONS BY A PARTNERSHIP OR S CORPORATION TO A HEALTH PLAN COVERING ITS PARTNERS OR SHAREHOLDERS.

(a) S CORPORATIONS.—Section 1372 of the Internal Revenue Code of 1986 (relating to partnership rules to apply for fringe benefit purposes) is amended by adding at the end thereof the following new subsection:

''(c) EXCEPTION FOR COVERAGE PROVIDED UNDER SUBSIDIZED ACCIDENT OR HEALTH PLAN.—This section

shall not apply to coverage under a subsidized accident or health plan maintained by the S corporation for its employees.''

(b) PARTNERSHIPS.—Section 707 of such Code (relating to transactions between partner and partnership) is amended by adding at the end thereof the following new subsection:

''(d) EXCLUSION FOR COVERAGE PROVIDED UNDER SUBSIDIZED ACCIDENT OR HEALTH PLAN.—In the case of coverage under a subsidized accident or health plan maintained by a partnership for its partners, for purposes of sections 104, 105, 106, and 162(l)(2)(B), the partnership shall be treated as the employer of each partner who is an employee within the meaning of section 401(c)(1).''

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

SEC. 1005. EMPLOYER OBLIGATIONS.

(a) SMALL EMPLOYERS.—Each small employer (as defined in section 1701(c)(2)) shall—

(1) have in effect an agreement described in section 1103 with the health plan purchasing cooperative (requiring the offering to employees of coverage through accountable health plans) for the

HPPC area in which the employer has its principal place of business, and

(2) comply with such agreement.

(b) OTHER EMPLOYERS.—

(1) IN GENERAL.—Each employer that is not a small employer shall—

(A) offer to each employee (in a time and manner specified by the Health Care Standards Commission) enrollment in a qualifying accountable health plan (as defined in paragraph (3)) both on an individual basis, and, if applicable and at the employee's option, on a family basis; and

(B) provide, at the option of the employee, for deduction from wages or other compensation (in the manner specified in section 1103(c)) of amount of any premiums due for such enrollment (taking into account the amount of any employer contribution).

(2) OPEN ENROLLMENT PERIODS.—For purposes of paragraph (1)(A), the Commission shall provide for—

(A) initial enrollment periods (of not less than 30 days) during which newly employed in-

dividuals are offered enrollment under a qualifying accountable health plan;

(B) an annual open enrollment period (of not less than 30 days) in which employees are offered enrollment under a qualifying accountable health plan (and, if there is a choice among such plans, the opportunity to change the plan in which the employee is enrolled); and

(C) special enrollment periods during which, because of a change in family situation (such as marriage, birth or adoption of a child, divorce, separation, or death), the employee is offered the opportunity to change the type of enrollment provided.

(3) QUALIFYING ACCOUNTABLE HEALTH PLAN.—For purposes of this subsection, the term ''qualifying accountable health plan'' means, with respect to an employee, an accountable health plan—

(A) that serves the area in which the employee resides, and

(B) for which the premium charged to the employee for a premium class does not exceed (except as provided in paragraph (4)) the premium of the least expensive accountable health plan offered to individuals by a health plan pur-

chasing cooperative in the HPPC area in which the employee resides for that premium class.

Nothing in this subsection shall be construed as preventing an employer from offering, or an employee from electing enrollment in, a health plan that serves the area in which the employee is employed, rather than the area in which the employee resides.

(4) SPECIAL RULE FOR CERTAIN CLOSED AHPS ELECTING SPECIAL COMMUNITY RATING.—In the case of a closed AHP offered to an employee, if the plan has made an election described in section 1205(b)(3), paragraph (3)(B) shall be applied to the plan based on the weighted average of premiums determined without regard to age, HPPC area, or both (as elected under such section), rather than on the basis of premium class.

(c) NONDISCRIMINATION UNDER GROUP HEALTH PLANS.—

(1) APPLICATION OF RULES SIMILAR TO MEDICARE NONDISCRIMINATION RULES.—Subject to paragraph (2), the provisions of paragraphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of section 1862(b) of the Social Security Act shall apply to an individual eligible for low-income assistance under subtitle A of title II in the same manner as such

provisions apply to an individual age 65 or over who is entitled to benefits under title XVIII of such Act under section 226(a) of such Act.

(2) RULES OF APPLICATION.—In applying paragraph (1) under this Act—

(A) in applying clauses (ii) and (iii) of section 1862(b)(1)(A) of the Social Security Act, any reference to ''20 or more employees'' is deemed a reference to ''5 or more employees'';

(B) clause (iv) of section 1862(b)(1)(A) of such Act shall not apply; and

(C) any reference to title XVIII of such Act is deemed a reference to assistance under subtitle A of title II of this Act.

(d) ENFORCEMENT.—

(1) CIVIL MONEY PENALTIES.—

(A) SMALL EMPLOYER AGREEMENTS.—Failure to have in effect or comply with an agreement under subsection (a)(1)(A) is subject to a civil monetary penalty (not to exceed $500) for each day in which the violation continues.

(B) FAILURE TO OFFER COVERAGE OR PROVIDE FOR WAGE DEDUCTION.—Failure to offer coverage or provide for deduction from wages required under subsection (b)(1) is sub-

ject to a civil monetary penalty (not to exceed $500) for each day in which the violation continues.

(C) VIOLATION OF NONDISCRIMINATION REQUIREMENTS.—Failure to comply with the requirement of subsection (c) is subject to a civil monetary penalty (not to exceed $500) for each day for each individual with respect to which the failure occurs.

(2) DIRECT ENFORCEMENT.—

(A) HPPC AGREEMENT.—An agreement in effect between a small employer and a HPPC is directly enforceable by civil action by the HPPC or by an employee (as a third-party beneficiary of the agreement). In any such action, if the HPPC or employee substantially prevails, the HPPC or employee is entitled to reasonable attorneys' fees.

(B) OFFER.—The obligation to offer coverage under subsection (b) with respect to an employee is directly enforceable by civil action by the employee. In any such action, if the employee substantially prevails, the employee is entitled to reasonable attorneys' fees.

SEC. 1006. ENCOURAGING GROUP PURCHASING FOR LARGE EMPLOYER BY ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

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

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

(2) by adding at the end the following:

''(B) Any determination of whether a health plan maintained by one or more large employers (within the meaning of section 1701(c)(2) of the Managed Competition Act of 1993) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if the plan is an accountable health plan (as defined in section 1701(b)(1) of such Act).''

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1994.

SEC. 1007. SIMPLIFYING FILING OF REPORTS BY PERMITTING SINGLE ANNUAL FILING FOR ALL EMPLOYERS COVERED UNDER AN INSURED MULTIPLE EMPLOYER HEALTH PLAN.

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

''(c) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are covered under the same fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulations).''.

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

Subtitle B—Health Plan Purchasing Cooperatives (HPPCs)

SEC. 1101. ESTABLISHMENT AND ORGANIZATION; HPPC AREAS.

(a) HPPC AREAS.—

(1) IN GENERAL.—For purposes of carrying out this title, subject to paragraphs (2) and (3), each State shall be considered a HPPC area.

(2) ALTERNATIVE, INTRASTATE AREAS.—Each State may provide for the division of the State into HPPC areas so long as—

(A) all portions of each metropolitan statistical area in a State are within the same HPPC area, and

(B) the number of eligible individuals residing within a HPPC area is not less than 250,000.

(3) ALTERNATIVE, INTERSTATE AREAS.—In accordance with rules established by the Health Care Standards Commission, one or more contiguous States may provide for the establishment of a HPPC area that includes adjoining portions of the States so long as such area, if it includes any part of a metropolitan statistical area, includes all of such area. In the case of a HPPC serving a multi-state

area, section 1701(c)(2)(C) shall only apply to the area if all the States encompassed in the area by law agree to the number to be substituted.

(b) ESTABLISHMENT OF HPPCS.—

(1) IN GENERAL.—Each State shall provide, by legislation or otherwise, for the establishment by not later than July 1, 1994, as a not-for-profit corporation, with respect to each HPPC area (specified under subsection (a)) of a health plan purchasing cooperative (each in this title referred to as a ''HPPC'').

(2) INTERSTATE HPPC AREAS.—HPPCs with respect to interstate areas specified under subsection (a)(3) shall be established in accordance with rules of the Health Care Standards Commission.

(c) COOPERATIVE BOARD.—

(1) ESTABLISHMENT.—Each HPPC shall be governed by a Cooperative Board which shall be initially appointed by the Governor or other chief executive officer of the State (or as otherwise provided under State law or by the Health Care Standards Commission in the case of a HPPC described in subsection (b)(2)). The Cooperative Board for a HPPC shall be responsible for ensuring the performance of the duties of the HPPC under subsection (d).

(2) ELECTION.—By not later than January 1, 1996, each HPPC shall provide under State law (or in the case of a HPPC described in subsection (b)(2), under rules established by the Health Care Standards Commission) for the election of members to the Cooperative Board from among eligible individuals who are enrolled in an accountable health plan offered by the HPPC and who do not receive remuneration from the HPPC or any such accountable health plan for any services provided.

(3) LIMITATION ON COMPENSATION.—A HPPC shall not provide compensation to members of the Cooperative Board other than reimbursement for reasonable and necessary expenses incurred in the performance of their duties as members of the Cooperative Board.

(d) DUTIES OF HPPCS.—

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

(A) enter into agreements with accountable health plans under section 1102;

(B) enter into agreements with small employers under section 1103;

(C) offer enrollment and enroll individuals under accountable health plans, in accordance with section 1104;

(D) charge, receive, and forward adjusted premiums, in accordance with section 1105, including reconciling low-income assistance among accountable health plans;

(E) provide for coordination with other HPPCs, in accordance with section 1106;

(F) provide for establishment of a complaint process and appointment of an ombudsman, in accordance with section 1107;

(G) conduct and analyze surveys of enrollee satisfaction and monitor enrollee disenrollment, in accordance with section 1108; and

(H) carry out other functions provided for under this title.

(2) LIMITATION ON ACTIVITIES.—A HPPC shall not—

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

(B) except as specifically provided under sections 1102, 1105, or 1106(c), perform any

activity (including review, approval, or enforcement) relating to premium rates for health plans;

(C) perform any activity (including registration or enforcement) relating to compliance of accountable health plans with the requirements of part 1 of subtitle C (other than as required to carry out its specific duties under this subtitle or under section 1305(c)(2));

(D) discriminate among such plans, other than on the basis of the performance of such plans under this title, as determined in accordance with standards established by the Health Care Standards Commission under this title;

(E) assume financial risk in relation to any such plan; or

(F) perform other activities identified by the Health Care Standards Commission as being inconsistent with the performance of its duties under paragraph (1).

(e) PERFORMANCE OF DUTIES.—

(1) IN GENERAL.—If the Health Care Standards Commission finds that a HPPC is not carrying out its duties as required under subsection (d), the Commission shall notify the Cooperative Board of

the HPPC, and the Governor (or other chief executive officer) of each State in which the HPPC operates, of such finding and permit the Board an opportunity to take such action as may be necessary for the HPPC to carry out such duties.

(2) CORRECTIVE ACTION.—If, after such an opportunity, the deficiency has not been corrected, the Health Care Standards Commission may—

(A) order the HPPC to hold a new election for members of the Cooperative Board, and

(B) take such other action as may be appropriate in order to assure the performance of such duties.

(3) PERFORMANCE CRITERIA.—

(A) DEVELOPMENT.—The Health Care Standards Commission shall develop criteria relating to HPPC performance of duties. Such criteria shall include criteria relating to the following:

(i) OVERHEAD.—The HPPC overhead percentage (computed under section 1105(b)(2)) for the HPPC.

(ii) FLOAT.—The average period (described in section 1102(d)(2)) between the

HPPC's receipt and payment of funds received.

(iii) SATISFACTION OF ELIGIBLE INDIVIDUALS.—The satisfaction of eligible individuals with the performance of the HPPC (as measured under surveys under section 1108).

(iv) ENROLLMENT OF AT RISK INDIVIDUALS.—The effectiveness of the HPPC's activities under section 1102(b)(3) in enrolling individuals who are eligible for low-income assistance or who reside in medically underserved areas.

(B) REPORT.—Each HPPC shall report to the Health Care Standards Commission, at such time and in such manner as the Commission specifies, such information as the Commission may require in order to evaluate the performance of the HPPC in accordance with the criteria developed under subparagraph (A).

(C) PUBLICATION.—The Health Care Standards Commission shall publish annually a report that provides a comparison of the relative performance of each HPPC, based on such criteria.

(f) EDUCATION AND DEVELOPMENT GRANTS.—There are authorized to be appropriated $25,000,000 for fiscal year 1994 for grants to assist States in the development of HPPCs.

SEC. 1102. AGREEMENTS WITH ACCOUNTABLE HEALTH PLANS (AHPS).

(a) AGREEMENTS.—

(1) OPEN AHPS.—Each HPPC for a HPPC area shall enter into an agreement under this section with each open accountable health plan (described in section 1701(b)(4)(B)) that serves residents of the area. Each such agreement under this section shall include (as specified by the Health Care Standards Commission) provisions consistent with the requirements of the succeeding subsections of this section. A HPPC may not terminate such an agreement except as provided in paragraph (3)(A).

(2) CLOSED AHPS.—Each HPPC for a HPPC area shall enter into a special agreement under this paragraph with each closed AHP that serves residents of the area, in order to carry out subsection (e). Except as otherwise specifically provided, any reference in this Act to an agreement under this section shall not be considered to be a reference to an agreement under this paragraph.

(3) TERMINATION OF AGREEMENT.—In accordance with regulations of the Health Care Standards Commission—

(A) the HPPC may terminate an agreement under paragraph (1) or (2) if—

(i) the AHP's registration under part 1 of subtitle C is revoked, or

(ii) the AHP is determined (in accordance with rules established by the Commission) substantially to have violated the conditions of such agreement; and

(B) the AHP may terminate either such agreement only upon sufficient notice in order to provide for the orderly enrollment of enrollees under other AHPs.

The Commission shall establish a process for the termination of agreements under this paragraph.

(b) OFFER OF ENROLLMENT OF INDIVIDUALS.—

(1) IN GENERAL.—Under an agreement under this section between an AHP and a HPPC, the HPPC shall offer, on behalf of the AHP, enrollment in the AHP to eligible individuals (as defined in section 1701(a)(1)) at the applicable monthly premium rates (specified under section 1105(a)).

(2) TIMING OF OFFER.—The offer of enrollment shall be available—

(A) to eligible individuals who are employees of small employers, during the 30-day period beginning on the date of commencement of employment, and

(B) to other eligible individuals, at such time (including an annual open enrollment period specified by the Health Care Standards Commission) as the HPPC shall specify, consistent with section 1104(b).

(3) OUTREACH.—In carrying out the responsibilities under paragraph (1), a HPPC shall perform such activities, including outreach, as may be necessary to seek actively the enrollment of eligible individuals, including individuals who are eligible for low-income assistance or who reside in medically underserved areas.

(c) RECEIPT OF GROSS PREMIUMS.—

(1) IN GENERAL.—Under an agreement under this section between a HPPC and an AHP, payment of premiums shall be made, by individuals or employers on their behalf, directly to the HPPC for the benefit of the AHP.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums shall be payable on a monthly basis (or, at the option of an eligible individual described in paragraph (2)(B), on a quarterly basis). The HPPC may provide for penalties and grace periods for late payment.

(3) AHPS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a HPPC any risk associated with failure to make prompt payment of premiums (other than the portion of the premium representing the HPPC overhead amount). Each eligible individual who enrolls with an AHP through the HPPC is liable to the AHP for premiums.

(d) FORWARDING OF ADJUSTED PREMIUMS.—

(1) IN GENERAL.—Under an agreement under this section between an AHP and a HPPC, subject to section 1205(c), the HPPC shall forward to each AHP in which an eligible individual in an enrollee unit has been enrolled an amount equal to the sum of—

(A) the standard premium rate (established under section 1205) received for the premium class, and

(B) the product of (i) the lowest standard premium rate offered by an open AHP for the premium class, and (ii) a risk-adjustment factor (determined and adjusted in accordance with section 1306(b)) for the enrollee unit.

(2) PAYMENTS.—Payments shall be made by the HPPC under this subsection within a period (specified by the Health Care Standards Commission and not to exceed 3 business days) after the time of receipt of the premium from the employer of the eligible individual or the eligible individual, as the case may be, based on estimates of applicable risk-adjustment factors. Subsequent payments shall be adjusted as appropriate to reflect differences between the payments that were made based on estimates and the payments that should have been made based on reported (and audited) information.

(3) ADJUSTMENTS FOR DIFFERENCES IN NONPAYMENT RATES.—In accordance with rules established by the Health Care Standards Commission, each agreement between an AHP and a HPPC under this section shall provide that, if a HPPC determines that the rates of nonpayment of premiums during grace periods established under subsection (c)(2) vary appreciably among AHPs, the HPPC

shall provide for such adjustments in the payments made under this subsection as will place each AHP in the same position as if the rates of nonpayment were the same.

(e) RECONCILIATION OF LOW-INCOME ASSISTANCE AMONG ACCOUNTABLE HEALTH PLANS.—

(1) IN GENERAL.—Each agreement between an AHP and a HPPC under this section (including a special agreement entered into under subsection (a)(2)) shall provide for such payments from the AHP to the HPPC, and such payments from the HPPC to the AHP, as the Health Care Standards Commission determines is necessary in order to assure the equitable distribution among all AHPs, nationwide, of reductions in premiums and cost-sharing under section 1205(c) and section 1202(c), respectively.

(2) INTER-HPPC COORDINATION.—For inter-HPPC coordination of reconciliation processes under paragraph (1), see section 1106(c).

(f) NOTICE OF DISENROLLMENT.—Within 3 business days after receiving a notice of disenrollment of an individual from an AHP offered by a HPPC, the HPPC shall notify the AHP of such notice.

(g) LIMITATION ON EMPLOYMENT.—An AHP agrees not to employ (or enter into a consulting or similar contract with) any individual who was, within the previous 2 years, an employee of the HPPC with which the AHP has an agreement in effect under this section.

(h) STANDARDS FOR OPERATIONAL SOFTWARE.—The Health Care Standards Commission shall establish standards for operational software that may be used by HPPCs and AHPs in carrying out agreements under this section.

SEC. 1103. AGREEMENTS WITH SMALL EMPLOYERS.

(a) IN GENERAL.—Each HPPC for a HPPC area shall enter into an agreement under this section with each small employer that employs individuals in the area. Each agreement under this section, between a small employer and a HPPC shall include (as specified by the Health Care Standards Commission) provisions consistent with the requirements specified in the succeeding subsections of this section.

(b) FORWARDING INFORMATION ON ELIGIBLE EMPLOYEES.—

(1) IN GENERAL.—Under an agreement under this section between a small employer and a HPPC, the employer must forward to the appropriate HPPC the name and address (and other identifying

information required by the HPPC) of each employee (including part-time and seasonal employees).

(2) APPROPRIATE HPPC.—In this subsection, the term ''appropriate HPPC'' means the HPPC for the principal place of business of the employer or (at the option of an employee) the HPPC serving the place of residence of the employee.

(c) PAYROLL DEDUCTION.—

(1) IN GENERAL.—Under an agreement under this section between a small employer and a HPPC, if the HPPC notifies the employer that an eligible employee is enrolled in an AHP through the HPPC, the employer shall provide for—

(A) the deduction, from the employee's wages or other compensation, of the amount of the premium due (less the amount of any employer contribution), and

(B) payment of such amount (including any such contribution) to the HPPC.

In the case of an employee who is paid wages or other compensation on a monthly or more frequent basis, an employer shall not be required to provide for payment of amounts to a HPPC other than at the same time at which the amounts are deducted from wages or other compensation. In the case of an

employee who is paid wages or other compensation less frequently than monthly, an employer may be required to provide for payment of amounts to a HPPC on a monthly basis.

(2) ADDITIONAL PREMIUMS.—If the sum of the amount of the employer contribution and the amount withheld under paragraph (1) is not sufficient to cover the entire cost of the premiums, the employee shall be responsible for paying directly to the HPPC the difference between the amount of such premiums and such sum.

(d) LIMITED EMPLOYER OBLIGATIONS.—Nothing in this section shall be construed as—

(1) requiring an employer to provide directly for enrollment of eligible employees under an accountable health plan or other health plan,

(2) requiring an employer to make, or preventing an employer from making, information about such plans available to such employees, or

(3) requiring an employer to make, or preventing an employer from making, an employer contribution for coverage of such individuals under such a plan.

SEC. 1104. ENROLLING INDIVIDUALS IN ACCOUNTABLE HEALTH PLANS THROUGH A HPPC.

(a) OFFER OF ENROLLMENT.—

(1) IN GENERAL.—Each HPPC shall offer in accordance with this section eligible individuals the opportunity to enroll in an AHP for the HPPC area in which the individual resides.

(2) FREEZING ENROLLMENT IN INSOLVENT PLANS.—If a State superintendent of insurance, State insurance commissioner, or other State official with regulatory authority over an AHP has determined that the AHP is insolvent, a HPPC may discontinue offering enrollment in the AHP to individuals not previously enrolled in the plan.

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—Each HPPC shall establish an enrollment (and disenrollment) process in accordance with rules established by the Health Care Standards Commission consistent with this subsection.

(2) INITIAL ENROLLMENT PERIOD.—For each eligible individual, at the time the individual first becomes an eligible individual in a HPPC area of a HPPC, there shall be an initial enrollment period (of not less than 30 days) during which the individual may enroll in an AHP.

(3) GENERAL ENROLLMENT PERIOD.—Each HPPC shall establish an annual period, of not less than 30 days, during which eligible individuals may enroll in an AHP or change the AHP in which the individual is enrolled.

(4) SPECIAL ENROLLMENT PERIODS.—In the case of individuals who—

(A) through marriage, divorce, birth or adoption of a child, or similar circumstances, experience a change in family composition, or

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

each HPPC shall provide for a special enrollment period in which the individual is permitted to change the individual or family basis of coverage or the AHP in which the individual is enrolled. The circumstances under which such special enrollment periods are required and the duration of such periods shall be specified by the Health Care Standards Commission.

(5) TRANSITIONAL ENROLLMENT PERIOD.—Each HPPC shall provide for a special transitional enrollment period (during a period beginning in the Fall of 1994 specified by the Health Care Standards

Commission) during which eligible individuals may first enroll.

(6) NO DUPLICATE ENROLLMENT.—No HPPC shall permit an individual to be enrolled in more than one AHP at a time.

(7) INDIVIDUAL ENROLLMENT OF FAMILY MEMBERS PERMITTED.—Nothing in this section shall be construed as preventing an eligible individual who is an eligible family member of an eligible employee or other principal enrollee from electing to enroll on an individual basis in a plan.

(c) ANALYSIS AND DISTRIBUTION OF COMPARATIVE INFORMATION.—

(1) ANALYSIS OF INFORMATION.—Each HPPC shall analyze the information reported under section 1203(a) on AHPs for which the HPPC is offering enrollment (and may analyze such information on closed AHPs serving residents of the HPPC area) in order to distribute the information under paragraph (2) in a form, consistent with section 1307(a)(2), that permits the direct comparison of different AHPs on the basis of the ability of the AHPs—

(A) to maintain and improve clinical health, functional status, and well-being, and

(B) to satisfy enrolled individuals.

Such comparison may also be made to show changes in the performance of AHPs over time.

(2) DISTRIBUTION OF INFORMATION.—

(A) IN GENERAL.—Each HPPC shall distribute, to eligible individuals and employers, information, in comparative form, on the prices, health outcomes, and enrollee satisfaction of the different AHPs for which it is offering enrollment and may provide other information pertaining to the quality of such AHPs. Such distribution shall occur at least annually before each general enrollment period. Each HPPC also shall make such information available to other interested persons.

(B) ADDITIONAL INFORMATION.—Such information shall include—

(i) a summary of the analysis of information collected under paragraph (1) and information collected under section 1108(a)(2), and

(ii) a breakdown of the portion of AHP premiums attributable to the HPPC overhead amount (specified under section 1105(b)(3)).

(d) PERIOD OF COVERAGE.—

(1) INITIAL ENROLLMENT PERIOD.—In the case of an eligible individual who enrolls with an AHP through a HPPC during an initial enrollment period, coverage under the plan shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the Health Care Standards Commission shall specify.

(2) GENERAL ENROLLMENT PERIODS.—In the case of an eligible individual who enrolls with an AHP through a HPPC during a general enrollment period, coverage under the plan shall begin on the first day of the first month beginning at least 15 days after the end of such period.

(3) SPECIAL ENROLLMENT PERIODS.—

(A) IN GENERAL.—In the case of an eligible individual who enrolls with an AHP during a special enrollment period described in subsection (b)(4), coverage under the plan shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the Commission shall specify, except that coverage of family members shall begin as soon as possible on or

after the date of the event that gives rise to the special enrollment period.

(B) TRANSITIONAL SPECIAL ENROLLMENT PERIOD.—In the case of an eligible individual who enrolls with an AHP during the transitional special enrollment period described in subsection (b)(5), coverage under the plan shall begin on January 1, 1995.

(4) MINIMUM PERIOD OF ENROLLMENT.—In order to avoid adverse selection, each HPPC may require, consistent with rules of the Health Care Standards Commission, that enrollments with AHPs be for not less than a specified minimum enrollment period (with exceptions permitted for such exceptional circumstances as the Commission may recognize).

SEC. 1105. RECEIPT OF PREMIUMS.

(a) ENROLLMENT CHARGE.—The amount charged by a HPPC for coverage under an AHP in a HPPC area is equal to the sum of—

(1) the amount of the premium applicable to the individual under section 1205(a)(1)(B) for such coverage, and

(2) the HPPC overhead amount established under subsection (b)(3) for enrollment of individuals in the HPPC area.

(b) HPPC OVERHEAD AMOUNT.—

(1) HPPC BUDGET.—Each HPPC shall establish a budget for each year for each HPPC area in accordance with regulations established by the Health Care Standards Commission.

(2) HPPC OVERHEAD PERCENTAGE.—The HPPC shall compute for each HPPC area an overhead percentage which, when applied for each enrollee unit (whether enrolled on a family or individual basis) to the weighted average of the standard premium amounts for premium classes for enrollment on an individual basis (taking into account any reduction in premiums attributable to low-income assistance under section 2002), will provide for revenues equal to the budget for the HPPC area for the year. Such percentage may in no case exceed 1 percentage point.

(3) HPPC OVERHEAD AMOUNT.—The HPPC overhead amount for enrollment, whether on an individual or family basis, in an AHP for a HPPC area for a month is equal to the applicable HPPC overhead percentage (computed under paragraph (2))

multiplied by the weighted average of the standard premium amounts for premium classes for enrollment on an individual basis under the AHP for the month (taking into account any reduction in premiums attributable to low-income assistance under section 2002).

SEC. 1106. COORDINATION AMONG HPPCS.

(a) IN GENERAL.—The Health Care Standards Commission shall establish rules consistent with this section for—

(1) coordination among HPPCs in cases where small employers are located in one HPPC area and their employees reside in a different HPPC area (and are eligible for enrollment with AHPs located in the other area), and

(2) coordination among HPPCs in the low-income assistance reconciliation processes under section 1102(e)(1).

The Commission shall establish standards for operational software in order to promote coordination among HPPCs under this title.

(b) COORDINATION RULES.—Under the rules established under subsection (a)(1)—

(1) HPPC FOR EMPLOYER.—The HPPC for the principal place of business of a small employer shall be responsible—

(A) for providing information to the employer's employees on AHPs for areas in which employees reside;

(B)(i) for enrolling employees under the AHP selected (even if the AHP selected is not in the same HPPC area as the HPPC) and (ii) if the AHP chosen is not in the same HPPC area as the HPPC, for forwarding the enrollment information to the HPPC for the area in which the AHP selected is located; and

(C) in the case of premiums to be paid through payroll deduction, or employer contribution, or both, to receive such premiums and forward them to the HPPC for the area in which the AHP selected is located.

(2) HPPC FOR EMPLOYEE RESIDENCE.—The HPPC for the HPPC area in which an employee resides shall be responsible for providing other HPPCs with information concerning AHPs being offered in such HPPC area.

(c) COORDINATION OF RECONCILIATION OF LOW-INCOME ASSISTANCE.—Under the rules established under

subsection (a)(2), the Commission shall provide for such payments among the different HPPCs as the Commission determines is necessary in order to assure the equitable distribution among AHPs in different HPPC areas of adjustments in premiums and cost-sharing under section 1205(c) and section 1202(c), respectively.

SEC. 1107. COMPLAINT PROCESS; OMBUDSMAN.

(a) COMPLAINT PROCESS.—Each HPPC shall establish a process for the receipt and disposition of complaints regarding the performance of its duties.

(b) OMBUDSMAN.—

(1) IN GENERAL.—Each HPPC shall provide—

(A) for the appointment of an ombudsman, and

(B) for a reasonable salary and staff for the ombudsman.

(2) DUTIES AND AUTHORITIES.—Each ombudsman shall have the duty and authority to do the following:

(A) RELATING TO HPPCS.—(i) To investigate complaints regarding the failure of a HPPC to perform its duties.

(ii) To assist AHPs and eligible individuals in resolving grievances with the HPPC.

(iii) To issue public reports and reports to the Health Care Standards Commission on the HPPC's performance of such duties.

(B) RELATING TO AHPS.—(i) To investigate complaints concerning the failure of an AHP to meet the applicable requirements of part 1 of subtitle C.

(ii) To assist enrollees in AHPs in resolving grievances with such plans.

(iii) To issue public reports and reports to the Health Care Standards Commission on any finding that an AHP has failed to meet the applicable requirements of part 1 of subtitle C.

(3) ACCESS TO INFORMATION.—The HPPC shall provide the ombudsman and the ombudsman's staff with access to such information as may be necessary to carry out such duties.

SEC. 1108. ENROLLEE SATISFACTION SURVEYS; MONITORING ENROLLEE DISENROLLMENT.

(a) ENROLLEE SATISFACTION SURVEYS.—

(1) IN GENERAL.—Each HPPC, using a standard survey instrument prescribed by the Health Care Standards Commission, shall collect information on the satisfaction of eligible individuals with—

(A) the performance of the HPPC, and

(B) the performance of the AHP in which they are enrolled.

(2) ANALYSIS.—Each HPPC shall—

(A) analyze the information collected under paragraph (1),

(B) submit to the Health Care Standards Commission an annual report that summarizes such analysis, and

(C) make a summary of such analysis available to enrollees under section 1104(c)(2).

(b) MONITORING ENROLLEE DISENROLLMENT.—Each HPPC shall monitor enrollee disenrollment from AHPs in order to determine whether there is a pattern of disenrollment which does not reflect the distribution of age, income, health condition, place of residence, and other potential risk characteristics of their enrollees. If a HPPC determines that such a pattern exists, the HPPC shall provide the Health Care Standards Commission with such information on such pattern as the Commission may specify and may petition under section 1305(c)(2) for the revocation of the registration of the AHP.

Subtitle C—Accountable Health Plans (AHPs)

PART 1—REQUIREMENTS FOR ACCOUNTABLE HEALTH PLANS

SEC. 1201. REGISTRATION PROCESS; QUALIFICATIONS.

(a) IN GENERAL.—The Health Care Standards Commission shall provide a process whereby a health plan (as defined in section 1701(c)(1)) may be registered with the Commission by its sponsor as an accountable health plan. Such a registered AHP is authorized to allocate its resources (except as otherwise specifically required under this subtitle) to maximize the health of its enrollees.

(b) QUALIFICATIONS.—In order to be eligible to be registered, a plan must—

(1) provide, in accordance with section 1202, for coverage of the uniform set of effective benefits specified by the Commission, for adjustments in cost-sharing in the case of low-income individuals, and for meeting quality standards established by the Commission;

(2) provide, in accordance with section 1203, for the collection and provision to the Commission and HPPCs of certain information regarding its enrollees and provision of services;

(3) not discriminate in enrollment or benefits, as required under section 1204;

(4) establish standard premiums for the uniform set of effective benefits, in accordance with section 1205;

(5) meet financial solvency requirements, in accordance with section 1206;

(6) meet requirements relating to grievance procedures, physician incentive plans, advance directives, and agent commissions, in accordance with section 1207;

(7) in the case of an open plan (as defined in section 1701(b)(4)(B)), meet certain additional requirements under section 1208 (relating to offering of plans, acceptance of enrollees, and participation as a plan under the medicare program and under the Federal employees health benefits program);

(8) provide for coordination of benefits with low-income assistance under subtitle A of title II, in accordance with section 1209;

(9) provide for any required medicare adjustment payments, in accordance with section 1210;

(10) pay certain premiums to the National Medical Education Fund, in accordance with section 1211; and

(11) pay registration fees imposed under sections 1303(d)(1) and 1304(d).

(c) MINIMUM SIZE FOR CLOSED PLANS.—No plan may be registered as a closed AHP under this section unless the plan covers at least a number of employees greater than the applicable number of employees specified in or under section 1701(c)(2).

SEC. 1202. SPECIFIED UNIFORM SET OF EFFECTIVE BENEFITS; REDUCTION IN COST-SHARING FOR LOW-INCOME INDIVIDUALS; QUALITY STANDARDS.

(a) BENEFITS.—The Health Care Standards Commission shall not accept the registration of a health plan as an AHP unless, subject to subsection (b), the plan—

(1) offers only the uniform set of effective benefits, established under section 1302(a)(1);

(2) has entered into arrangements with a sufficient number, distribution, and variety of providers to assure that the uniform set of effective benefits is—

(A) available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and

(B) when medically necessary, available and accessible twenty-four hours a day and seven days a week,

without imposing cost-sharing in excess of the cost-sharing described in paragraph (4);

(3) provides for the application of coverage standards, with respect to the uniform set of effective benefits, which are disclosed by the plan to plan enrollees (in a manner specified by the Commission) and which are consistent with coverage criteria under section 1302(b) (as interpreted by the Commission);

(4) if it is a network plan (as defined in section 1222(b)(1)), (A) selects providers of each type of good or service offered by the plan based on a competitive criteria, including price, quality, and services offered, and (B) publicizes and makes available, upon request, before the selection of participating providers such competitiive criteria;

(5)(A) provides, subject to subsection (c), for imposition of uniform cost-sharing, specified under such section as part of such set of benefits; and

(B) does not permit providers participating in the plan under paragraph (2) to charge for services

included in the uniform set of effective benefits services amounts in excess of such cost-sharing; and

(6) does not accept enrollment of an individual who is enrolled under another AHP unless, as of the effective date of the enrollment, the enrollment under the other plan will be terminated.

(b) TREATMENT OF ADDITIONAL BENEFITS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), subsection (a) shall not be construed as preventing an AHP from offering benefits in addition to the uniform set of effective benefits, if such additional benefits are offered, and priced, separately from the benefits described in subsection (a).

(2) NO DUPLICATIVE BENEFITS OR COVERAGE OF COST-SHARING.—An AHP or other entity may not offer under paragraph (1) or otherwise any additional benefits or plan that has the effect—

(A) of duplicating the benefits required under subsection (a), or

(B) of reducing the cost-sharing below the uniform cost-sharing.

The Health Care Standards Commission may file an action, in any appropriate court, to enjoin an entity (other than an AHP) that violates this paragraph.

(c) REDUCTION IN COST-SHARING FOR LOW-INCOME INDIVIDUALS.—In the case of a low-income individual (as defined in section 2009(a)(1)) eligible for cost-sharing assistance under section 2003(a) and enrolled with an AHP, the AHP shall reduce the cost-sharing otherwise applicable to amounts that are nominal (as specified for purposes of section 2003(a)(1)).

(d) LIMITATION ON IMPOSITION OF COST-SHARING.—In order to assure that providers of services for which benefits are available through an AHP do not impose cost-sharing in excess of that permitted under subsection (a)(5), each AHP may not provide payment for services (other than emergency services) furnished by a provider with an arrangement described in subsection (a)(2) to meet the uniform set of effective benefits unless the provider has agreed (in a manner specified by the Health Care Standards Commission) not to impose cost-sharing in excess of that so specified.

(e) QUALITY STANDARDS.—The Health Care Standards Commission shall establish standards relating to the minimum level of acceptable quality for an AHP's provision of the uniform set of effective benefits. In order for a plan to be registered under this subtitle, the plan must agree to provide benefits in a manner that complies with such standards.

SEC. 1203. COLLECTION AND PROVISION OF STANDARDIZED INFORMATION.

(a) PROVISION OF INFORMATION.—

(1) IN GENERAL.—Each AHP must provide the applicable HPPC and the Health Care Standards Commission (at a time, not less frequently than annually, and in an electronic, standardized form and manner specified by the Commission) such information as the Commission determines to be necessary, consistent with this subsection and sections 1104(c) and 1307, to forward payments to AHPs under section 1102(d) and to evaluate the performance of the AHP in providing the uniform set of effective benefits to enrollees in each HPPC area.

(2) INFORMATION TO BE INCLUDED.—Subject to paragraph (3), information to be provided under this subsection shall include at least the following:

(A) Information on the characteristics of enrollees that may affect their need for or use of health services and the determination of risk-adjustment factors for enrollee units.

(B) Information on the types of treatments and outcomes of treatments with respect to the clinical health, functional status, and well-being of enrollees.

(C) Information on health care expenditures, volume and prices of procedures, and use of specialized centers of care (for which information is submitted under section 1308).

(D) Information on the flexibility permitted by plans to enrollees in their selection of providers.

(3) SPECIAL TREATMENT.—The Commission may waive the provision of such information under paragraph (2), or require such other information, as the Commission finds appropriate in the case of a newly established AHP for which such information is not available.

(b) CONDITIONING CERTAIN PROVIDER PAYMENTS.—

(1) IN GENERAL.—In order to assure the collection of all information required from the direct providers of services for which benefits are available through an AHP, each AHP may not provide payment for services (other than emergency services) furnished by a provider to meet the uniform set of effective benefits unless the provider has given the AHP (or has given directly to the Health Care Standards Commission and the applicable HPPC)

standard information (specified by the Commission) respecting the services.

(2) FORWARDING INFORMATION.—If information under paragraph (1) is given to the AHP, the AHP is responsible for forwarding the information to the Commission and the applicable HPPC.

(c) AUDITING.—Each AHP shall provide, in accordance with standards established by the Commission, for the auditing of information provided under this section.

SEC. 1204. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN CONDITIONS; LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Except as provided under subsection (b), an AHP may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status of an individual, claims experience of an individual, receipt of health care by an individual, medical history of an individual, receipt of public subsidies by an individual, lack of evidence of insurability of an individual, or any other characteristic of the individual that may relate to the need for health care services.

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an AHP may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months beginning on the date of coverage under the plan. The exclusion of coverage shall not apply to services furnished to newborns and to pregnant women.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—An AHP shall provide that if an enrollee is in a period of continuous coverage (as defined in subparagraph (B)(i)) as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—

(I) IN GENERAL.—The term ''period of continuous coverage'' means the period beginning on the date an

individual is enrolled under an AHP and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(II) TRANSITIONAL AMNESTY AT TIME OF INITIAL ENROLLMENT.—For purposes of this clause, each individual who enrolls in an AHP before July 1, 1995, is considered to have had a period of continuous coverage during the 6 months ending January 1, 1995.

(ii) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under an AHP, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(3) LIMITATION TO UNIFORM SET OF EFFECTIVE BENEFITS.—This subsection shall not apply to treatment which is not within the uniform set of effective benefits.

(4) SPECIAL RULE FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health mainte-

nance organization that is an AHP shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the type described in paragraph (1) so long as such exclusion is applied consistent with the previous provisions of this subsection.

SEC. 1205. USE OF STANDARD PREMIUMS.

(a) STANDARD PREMIUMS FOR OPEN AHPS.—

(1) IN GENERAL.—

(A) ESTABLISHMENT.—Subject to subsection (c), each open AHP shall establish a standard premium for the uniform set of effective benefits within each HPPC area in which the plan is offered.

(B) APPLICABLE PREMIUM.—The amount of premium applicable for all individuals within a premium class (established under paragraph (2)) is the standard premium amount multiplied by the premium class factor specified by the Commission for that class under paragraph (2)(B).

(C) UNIFORMITY WITHIN A YEAR.—Within a HPPC area for individuals within a premium class for months in a calendar year, the stand-

ard premium for all individuals in the class for each month shall be the same.

(2) PREMIUM CLASSES.—

(A) IN GENERAL.—The Health Care Standards Commission shall establish premium classes—

(i) based on types of enrollment (described in section 1701(c)(6)), and

(ii) within each type of enrollment, based on the age of the principal enrollee (or based on the age of another family member of such enrollee in such cases as the Commission may provide).

In carrying out clause (ii), the Commission shall establish reasonable age bands within which premium amounts will not vary for a type of enrollment.

(B) PREMIUM CLASS FACTORS.—

(i) IN GENERAL.—For each premium class established under subparagraph (A), the Health Care Standards Commission shall establish a premium class factor that reflects, subject to clause (ii), the relative actuarial value of benefits for that class compared to the actuarial value of benefits

for an average class. The weighted average of the premium class factors shall be 1. Such premium class factors shall be computed based on the actuarial value of benefits for such population group within the class (which shall include the population eligible to enroll with open AHPs through HPPCs) as the Commission determines to be appropriate.

(ii) LIMIT ON VARIATION IN PREMIUM CLASS FACTORS WITHIN A TYPE OF ENROLLMENT.—The highest premium class factor within a type of enrollment may not exceed twice the lowest premium class factor for that type of enrollment. The previous sentence shall not apply to premiums imposed pursuant to a risk-sharing contract under section 1876 of the Social Security Act.

(3) METHODOLOGY.—The amount of premiums forwarded to AHPs is adjusted in accordance with section 1102(d)(1).

(b) STANDARD PREMIUMS FOR CLOSED AHPS.—

(1) ESTABLISHMENT.—Subject to subsection (c) and paragraph (3), each closed AHP shall estab-

lish a standard premium for the uniform set of effective benefits within each HPPC area in which the plan is offered.

(2) APPLICATION BY PREMIUM CLASS.—Subject to paragraph (3)—

(A) the amount of premium applicable for all individuals within a premium class is the standard premium amount multiplied by the premium class factor specified by the Commission for that class under subsection (a)(2)(B), and

(B) within a HPPC area for individuals within a premium class, the standard premium for all individuals in the premium class shall be the same.

(3) COMMUNITY RATING PERMITTED.—

(A) SAME RATES WITHIN TYPE OF ENROLLMENT WITHOUT REGARD TO AGE.—A closed AHP may elect (in a manner specified by the Health Care Standards Commission) to apply this subsection on the basis of type of enrollment rather than premium class. In such case, all references in this subsection to premium class are deemed a reference to type of enrollment and the reference to premium class

factor (for a type of enrollment) is the weighted average of such factors for the plan within the type of enrollment.

(B) COMMUNITY RATING ACROSS HPPC AREAS.—A closed AHP may elect (in a manner specified by the Commission) to apply this subsection by treating two or more HPPC areas as a single HPPC area. In such case, subject to subparagraph (A), the premium class factor to be applied shall be the weighted average of such factors for the plan for the HPPC areas involved.

(c) ADJUSTMENT OF PREMIUMS FOR LOW-INCOME INDIVIDUALS.—

(1) VERY LOW-INCOME INDIVIDUALS.—In the case of a very low-income individual (as defined in section 2009(a)(3)) eligible for premium assistance under section 2002 and enrolled with an AHP—

(A) the AHP shall adjust the premium otherwise applicable so that the premium does not exceed the sum of—

(i) the base Federal premium amount (as defined in section 2005(a)(1)) for enrollment under the plan, and

(ii) 10 percent of the amount (if any) by which (I) the premium for the AHP in which the individual is enrolled exceeds (II) the reference premium rate (as defined in section 2009(c)(4)); and

(B) the AHP shall credit against the premium owed the applicable Federal assistance amount (as defined in section 2009(c)(1)) provided the plan under section 2002(a)(1)(B).

(2) MODERATELY LOW-INCOME INDIVIDUALS.—In the case of a moderately low-income individual (as defined in section 2009(a)(2)) eligible for premium assistance under section 2002 and enrolled with an AHP—

(A) the AHP shall adjust the premium otherwise applicable so that the premium does not exceed the sum of—

(i) applicable low-income premium amount (as defined in section 2009(c)(2)) for enrollment under the plan, plus

(ii) the individual responsibility percentage (as defined in section 2009(c)(5), or 10 percentage points, whichever is greater) of the amount by which (I) the premium for the AHP in which the individ-

ual is enrolled exceeds (II) the reference premium rate (as defined in section 2009(c)(4)) for the individual; and

(B) the AHP shall credit against the premium owed the applicable Federal assistance amount (as defined in section 2009(c)(1)) provided the plan under section 2002(a)(2)(B).

If the premium reduction under subparagraph (A) is not a multiple of $1, the Commission may provide for the rounding of such reduction to a multiple of $1.

SEC. 1206. FINANCIAL SOLVENCY REQUIREMENTS.

(a) SOLVENCY PROTECTION.—

(1) FOR INSURED PLANS.—In the case of an AHP that is an insured plan (as defined by the Health Care Standards Commission) and is issued in a State, in order for the plan to be registered under this subtitle the Commission must find that the State has established satisfactory protection of enrollees with respect to potential insolvency of the plan.

(2) FOR OTHER PLANS.—In the case of an AHP that is not an insured plan, the Commission may require the plan to provide for such bond or provide other satisfactory assurances that enrollees

under the plan are protected with respect to potential insolvency of the plan.

(b) PROTECTION AGAINST PROVIDER CLAIMS.—In the case of a failure of an AHP to make payments with respect to the uniform set of effective benefits, under standards established by the Commission, an individual who is enrolled under the plan is not liable to any health care provider or practitioner with respect to the provision of health services within such uniform set for payments in excess of the amount for which the enrollee would have been liable if the plan were to have made payments in a timely manner.

SEC. 1207. GRIEVANCE MECHANISMS; ENROLLEE PROTECTIONS; WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES; AGENT COMMISSIONS.

(a) EFFECTIVE GRIEVANCE PROCEDURES.—

(1) IN GENERAL.—Each AHP shall provide for effective procedures for hearing and resolving grievances between the plan and individuals enrolled under the plan, which procedures meet standards specified by the Health Care Standards Commission.

(2) ACCESS OF OMBUDSMAN TO INFORMATION.—Each AHP shall provide the ombudsman, appointed under section 1107(b) for the HPPC area

in which the AHP operates, and the ombudsman's staff with access to such information as may be necessary for the ombudsman to carry out duties under such section.

(b) RESTRICTION ON CERTAIN PHYSICIAN INCENTIVE PLANS.—

(1) IN GENERAL.—A health plan may not be registered as an AHP if it operates a physician incentive plan (as defined in paragraph (2)) unless the requirements specified in clauses (i) through (iii) of section 1876(i)(8)(A) of the Social Security Act are met (in the same manner as they apply to eligible organizations under section 1876 of such Act).

(2) PHYSICIAN INCENTIVE PLAN DEFINED.—In this subsection, the term ''physician incentive plan'' means any compensation or other financial arrangement between the AHP and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled under the plan.

(c) WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES.—A health plan may not be registered as an AHP unless the plan meets the requirements of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respect-

ing advance directives), insofar as such requirements would apply to the plan if the plan were an eligible organization.

(d) PAYMENT OF AGENT COMMISSIONS.—An AHP—

(1) may pay a commission or other remuneration to an agent or broker in marketing the plan to individuals or groups, but

(2) may not vary such remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals to which the plan was sold.

SEC. 1208. ADDITIONAL REQUIREMENTS OF OPEN AHPS.

(a) REQUIREMENT OF AGREEMENT WITH HPPC.—In the case of a health plan which is an open plan (as defined in section 1701(b)(4)(B)), in order to be registered as an AHP the plan must have in effect an agreement (described in section 1102) with each HPPC for each HPPC area in which it is offered.

(b) REQUIREMENT OF OPEN ENROLLMENT.—

(1) IN GENERAL.—In the case of a health plan which is an open health plan, in order to be registered as an AHP the plan must, subject to paragraph (3), not reject the enrollment of any eligible individual whom a HPPC is authorized to enroll under an agreement referred to in subsection (a) if

the individual applies for enrollment during an enrollment period.

(2) LIMITATION ON TERMINATION.—Subject to paragraph (3), coverage of eligible individuals under an open AHP may not be refused nor terminated except for—

(A) nonpayment of premiums,

(B) fraud or misrepresentation, or

(C) termination of the plan at the end of a year (after notice and in accordance with standards established by the Health Care Standards Commission).

(3) TREATMENT OF NETWORK PLANS.—

(A) GEOGRAPHIC LIMITATIONS.—

(i) IN GENERAL.—An AHP which is a network plan (as defined in subparagraph (D)) may deny coverage under the plan to an eligible individual who is located outside a service area of the plan, but only if such denial is applied uniformly, without regard to health status or insurability of individuals.

(ii) SERVICE AREAS.—The Health Care Standards Commission shall establish standards for the designation by network

plans of service areas in order to prevent discrimination based on health status of individuals or their need for health services.

(B) SIZE LIMITS.—Subject to subparagraph (C), an AHP which is a network plan may apply to the Commission to cease enrolling eligible individuals under the AHP (or in a service area of the plan) if—

(i) it ceases to enroll any new eligible individuals, and

(ii) it can demonstrate that its financial or administrative capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation with such previously covered groups or individuals) will be impaired if it is required to enroll other eligible individuals.

(C) FIRST-COME-FIRST-SERVED.—A network plan is only eligible to exercise the limitations provided for in subparagraphs (A) and (B) if it provides for enrollment of eligible individuals on a first-come-first-served basis, except that the plan, under rules of the Commission,

shall provide preference for eligible individuals who are not eligible to enroll in another network plan.

(D) NETWORK PLAN.—In this paragraph, the term ''network plan'' means an eligible organization (as defined in section 1876(b) of the Social Security Act) and includes a similar organization, specified in regulations of the Commission, that requires a limitation on enrollment of employer groups or individuals due to the manner in which the organization provides health care services.

(c) REQUIREMENT OF PARTICIPATION IN MEDICARE RISK-BASED CONTRACTING.—

(1) IN GENERAL.—In the case of a health plan which is an open health plan and which is an eligible organization (as defined in section 1876(b) of the Social Security Act), in order to be registered as an AHP the plan must enter into a risk-sharing contract under section 1876 of the Social Security Act for the offering of benefits to medicare beneficiaries in accordance with such section.

(2) EXPANSION OF MEDICARE SELECT PROGRAM.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (104 Stat.

1388–137) is amended by striking ''only apply in 15 States'' and all that follows through the end and inserting ''on and after January 1, 1992.''.

(3) ELIGIBILITY FOR PAYMENT.—An AHP that meets the requirement of paragraph (1) is eligible to receive adjustment payments under section 1210(b).

(d) PARTICIPATION IN FEHBP.—

(1) IN GENERAL.—In the case of a health plan which is an open health plan, in order to be registered as an AHP the plan must have entered into an agreement with the Office of Personnel Management to offer a health plan to Federal employees and annuitants, and family members, under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code, under the same terms and conditions (other than the amount of premiums) offered by the AHP for enrollment of eligible individuals through HPPCs.

(2) CHANGE IN CONTRIBUTION AND OTHER FEHBP RULES.—Notwithstanding any other provision of law, effective January 1, 1995—

(A) enrollment shall not be permitted under a health benefits plan under chapter 89 of title 5, United States Code, unless the plan is an AHP; and

(B) the amount of the Federal Government contribution under such chapter—

(i) for any premium class shall be the same for all AHPs in a HPPC area,

(ii) for any individual in a premium class shall not exceed the base individual premium (as defined in section 2009(c)(3)), and

(iii) in the aggregate for any fiscal year shall be equal to the aggregate amount of Government contributions that would have been made but for this subsection.

SEC. 1209. COORDINATION OF BENEFITS WITH LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Each AHP shall provide for—

(1) acceptance of information, electronically, from the Health Care Standards Commission on the eligibility of individuals (and family members) for low-income assistance under subtitle A of title II,

(2) an adjustment, in accordance with sections 1202(c) and 1205(c), in the cost-sharing or premium amounts otherwise imposed to reflect the cost-sharing and premium assistance provided under such subtitle, and

(3) such reconciliation payments as may be required under section 1102(e).

(b) REQUIREMENT OF SPECIAL AGREEMENTS FOR NON-OPEN PLANS.—In the case of a health plan which is not an open health plan, in order to be registered as an AHP the plan must have in effect a special agreement (described in section 1102(a)(2)) with each HPPC for each HPPC area in which it is offered.

SEC. 1210. ADDITIONAL REQUIREMENT OF CERTAIN AHPS.

(a) MEDICARE ADJUSTMENT PAYMENT REQUIRED.—Each AHP which is not described in section 1208(c)(1) shall provide for payment to the Health Care Standards Commission of such amounts as may be required as to put the plan in the same financial position as the AHP would be in if it was required to meet the requirement of such section.

(b) REDISTRIBUTION OF PAYMENTS TO PLANS.—The Commission shall provide for the distribution of amounts to be paid under subsection (a) among AHPs meeting the requirement of section 1208(c)(1) in such manner as reflects the relative financial impact of such requirement among such plans.

SEC. 1211. FUNDING FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS AND PHYSICIAN RETRAINING PROGRAMS.

(a) REQUIREMENT.—Each AHP shall provide for payment of 1 percent of gross premium receipts (as defined in subsection (c)) to the National Medical Education Fund established under section 3005.

(b) PAYMENT METHOD.—

(1) OPEN AHPS.—In the case of an open AHP, the payment under subsection (a) shall be made through a reduction of 1 percent in the payments made by each HPPC to the AHP.

(2) CLOSED AHPS.—In the case of a closed AHP, the payment under subsection (a) shall be made on a monthly (or other basis) as specified by the Commission. Failure of a closed AHP to make such a payment on a timely basis is grounds for revocation of the registration of the AHP under this part.

(c) GROSS PREMIUM RECEIPTS DEFINED.—In this section, the term ''gross premium receipts'' means, with respect to—

(1) an open AHP, the payment amounts otherwise payable by a HPPC to the AHP, or

(2) a closed AHP, an actuarial equivalent value (as established in accordance with rules of the Com-

mission, similar to the rules established for purposes of section 4980C(d)(1) of the Internal Revenue Code of 1986).

PART 2—PREEMPTION OF STATE LAWS FOR ACCOUNTABLE HEALTH PLANS

SEC. 1221. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1995, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of an AHP, of any services, category of care, or services of any class or type of provider that is different from the uniform set of effective benefits;

(2) specifies the individuals to be covered under an AHP or the duration of such coverage; or

(3) requires a right of conversion from a group health plan that is an AHP to an individual health plan.

SEC. 1222. PREEMPTION OF STATE LAW RESTRICTIONS ON NETWORK PLANS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1995—

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

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

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers under a network plan;

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

(5) a State may not prohibit or limit a network plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers; and

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

(b) DEFINITIONS.—In this section:

(1) NETWORK PLAN.—The term ''network plan'' means an AHP—

(A) which—

(i) limits coverage of the uniform set of effective benefits to those provided by participating providers, or

(ii) provides, with respect to such services provided by persons who are not participating providers, for cost-sharing

which are in excess of those permitted under the uniform set of effective benefits for participating providers;

(B) which has a sufficient number and distribution of participating providers to assure that the uniform set of effective benefits (i) is available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, is available and accessible twenty-four hours a day and seven days a week; and

(C) which provides benefits for the uniform set of effective benefits not furnished by participating providers if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services under a contract with a network plan, which contract does not permit—

(A) cost-sharing in excess of the cost-sharing permitted under the uniform set of effective benefits, and

(B) any enrollee charges (for such services covered under such set) in excess of such cost-sharing.

SEC. 1223. PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—Effective January 1, 1995, no State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in subsection (b)).

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

PART 3—ANTITRUST PROVISIONS

SEC. 1231. PUBLICATION OF GUIDELINES FOR ACCOUNTABLE HEALTH PLANS.

(a) IN GENERAL.—The President shall provide for the development and publication of explicit guidelines on the application of Federal antitrust laws to AHPs. The

guidelines shall be designed to facilitate AHP development and operation, consistent with the Federal antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which an AHP (or organization that proposes to establish an AHP) may obtain a prompt opinion from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) ANTITRUST LAWS DEFINED.—In this section, the term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition.

SEC. 1232. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

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

date). Such venture, and the parties to such venture, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such venture if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

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

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

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

(2) FACTORS TO BE CONSIDERED.—

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

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

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

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

(vi) to reduce inefficient health care resource duplication.

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

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care joint venture and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

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

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

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

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

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

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

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

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care joint venture submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expi-

ration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

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

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

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

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revoca-

tion, in an appropriate district court of the United States for review of the record of such denial or revocation.

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

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

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

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

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

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws''—

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

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

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

(3) The term ''health care joint venture'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-shar-

ing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

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

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

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

Subtitle D—Health Care Standards Commission

SEC. 1301. ESTABLISHMENT OF HEALTH CARE STANDARDS COMMISSION.

(a) IN GENERAL.—There is hereby established, as an independent agency in the Executive Branch, a Health Care Standards Commission (in this title referred to as the ''Commission'').

(b) COMPOSITION AND TERMS.—

(1) APPOINTMENT.—The Commission shall be composed of 5 members appointed by the President by and with the advice and consent of the Senate. In appointing members to the Commission, the President shall provide that all members shall demonstrate experience with and knowledge of the health care system.

(2) CHAIRMAN.—The President shall designate one of the members to be Chairman of the Commission.

(3) TERMS.—Each member of the Commission shall be appointed for a term of 7 years, except that, of the members first appointed, 1 shall each be appointed for terms of 3, 4, 5, 6, and 7 years, as designated by the President at the time of appointment. Members appointed to fill vacancies shall serve for the remainder of the terms of the vacating members.

(4) PARTY AFFILIATION.—Not more than 3 members of the Commission shall be of the same political party.

(5) OTHER EMPLOYMENT PROHIBITED.—A member of the Commission may not, during the term as a member, engage in any other business, vocation, profession, or employment.

(6) QUORUM.—Three members of the Commission shall constitute a quorum, except that 2 members may hold hearings.

(7) MEETINGS.—The Commission shall meet at the call of the Chairman or 3 members of the Commission.

(8) COMPENSATION.—Each member of the Commission shall be entitled to compensation at the rate provided for level II of the Executive Schedule, subject to such amounts as are provided in advance in appropriation Acts.

(c) PERSONNEL.—

(1) IN GENERAL.—The Commission shall appoint an Executive Director and such additional officers and employees as it considers necessary to carry out its functions under this Act. Except as otherwise provided in any other provision of law, such officers and employees shall be appointed, and their compensation shall be fixed, in accordance with title 5, United States Code.

(2) EXPERTS AND CONSULTANTS.—The Commission may procure the services of experts and consultants in accordance with the provisions of section 3109 of title 5, United States Code.

(d) USE OF U.S. MAIL.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

SEC. 1302. SPECIFICATION OF UNIFORM SET OF EFFECTIVE BENEFITS.

(a) SPECIFICATION OF UNIFORM SET OF EFFECTIVE BENEFITS; CONGRESSIONAL CONSIDERATION.—

(1) TRANSMITTAL OF RECOMMENDATIONS TO CONGRESS.—

(A) FOR 1995.—The Commission shall transmit to Congress, by not later than July 1, 1994, recommendations for the uniform set of effective benefits to apply under this title for 1995 and, subject to subparagraph (B), subsequent years.

(B) LATER YEARS.—The Commission may transmit to Congress, by not later than July 1 of a subsequent year, recommendations for changes in the uniform set of effective benefits to apply under this title for the following year (and, subject to this subparagraph, subsequent years).

(C) CONGRESSIONAL CONSIDERATION.—

(i) IN GENERAL.—Recommendations transmitted under subparagraph (A) or (B) shall apply under this title unless a joint resolution (described in clause (ii)) disapproving such recommendations is enacted, in accordance with the provisions of clause (iii), before the end of the 44-day period beginning on the date on which such recommendations were transmitted. For purposes of applying the preceding sentence and clauses (ii) and (iii), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(ii) JOINT RESOLUTION OF DISAPPROVAL.—A joint resolution described in this clause means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Commission transmits recommendations under subparagraph (A) or (B) and—

(I) which does not have a preamble;

(II) the matter after the resolving clause of which is as follows: ''That Congress disapproves the recommendations of the Health Care Standards Commission concerning the uniform set of effective benefits as transmitted by the Commission on _____.'', the blank space being filled in with the appropriate date; and

(III) the title of which is as follows: ''Joint resolution disapproving the recommendations of the Health Care Standards Commission concerning the uniform set of effective benefits as transmitted by the Commission on _____.'', the blank space being filled in with the appropriate date.

(iii) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF DISAPPROVAL.—Subject to clause (iv), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply

to the consideration of a joint resolution described in clause (ii) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(iv) SPECIAL RULES.—For purposes of applying clause (iii) with respect to such provisions—

(I) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to the Committee on Energy and Commerce of the House of Representatives and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate; and

(II) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Commission transmits a recommendation under subparagraph (A) or (B).

(D) TREATMENT OF DISAPPROVAL.—

(i) FOR 1995.—If recommendations transmitted under subparagraph (A) are disapproved by joint resolution under subparagraph (C), then the Commission shall transmit to Congress, by not later than 15 days after the date of adoption of the resolution, recommendations for the uniform set of effective benefits to apply under this title for 1995 and, subject to subparagraph (B), subsequent years. The provisions of subparagraph (C) shall apply to such new recommendations in the same manner as they applied to the recommendations previously transmitted under subparagraph (A), except that any time period specified in such subparagraph shall be half the period otherwise provided.

(ii) FOR SUBSEQUENT YEARS.—If recommendations transmitted under subparagraph (B) are disapproved by joint resolution under subparagraph (C), then such recommendations shall not take effect and the recommendations not previously disapproved under this paragraph shall continue in effect until otherwise changed.

(2) SPECIFICATION OF ALL MEDICALLY APPROPRIATE TREATMENTS.—

(A) MEDICALLY APPROPRIATE TREATMENTS.—The uniform set of effective benefits submitted under paragraph (1) shall include such categories of health care services that the Commission determines will provide for the delivery of medically appropriate treatment by AHPs.

(B) COVERAGE OF CLINICAL PREVENTIVE SERVICES.—Such benefits shall include the full range of effective clinical preventive services (including appropriate screening, counseling, and immunization and chemoprophylaxis), specified by the Commission, appropriate to age and other risk factors.

(C) COVERAGE OF DIAGNOSTIC SERVICES.—Such benefits shall include a full range of diagnostic services not covered under subparagraph (B).

(D) GUIDELINES.—Nothing in this paragraph shall prohibit the Commission from developing guidelines that would specify the appropriate uses of treatment in greater detail.

(D) ADDITIONAL COVERAGE.—Nothing in this paragraph shall be construed as preventing a plan from providing coverage of treatment that has not been determined (under subsection (b)) by the Commission to be medically appropriate for purposes of this paragraph.

(3) COST-SHARING.—

(A) IN GENERAL.—Subject to subparagraph (B), such set shall include uniform cost-sharing associated with such benefits consistent with subsection (c).

(B) TREATMENT OF NETWORK PLANS.—In the case of a network plan (as defined in section 1222(b)), the plan may provide for charging cost-sharing in excess of the uniform cost-sharing under subparagraph (A) in the case of services provided by providers that are not participating providers (as defined in such section).

(b) CRITERIA FOR DETERMINATION OF MEDICALLY APPROPRIATENESS FOR BENEFIT COVERAGE.—

(1) IN GENERAL.—An AHP is required to provide for coverage of the uniform set of effective benefits only for treatments and diagnostic procedures that are medically appropriate. Subject to the succeeding provision of this subsection, for purposes of

this section, a treatment (as defined in paragraph (6)(A)) or diagnostic procedure is considered to be ''medically appropriate'' if the following criteria are met (as interpreted by the Commission):

(A) TREATMENT OR DIAGNOSIS OF MEDICAL CONDITION.—

(i) IN GENERAL.—The treatment or diagnostic procedure is for a medical condition.

(ii) MEDICAL CONDITION DEFINED.—The term ''medical condition'' means a disease, illness, injury, or biological or psychological condition or status for which treatment is indicated to improve, maintain, or stabilize a health outcome (as defined in paragraph (6)(B)) or which, in the absence of treatment, could lead to an adverse change in a health outcome.

(iii) ADVERSE CHANGE IN HEALTH OUTCOME DEFINED.—In clause (ii), an adverse change in a health outcome occurs if there is a biological or psychological decremental change in a health status or if the original endowment for a feature lies outside the normal range.

(B) NOT INVESTIGATIONAL.—There must be sufficient evidence on which to base conclusions about the existence and magnitude of the change in health outcome resulting from the treatment or diagnostic procedure compared with the best available alternative (or with no treatment or diagnostic procedure if no alternative treatment or procedure is available).

(C) EFFECTIVE AND SAFE.—The evidence must demonstrate that the treatment or diagnostic procedure can reasonably be expected to produce the intended health result or provide intended health information and is safe and the treatment or diagnostic procedure provides a clinically meaningful benefit with respect to safety and effectiveness in comparison to other available alternatives.

(2) TREATMENT OR DIAGNOSTIC PROCEDURE CONSISTENT WITH PRACTICE GUIDELINES.—A treatment or diagnostic procedure that is provided consistent with a practice guideline established by the Agency for Clinical Evaluations, established under section 1309, (or its predecessor) is deemed to be medically appropriate.

(3) RELATIONSHIP TO FDA REVIEW.—

(A) APPROVED DRUGS, BIOLOGICALS, AND MEDICAL DEVICES.—

(i) DRUGS.—A drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness).

(ii) BIOLOGICALS.—A biological that has been found to be safe and effective under section 351 of the Public Health Service Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to not investigational and safety and effectiveness).

(iii) MEDICAL DEVICES.—A medical device that is marketed after the provision of a notice under section 510(k) of the Federal Food, Drug, and Cosmetic Act or that has an application for premarket approval approved under section 515 of such Act is deemed to meet the requirements of paragraphs (1)(B) and (1)(C) (relating to

not investigational and safety and effectiveness).

(B) OTHER DRUGS, BIOLOGICALS, AND DEVICES.—A drug, biological, or medical device not described in subparagraph (A) shall be considered to be investigational. Nothing shall prohibit a AHP from covering such drugs, biologicals, and medical devices, including treatment investigational new drugs (IND).

(C) OFF-LABEL USE.—An off-label use for a drug described in subparagraph (A)(i) is presumed to meet the requirements of paragraph (1)(C) if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

(4) COVERAGE OF INVESTIGATIONAL TREATMENTS IN APPROVED RESEARCH TRIALS.—

(A) IN GENERAL.—Coverage of the routine medical costs (as defined in subparagraph (C)) associated with the delivery of investigational treatments (as defined in subparagraph (B)) shall be considered to be medically appropriate

only if the treatment is part of an approved research trial (as defined in subparagraph (D)).

(B) INVESTIGATIONAL TREATMENT DEFINED.—In subparagraph (A), the term ''investigational treatment'' means a treatment for which there is not sufficient evidence to determine the health outcome of the treatment compared with the best available alternative treatment (or with no treatment if there is no alternative treatment).

(C) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term ''routine medical costs'' means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Commission). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

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

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

(ii) approved by the Secretary of Health and Human Services.

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

(5) DOCUMENTATION.—

(A) IN GENERAL.—Each AHP is responsible for maintaining documentary evidence supporting the plan's decisions to cover or to deny coverage based on the criteria specified in this subsection.

(B) REFERENCES.—The evidence that may be used in making such coverage decisions includes—

(i) published peer-reviewed literature,

(ii) opinions of medical specialty groups and other medical experts,

(iii) evidence of general acceptance by the medical community, and

(iv) recommendations of the Commission.

(C) DISCLOSURE.—Each AHP shall disclose to its members, in a manner specified by the Commission, its coverage decisions and must submit information on such decisions to the Benefits, Evaluations, and Data Standards Board.

(6) TREATMENT AND HEALTH OUTCOME DEFINED.—In this subsection (and subsection (a)(2)):

(A) IN GENERAL.—The term ''treatment'' means any health care intervention undertaken, with respect to a specific indication, to improve, maintain, or stabilize a health outcome or to prevent or mitigate an adverse change in a health outcome.

(B) HEALTH OUTCOME DEFINED.—The term ''health outcome'' means an outcome that affects the length or quality of an enrollee's life.

(c) BASIS FOR COST-SHARING.—In establishing cost-sharing that is part of the uniform set of effective benefits, the Commission shall—

(1) include only such cost-sharing as will restrain consumers from seeking unnecessary services,

(2) not impose cost-sharing for covered clinical preventive services,

(3) balance the effect of the cost-sharing in reducing premiums and in affecting utilization of appropriate services,

(4) establish a limit on the total cost-sharing that may be incurred by an individual (or enrollee unit) in a year, and

(5) incorporate, consistent with the previous provisions, incentives for individuals to control their utilization of health care services and shall (for this purpose) consider incorporating the concepts of medical savings accounts and wellness dividends.

To the extent consistent with the previous provisions, the Commission shall design such cost-sharing in a manner so to maintain overall utilization levels at a level no higher than current overall utilization levels.

(d) AUTHORITY RESPECTING PROVIDERS.—

(1) NO AUTHORITY TO RESTRICT USE OF PROVIDERS.—In the case of treatment included in the

uniform set of effective benefits, the Commission is not authorized—

(A) to restrict the coverage of such treatment only to, or

(B) to require an AHP to provide coverage of such treatment by,

a particular class (or classes) of providers, among the providers that are legally authorized to provide such treatment.

(2) AUTHORITY WITH RESPECT TO SCOPE OF PRACTICE OF QUALIFIED PROVIDERS.—A State may not prohibit or limit the scope of practice of a provider of health services, with respect to the provision of the uniform set of effective benefits by an AHP, to the extent that the Commission finds that such prohibition or limitation restricts the utilization of qualified providers.

SEC. 1303. BENEFITS, EVALUATIONS, AND DATA STANDARDS BOARD.

(a) ESTABLISHMENT.—The Commission shall provide for the initial organization, as a nonprofit corporation in the District of Columbia, of the Benefits, Evaluations, and Data Standards Board (in this section referred to as the ''BEDS Board''), under the direction of a board of directors consisting of 5 directors.

(b) APPOINTMENT OF DIRECTORS.—

(1) SOLICITATION.—The Commission shall solicit nominations for the initial board of directors of the BEDS Board from organizations that represent the various groups with an interest in the health care system and the functions of the Board.

(2) CONTINUATION.—The by-laws of the BEDS Board shall provide for the board of directors subsequently to be appointed by the board in a manner that ensures a broad range of representation of through groups with an interest in providing and purchasing health care.

(3) TERMS OF DIRECTORS.—The term of each member of the board of directors shall be for 7 years, except that in order to provide for staggered terms, the terms of the members initially appointed shall be for 3, 4, 5, 6, and 7 years. In the case of a vacancy by death or resignation, the replacement shall be appointed for the remainder of the term. No individual may serve as a director of the board for more than 14 years.

(c) FUNCTIONS.—

(1) IN GENERAL.—The BEDS Board shall make recommendations to the Commission concerning each of the following:

(A) The uniform set of effective benefits.

(B) The standards for information to be provided by AHPs.

(C) Auditing standards to ensure the accuracy of such information.

(D) Aggregate data on coverage decisions made by AHPs and recommendations for evaluations of particular technologies.

Before making recommendations described in subparagraphs (B) and (D), the BEDS Board shall consult with the Agency for Clinical Evaluations regarding the need for information in performing its activities.

(2) EVALUATIONS.—The BEDS Board shall advise the Commission on—

(A) matters related to the evaluation of health care services, including information from clinical and epidemiological studies, and

(B) information provided by AHPs, including AHP-specific information on clinical health, functional status, well-being, and plan satisfaction of enrolled individuals.

(3) NATIONAL HEALTH DATA SYSTEM.—The BEDS Board shall provide the Commission with its

assistance in the development of the standards for the national health data system under section 1307.

(d) FUNDING.—

(1) IN GENERAL.—In order to provide funding for the BEDS Board, the Health Care Standards Commission shall establish an annual registration fee for AHPs which is imposed on a per-covered-individual-basis and is sufficient, in the aggregate, to provide each year for not more than the amount specified in paragraph (2) for the operation of the BEDS Board.

(2) AMOUNT OF FUNDS.—The amount specified in this paragraph for each of fiscal years 1994 and 1995, is $50,000,000, and, for each succeeding fiscal year, is $25,000,000.

SEC. 1304. HEALTH PLAN STANDARDS BOARD.

(a) ESTABLISHMENT.—The Commission shall provide for the initial organization, as a nonprofit corporation in the District of Columbia, of the Health Plan Standards Board (in this section referred to as the ''Plan Standards Board''), under the direction of a board of directors consisting of 5 directors.

(b) APPOINTMENT OF DIRECTORS.—

(1) SOLICITATION.—The Commission shall solicit nominations for the initial board of directors of

the Plan Standards Board from organizations that represent the various groups with an interest in the health care system and the functions of the Board.

(2) CONTINUATION.—The by-laws of the Plan Standards Board shall provide for the board of directors subsequently to be appointed by the board in a manner that ensures a broad range of representation of through groups with an interest in providing and purchasing health care.

(3) TERMS OF DIRECTORS.—The term of each member of the board of directors shall be for 7 years, except that in order to provide for staggered terms, the terms of the members initially appointed shall be for 3, 4, 5, 6, and 7 years. In the case of a vacancy by death or resignation, the replacement shall be appointed for the remainder of the term. No individual may serve as a director of the board for more than 12 years.

(c) FUNCTIONS.—

(1) IN GENERAL.—The Plan Standards Board shall make recommendations to the Commission concerning the standards for AHPs (other than standards relating to the uniform set of effective benefits and the national health data system) and for HPPCs.

(2) ASSESSMENT OF RISK-ADJUSTMENT FACTORS.—The Plan Standards Board shall provide the Commission with its assessment of the risk-adjustment factors under section 1306.

(d) FUNDING.—In order to provide funding for the Plan Standards Board, the Health Care Standards Commission shall establish an annual registration fee for AHPs which is imposed on a per-covered-individual-basis and is sufficient, in the aggregate, to provide each year for not more than 60 percent of the amount specified in section 1303(d)(2) for the operation of the Plan Standards Board.

SEC. 1305. REGISTRATION OF ACCOUNTABLE HEALTH PLANS.

(a) IN GENERAL.—The Commission shall register those health plans that meet the standards under part 1 of subtitle C.

(b) TREATMENT OF STATE CERTIFICATION.—If (and so long as) the Commission determines that a State superintendent of insurance, State insurance commissioner, or other State official provides for the imposition of standards that the Commission finds are equivalent to the standards established under part 1 of subtitle C for registration of a health plan as an AHP, the Commission may provide for registration as AHPs of health plans that such

official certifies as meeting the standards for registration. Nothing in this subsection shall require a health plan to be certified by such an official in order to be registered by the Commission.

(c) REVOCATION OF REGISTRATION.—

(1) IN GENERAL.—The Commission shall provide for a process for revocation of such registration in cases where the Commission finds, after notice to the plan and appropriate due process specified by the Commission, that a health plan no longer substantially meets the standards for such registration or has failed to comply with a requirement under section 1402(a).

(2) INITIATION OF PROCESS.—Such process may be initiated upon the petition of a HPPC, the ombudsman for a HPPC, or by the Commission itself. If the process is not initiated by a HPPC or ombudsman, the Commission shall notify each HPPC involved that such a process has been initiated. A HPPC may provide notice to enrollees of an AHP at the time such a process is initiated with respect to the AHP.

(3) NOTICE TO HPPC AND ENROLLEES.—No registration of an AHP may be revoked unless the

Commission has provided for appropriate notice to the HPPC and enrollees involved.

SEC. 1306. SPECIFICATION OF RISK-ADJUSTMENT FACTORS.

(a) IN GENERAL.—The Commission shall establish rules for the process of risk-adjustment of premiums among AHPs by HPPCs under section 1102(d)(1).

(b) PROCESS.—

(1) IDENTIFICATION OF RELATIVE RISK.—The Commission shall determine risk-adjustment factors for types of enrollment that are correlated with increased or diminished risk for consumption of the type of health services included in the uniform set of effective benefits, taking into account differences in utilization resulting from low-income cost-sharing assistance provided under section 2003. To the maximum extent practicable, such factors shall be determined without regard to the methodology used by individual AHPs in the provision of such benefits. In determining such factors, with respect to an individual (in an enrollee unit) identified as having—

(A) a lower-than-average risk for consumption of the services, the factor shall be a number, less than zero, reflecting the degree of such lower risk;

(B) an average risk for consumption of the services, the factor shall be zero; or

(C) a higher-than-average risk for consumption of the services, the factor shall be a number, greater than zero, reflecting the degree of such higher risk.

For an enrollee unit, the factor to be applied (pursuant to section 1402(b)) shall reflect the factors applicable to all covered individuals in the unit.

(2) ADJUSTMENT OF FACTORS.—In applying under section 1102(d)(1)(B) the risk-adjustment factors determined under paragraphs (1) and (3), each HPPC shall adjust such factors, in accordance with a methodology established by the Commission, so that the sum of such factors is zero for all enrollee units in each HPPC area for which a premium payment is forwarded under section 1102(d) for each premium payment period.

(3) SPECIAL RISK-ADJUSTMENT FACTORS FOR UNDERSERVED AREAS.—The Commission shall determine the special risk-adjustment factors that may be applied in the case of individuals residing in areas designated as rural or urban underserved areas under section 1401.

SEC. 1307. NATIONAL HEALTH DATA SYSTEM.

(a) STANDARDIZATION OF INFORMATION.—

(1) IN GENERAL.—The Commission shall establish standards for the periodic provision by AHPs of information under section 1203(a) and the auditing of the information so provided.

(2) PATIENT CONFIDENTIALITY.—The standards shall be established in a manner that protects the confidentiality of individual enrollees, but may provide for the disclosure of information which discloses particular providers within an AHP.

(b) ANALYSIS OF INFORMATION.—

(1) IN GENERAL.—The Commission shall analyze the information provided to the Commission under section 1203(a) with respect to AHPs for which a HPPC is not performing an analysis under section 1104(c)(1).

(2) CENTRAL ACCESS.—The Commission shall make available, in a central location and consistent with subsection (a)(2), all of such analyses.

(3) DISTRIBUTION OF ANALYSES.—The Commission shall distribute the analyses in a form, consistent with subsection (a)(2), that reports, on a national, State, and community basis, the levels and trends of health care expenditures, the rates and trends in the provision of individual procedures, and

(to the extent such procedures are priced separately) the price levels and rates of price change for such procedures. The reports shall include both aggregate and per capita measures for areas and shall include comparative data for different areas.

(c) DISTRIBUTION OF INFORMATION.—

(1) ANNUAL REPORT ON EXPENDITURES.—The Commission shall publish annually (beginning with 1996) a report on expenditures on procedures, volumes of procedures, and, to the extent such procedures are priced separately, the prices of procedures. Such report shall be distributed to each AHP, each HPPC, each Governor, and each State legislature.

(2) ANNUAL REPORTS.—The Commission shall also publish an annual report, based on analyses under this section, that identifies—

(A) procedures for which, as reflected in variations in use or rates of increase, there appear to be the greatest need to develop valid clinical protocols for clinical decision-making and review,

(B) procedures for which, as reflected in price variations and price inflation, there appear to be the greatest need for strengthening competitive purchasing, and

(C) States and localities for which, as reflected in expenditure levels and rates of increase, there appear to be the greatest need for additional cost control measures.

(3) SPECIAL DISTRIBUTIONS.—The Commission may, whenever it deems appropriate, provide for the distribution—

(A) to an AHP of such information relating to the plan as may be appropriate in order to encourage the plan to improve its delivery of care, and

(B) to business, consumer, and other groups and individuals of such information as may improve their ability to effect improvements in the outcomes, quality, and efficiency of health services.

(4) ACCESS BY AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Commission shall make available to the Agency for Clinical Evaluations information obtained under section 1203(a) in a manner consistent with subsection (a)(2).

SEC. 1308. MEASURES OF QUALITY OF CARE OF SPECIALIZED CENTERS OF CARE.

(a) COLLECTION OF INFORMATION.—The Commission shall provide a process whereby a specialized center

of care (as defined in subsection (d)) may submit to the Commission such clinical and other information bearing on the quality of care provided with respect to the uniform set of effective benefits at the center as the Commission may specify. Such information shall include sufficient information to take into account outcomes and the risk factors associated with individuals receiving care through the center. Such information shall be provided at such frequency (not less often than annually) as the Commission specifies.

(b) MEASURES OF QUALITY.—Using information submitted under subsection (a) and information reported under section 1307, the Commission shall—

(1) analyze the performance of such centers with respect to the quality of care provided,

(2) rate the performance of such a center with respect to a class of services relative to the performance of other specialized centers of care and relative to the performance of AHPs generally, and

(3) publish such ratings.

(c) USE OF SERVICE MARK FOR SPECIALIZED CENTERS OF CARE.—The Commission may establish a service mark for specialized centers of care the performance of which has been rated under subsection (b). Such service mark shall be registrable under the Trademark Act of

1946, and the Commission shall apply for the registration of such service mark under such Act. For purposes of such Act, such service mark shall be deemed to be used in commerce. For purposes of this subsection, the ''Trademark Act of 1946'' refers to the Act entitled ''An Act to provide for the registration and protection of trademarks used in commerce, to carry out the provisions of international conventions, and for other purposes'', approved July 5, 1946 (15 U.S.C. 1051 and following).

(d) SPECIALIZED CENTER OF CARE DEFINED.—In this section, the term ''specialized center of care'' means an institution or other organized system for the provision of specific services, which need not be multi-disciplinary, and does not include (except as the Commission may provide) individual practitioners.

SEC. 1309. AGENCY FOR CLINICAL EVALUATIONS.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Agency for Clinical Evaluations (in this section referred to as the ''Agency'').

(b) APPOINTMENT OF ADMINISTRATOR.—There shall be at the head of the Agency an official to be known as the Administrator for Clinical Evaluations (in this section referred to as the ''Administrator''). The Administrator

shall be appointed by the President, by and with the advice and consent of the Senate.

(c) DUTIES.—

(1) IN GENERAL.—The Administrator shall assume the following responsibilities:

(A) Responsibilities of the Administrator for Health Care Policy and Research, under title IX of the Public Health Service Act and under section 1142 of the Social Security Act.

(B) Responsibilities of the Director of the National Center for Health Statistics (under section 306 of the Public Health Service Act).

(C) Responsibilities of the Director of the Office of Medical Applications of Research at the National Institutes of Health.

(D) Responsibilities of the Director of the Office of Research and Demonstrations of the Health Care Financing Administration, insofar as such responsibilities relate to clinical evaluations.

(2) SPECIFIC DUTIES.—In carrying out responsibilities under paragraph (1), the Administrator shall—

(A) set priorities for the research community to strengthen the research base;

(B) support research and evaluation (both on a contract and investigator-initiated basis) on medical effectiveness through technology assessment, consensus development, outcomes research practice guidelines, and other appropriate activities;

(C) conduct effectiveness trials in collaboration with medical specialty societies, medical educators, and AHPs;

(D) maintain a clearinghouse and other registries on clinical trials and outcomes research data;

(E) assure the systematic evaluation of existing as well as new treatments and diagnostic technologies in a constant, continuous effort to upgrade the knowledge base for clinical decisionmaking and policy choice; and

(F) design a computerized dissemination system for providers to provide an interactive system of information on outcomes research, practice guidelines, and other information.

(3) ASSISTANCE.—The Administrator shall provide the Benefits, Evaluations, and Data Standards Board with such information, on evaluations related to the uniform set of effective benefits and any other

information developed in the scope of carrying out the Administrator's responsibilities, as may be appropriate.

(4) COOPERATION WITH OTHER AGENCIES.—In carrying out responsibilities under this subsection, the Administrator shall cooperate and consult with the Director of the National Institutes of Health, the Commissioner of Food and Drugs, the Secretary of Veterans Affairs, and the heads of any other interested Federal department or agency.

(d) REFERENCES.—Any reference in any law to the Administrator for Health Care Policy and Research or to the Agency for Health Care Policy and Research is deemed a reference to the Administrator and Agency, respectively, under this section.

(e) TRANSFERS.—There are hereby transferred to the Agency the staff, funds, and other assets of the agencies for which the Agency is assuming responsibilities under subsection (c)(1).

(f) ADDITIONAL AUTHORIZATION OF APPROPRIATIONS.—In addition to the amounts transferred under subsection (e), there are authorized to be appropriated to the Agency $250,000 for each fiscal year (beginning with fiscal year 1995).

SEC. 1310. REPORT AND RECOMMENDATIONS ON ACHIEVING UNIVERSAL COVERAGE.

(a) FACTORS AFFECTING COVERAGE.—

(1) COLLECTION OF INFORMATION.—The Commission, on a continuing basis, shall collect information concerning and analyze the number and characteristics of eligible individuals (as defined in subsection (c)) who are not enrolled with AHPs compared to such number and characteristics of individuals enrolled. Such characteristics shall include age, sex, race, ethnicity, family status, employment status, whether the individual is an eligible employee, income, health status, health risk factors, geography, whether the individual resides in a rural or medically underserved area, and such other factors as may affect the election of an eligible individual to obtain health coverage.

(2) REPORT.—By not later than April 1 of each year (beginning with 1996), the Commission shall submit to Congress a report analyzing the information collected under paragraph (1). Such report shall include a description of the primary factors contributing to lack of coverage of identifiable groups of eligible individuals.

(b) RECOMMENDATIONS FOR INCREASING COVERAGE.—

(1) IN GENERAL.—By not later than January 1, 1997, the Commission shall submit to Congress recommendations on the feasibility, cost-effectiveness, and the economic impact of using different voluntary and other methods for increasing the coverage of eligible individuals.

(2) INDIVIDUAL MANDATE.—The Commission shall specifically make recommendations under paragraph (1) regarding establishing a requirement that all eligible individuals obtain health coverage through enrollment with an AHP.

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual''—

(1) includes individuals who would be eligible individuals but for section 1701(a)(4)(B), but

(2) does not include individuals eligible to enroll for benefits under part B of title XVIII of the Social Security Act.

SEC. 1311. NO AUTHORITY TO IMPOSE CONTROLS RELATING TO HEALTH CARE SPENDING.

The Commission is not authorized to establish or enforce any controls (such as global budgets, price controls, or premium limitations) on health care spending.

SEC. 1312. MONITORING REINSURANCE MARKET.

(a) IN GENERAL.—The Commission shall monitor the reinsurance market for AHPs.

(b) PERIODIC REPORTS.—The Commission shall periodically report to Congress respecting the availability of reinsurance for AHPs at reasonable rates and the impact of such availability on the establishment of new plans and on the financial solvency of current plans.

SEC. 1313. AUTHORIZATION OF APPROPRIATIONS; SUNSET.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Health Care Standards Commission for each of fiscal years 1994 through 2000 such sums as may be necessary to carry out activities under this Act.

(b) SUNSET.—Unless otherwise provided by law, the Health Care Standards Commission shall terminate on December 31, 1999.

Subtitle E—Managed Competition in Rural and Urban Underserved Areas

PART 1—SPECIAL TREATMENT OF DESIGNATED UNDERSERVED AREAS

SEC. 1401. DESIGNATION OF UNDERSERVED AREAS.

(a) IN GENERAL.—The Governor of any State may, subject to subsection (b), designate rural and urban areas of a State as underserved areas for purposes of this part.

In designating such areas, the Governor shall take into account—

(1) financial and geographic access to AHPs by residents of such areas, and

(2) the availability, adequacy, and quality of qualified providers and health care facilities in such areas.

(b) REVIEW BY COMMISSION.—No designation under subsection (a) shall take effect under this subsection unless the Commission—

(1) has been notified of the proposed designation, and

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

(c) CONSTRUCTION.—An area need not be designated as a medically underserved area (under section 330(b)(3) of the Public Health Service Act) or as a health professional shortage area (under section 332(a) of such Act) in order to be designated as an underserved area under this section.

(d) PERIOD OF DESIGNATION.—A designation under this section shall be effective for a period, specified by the Governor, of not longer than 3 years, except that such designation may be extended for additional 3-year periods.

SEC. 1402. SPECIAL TREATMENT.

(a) INCLUSION IN PLAN SERVICE AREA.—The HPPC serving an area designated under section 1401 may require AHPs, offered by the HPPC and with a service area adjoining such area, to include the area as part of their service area. The Commission may revoke under section 1305(c) registration of an AHP that fails to comply with such requirement.

(b) APPLICATION OF SPECIAL RISK ADJUSTMENT FACTORS.—In accordance with rules established by the Commission, for eligible individuals residing in an area designated under section 1401 and enrolled with an AHP, the HPPC may apply special risk-adjustment factors (determined under section 1306(b)(3)) in order to increase the compensation available to AHPs serving such individuals.

(c) DIRECT STATE SUBSIDIES.—The HPPC shall increase the amount of the payments made to AHPs serving individuals residing in an area designated under section 1401 by such amounts as the State makes available for this purpose.

(d) TECHNICAL ASSISTANCE IN ANTITRUST MATTERS.—The Department of Justice shall provide ongoing technical assistance to organizations in relation to the application of the Federal antitrust laws to the establishment of an AHP in an area designated under section 1401.

Such assistance shall be in addition to the review process provided under section 1231(b).

PART 2—TRANSITIONAL SUPPORT FOR DEVELOPMENT OF ACCOUNTABLE HEALTH PLANS IN UNDERSERVED AREAS

SEC. 1411. TECHNICAL ASSISTANCE FUNDING.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make funds available under this section to provide technical assistance and advice for entities (including Federally qualified health centers and rural health clinics) seeking to establish a network plan (as defined in section 1222(b)(1)) in an underserved rural or urban area.

(b) USE OF FUNDS.—Funds made available under this section may be used for—

(1) assistance in network development, utilizing existing local providers and facilities where appropriate;

(2) advice on obtaining the proper balance of primary and secondary facilities for the local population;

(3) assistance in coordinating arrangements for tertiary care;

(4) assistance in recruitment and retention of health care professionals; and

(5) assistance in coordinating the delivery of emergency services with the provision of services by an AHP.

(c) USE OF RURAL HEALTH OFFICES.—In carrying out this section with respect to entities in rural areas—

(1) the Secretary shall make funds available through the Office of Rural Health Policy, and

(2) priority shall be given to making funds available to State Offices of Rural Health.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 for each of fiscal years 1995 through 1999 to carry out this section. Of the amounts appropriated to carry out this section, one-half of such amounts shall be made available to entities for the establishment of network plans in rural areas and one-half of such amounts shall be made available to entities for the establishment of network plans in urban areas. Amounts appropriated under this section shall be available until expended.

SEC. 1412. RURAL DEVELOPMENT GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide financial assistance to eligible entities in order to provide for the development and implementation of AHPs in rural areas.

(b) ELIGIBLE ENTITIES.—

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

(A) is based in a rural area, and

(B) is undertaking to develop and implement an AHP in a rural area with the active participation of at least 3 health care providers or facilities in the area.

(2) FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—Nothing in this section shall be construed as preventing a Federally qualified health center or rural health clinic from qualifying for financial assistance under this section.

(c) USE OF FUNDS.—

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

(A) For development and implementation.

(B) For information systems, including telecommunications.

(C) For meeting solvency requirements for an AHP.

(D) For recruiting health care providers.

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

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

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

(d) APPLICATION.—

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

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

(A) a description of the proposed AHP, including service area and capacity,

(B) a plan for providing the continuum of services included in the uniform set of effective benefits, and

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

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $75,000,000 for each of fiscal years 1995 through 1999 to carry out this section. Amounts appropriated under this section shall be available until expended.

(2) INTEGRATION OF OTHER AUTHORIZATIONS.—In order to provide for the authorization of appropriations under paragraph (1), notwithstanding any other provision of law, no funds are authorized to be appropriated to carry out the following programs in fiscal years after fiscal year 1994:

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

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

SEC. 1413. MIGRANT HEALTH CENTERS.

Section 329(h) of the Public Health Service Act (42 U.S.C. 254b(h)) is amended—

(1) in paragraph (1)(A), by striking ''through 1994'' and inserting ''through 1999'',

(2) in paragraph (2)(A), by striking ''through 1994'' and inserting ''through 1999'', and

(3) by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

''(3)(A) For the purpose of carrying out subparagraph (B), there are authorized to be appropriated $11,500,000 for each of the fiscal years 1995 through 1999.

''(B) The Secretary may make grants to migrant health centers for the purpose of assisting such centers in integrating with AHPs and in providing (and coordinating the provision of) the uniform set of effective benefits under such a plan.''.

SEC. 1414. COMMUNITY HEALTH CENTERS.

Section 330(g) of the Public Health Service Act (42 U.S.C. 254c(g)) is amended—

(1) in paragraph (1)(A), by striking ''through 1994'' and inserting ''through 1999'',

(2) in paragraph (2)(A), by striking ''through 1994'' and inserting ''through 1999'', and

(3) by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

''(3)(A) For the purpose of carrying out subparagraph (B), there are authorized to be appropriated $88,500,000 for each of the fiscal years 1995 through 1999.

''(B) The Secretary may make grants to community health centers for the purpose of assisting such centers in developing and integrating with accountable health plans and in providing (and coordinating the provision of) the uniform set of effective benefits under such a plan.''.

PART 3—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS

SEC. 1421. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

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

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

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

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

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

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

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

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

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

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

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

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

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of

that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means medical and other health services furnished by a rural emergency access care hospital.''.

SEC. 1422. COVERAGE OF AND PAYMENT FOR SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during

a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

SEC. 1423. EFFECTIVE DATE.

The amendments made by this part shall apply to fiscal years beginning on or after October 1, 1994.

PART 4—TRANSITIONAL ASSISTANCE FOR SAFETY NET HOSPITALS

SEC. 1431. PAYMENTS TO HOSPITALS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make payments for transitional assistance to eligible hospitals whose applications for assistance have been approved under this part.

(b) GENERAL ELIGIBILITY REQUIREMENTS FOR ASSISTANCE.—

(1) HOSPITALS DESCRIBED.—

(A) IN GENERAL.—A hospital shall be generally eligible for assistance under this part if the hospital—

(i) receives an additional payment under section 1886(d)(5)(F) of the Social Security Act and is described in clause (i)(II) or clause (vii)(I) of such section, or is deemed a disproportionate share hospital

under a State plan for medical assistance under title XIX of such Act on the basis described in section 1923(b)(1) of such Act; or

(ii) is a hospital that the Secretary otherwise determines to be an appropriate recipient of assistance under this part on the basis of the existence of a patient care operating deficit, a demonstrated inability to secure or repay financing for a qualifying project on reasonable terms, or such other criteria as the Secretary considers appropriate.

(B) DEVELOPMENT OF CRITERIA.—For purposes of subparagraph (A)(ii), with respect to rural hospitals which are at risk or critical to health care access, the Prospective Payment Review Commission, not later than 6 months after the date of the enactment of this Act, shall develop criteria to assist the Secretary in deciding which such hospitals deserve assistance.

(2) OWNERSHIP REQUIREMENTS.—In order to qualify for assistance under this part, a hospital must—

(A) be owned or operated by a unit of State or local government;

(B) be a quasi-public corporation, defined as a private, nonprofit corporation or public benefit corporation which is formally granted one or more governmental powers by legislative action through (or is otherwise partially funded by) the State legislature, city or county council; or

(C) be a private nonprofit hospital which has contracted with, or is otherwise funded by, a governmental agency to provide health care services to low income individuals not eligible for benefits under title XVIII or title XIX of the Social Security Act, where revenue from such contracts constitute at least 10 percent of the hospital's operating revenues over the prior 3 fiscal years.

(c) MEETING ADDITIONAL SPECIFIC CRITERIA.—Hospitals that are generally eligible for assistance under this part under subsection (b) may apply for the specific programs described in this part and must meet any additional criteria for participation in such programs.

SEC. 1432. APPLICATION FOR ASSISTANCE.

(a) IN GENERAL.—No hospital may receive assistance for a project under this part unless the hospital—

(1) has filed with the Secretary, in a form and manner specified by the Secretary an application for assistance under this part;

(2) establishes in its application (for its most recent cost reporting period) that it meets the criteria for general eligibility under this part;

(3) includes a description of the project, including the community in which it is located, and describes utilization and services characteristics of the project and the hospital, and the patient population that is to be served;

(4) describes the extent to which the project will include the financial participation of State and local governments, and all other sources of financing sought for the project; and

(5) establishes, to the satisfaction of the Secretary, that the project meets the additional criteria for assistance under this part.

(b) CRITERIA FOR APPROVAL.—The Secretary shall determine for each application for assistance under this part—

(1) whether the hospital meets the general eligibility criteria under section 1431(b);

(2) whether the hospital meets any additional eligibility criteria;

(3) whether the project for which assistance is being requested meets the requirements of this part; and

(4) whether funds are available, pursuant to the limitations of each program, to fully fund the request for assistance.

SEC. 1433. PUBLIC SERVICE RESPONSIBILITIES.

(a) IN GENERAL.—Any hospital accepting assistance under this part shall agree—

(1) to make the services of the facility or portion thereof to be constructed, acquired, or modernized available to all persons residing in the territorial area of the applicant; and

(2) to provide a significant volume of services to persons unable to pay therefore, consistent with other provisions of this Act.

(b) ENFORCEMENT.—The Director of the Office of Civil Rights of the Department of Health and Human Services shall be given the power to enforce the public service responsibilities described in this section.

SEC. 1434. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated $50,000,000 for each of the fiscal years 1995 through 1999 to carry out this part.

Subtitle F—Treatment of Chronically Underserved Areas

SEC. 1501. PROMOTING STATE ACTION.

(a) STANDARDS FOR IDENTIFICATION OF CHRONICALLY UNDERSERVED AREAS.—The Health Care Standards Commission shall develop, not later than 2 years after the date of the enactment of this Act, standards for the identification of chronically underserved areas in which the special treatment provided under subsection (b) may be appropriate. Such standards shall be based on—

(1) inadequate access in an area to services included within the uniform set of effective benefits,

(2) insufficient price competition for such services in an area, and

(3) poor quality of such services in an area.

(b) STATE IDENTIFICATION OF AREAS AND PLAN.—On and after 3 years after the date of the enactment of this Act, a State may submit to the Commission—

(1) a finding that an area within the State meets the standards developed under subsection (a) to be identified as a chronically underserved area, and

(2) a plan for addressing the problem of health care delivery in such area.

No plan may be submitted under paragraph (2) for an area unless the plan has been developed in cooperation with each HPPC serving any portion of the area.

(c) CONTENTS OF PLAN.—A plan under subsection (b)(2) for a chronically underserved area may provide for the limitation of agreements under section 1102 to a single AHP, with such contract awarded on a competitive basis.

(d) REVIEW.—With respect to submissions under subsection (b), the Commission shall review—

(1) each finding described in subsection (b)(1), and

(2) each plan submitted under subsection (b)(2).

The Commission shall approve or disapprove such a finding and such a plan within 60 days of the date of its submission and shall notify the State of its decision. If the Commission disapproves the finding or the plan, the Commission shall provide the State with the reasons for the disapproval. If the Commission does not act within such period, the Commission is deemed to have approved the finding and the plan.

Subtitle G—Repeal of COBRA Continuation Requirements

SEC. 1601. REPEAL OF COBRA CONTINUATION REQUIREMENTS.

(a) INTERNAL REVENUE CODE PROVISIONS.—

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

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

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

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

(b) ERISA.—

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

(A) by striking sections 601 through 606, and

(B) in section 609, as added by section 4301 of the Omnibus Budget Reconciliation Act of 1993, by striking subsection (d).

(2) CONFORMING AMENDMENT.—Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is

amended by striking ''paragraph (1) or (4) of section 606 or''.

(c) PUBLIC HEALTH SERVICE ACT.—Title XXII of the Public Health Service Act is repealed.

(d) EFFECTIVE DATE.—The repeals and amendments made by this section shall apply to health plans of employers as of the January 1, 1995.

(e) NOTICE OF BENEFITS.—In the case of continuation coverage which is in effect on January 1, 1995, under a provision of law repealed by this section, such continuation may not be discontinued without 30-day notice to the individual of such discontinuation. Such notice shall include such information with respect to continuation of coverage through a health plan purchasing cooperative as the Health Care Standards Commission shall specify.

Subtitle H—Definitions

SEC. 1701. DEFINITIONS.

(a) ELIGIBILITY.—In this title and title II:

(1) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to a HPPC area, an individual who—

(A) is an eligible employee,

(B) is an eligible resident, or

(C) an eligible family member of an eligible employee or eligible resident.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to a HPPC area, an individual residing in the area who is the employee of a small employer.

(3) ELIGIBLE FAMILY MEMBER.—The term ''eligible family member'' means, with respect to an eligible employee or other principal enrollee, an individual who—

(A)(i) is the spouse of the employee or principal enrollee, or

(ii) is an unmarried dependent child under 22 years of age, including—

(I) an adopted child or recognized natural child, and

(II) a stepchild or foster child but only if the child lives with the employee or principal enrollee in a regular parent-child relationship,

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(B) is a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien oth-

erwise lawfully residing permanently in the United States under color of law; and

(C) with respect to an eligible resident, is not a medicare-eligible individual.

(4) ELIGIBLE RESIDENT.—

(A) IN GENERAL.—The term ''eligible resident'' means, with respect to a HPPC area, an individual who is not an eligible employee, is residing in the area, and is a citizen or national of the United States, an alien lawfully admitted for permanent residence, and an alien granted asylum, admitted as a refugee, or whose deportation has been withheld.

(B) EXCLUSION OF CERTAIN INDIVIDUALS OFFERED COVERAGE THROUGH A LARGE EMPLOYER.—

(i) IN GENERAL.—The term ''eligible resident'' does not include an individual who—

(I) is covered under an AHP pursuant to an offer made under section 1005(b)(1)(A), or

(II) subject to clause (ii), could be covered under an AHP as the prin-

cipal enrollee pursuant to such an offer if such offer had been accepted.

(ii) EXCEPTION FOR PART-TIME, SEASONAL, AND TEMPORARY EMPLOYEES.—Subclause (II) of clause (i) shall not apply to an individual who is offered coverage under an AHP by an employer and who is only a part-time, seasonal, or temporary employee of that employer. For purposes of the previous sentence, the term ''part-time'' means employment for an average of less than 25 hours a week on a monthly basis and an employee who is employed for more than 8 weeks in a 12-month period for an employer shall not be considered to be seasonal or temporary employee.

(C) TREATMENT OF MEDICARE BENEFICIARIES.—The term ''eligible resident'' does not include a medicare-eligible beneficiary.

(5) ENROLLEE UNIT.—The term ''enrollee unit'' means one unit in the case of coverage on an individual basis or in the case of coverage on a family basis.

(6) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enti-

tled to benefits under part A of title XVIII of the Social Security Act, including an individual who is entitled to such benefits pursuant to an enrollment under section 1818 or 1818A of such Act.

(7) MEDICARE-ELIGIBLE INDIVIDUAL.—The term ''medicare-eligible individual'' means an individual who—

(A) is a medicare beneficiary, or

(B) is not a medicare beneficiary but is eligible to enroll under part A or part B of title XVIII of the Social Security Act.

(b) ABBREVIATIONS.—In this Act, except as otherwise provided:

(1) AHP; ACCOUNTABLE HEALTH PLAN.—The terms ''accountable health plan'' and ''AHP'' mean a health plan registered with the Commission under section 1201(a).

(2) COMMISSION.—The term ''Commission'' means the Health Care Standards Commission established under subtitle D.

(3) HPPC; HEALTH PLAN PURCHASING COOPERATIVE.—The terms ''health plan purchasing cooperative'' and ''HPPC'' mean a health plan purchasing cooperative established under subtitle B.

(4) CLOSED AND OPEN PLANS.—

(A) CLOSED.—

(i) IN GENERAL.—A plan is ''closed'' if the plan is limited by structure or law to one or more large employers.

(ii) GRANDFATHER FOR TAFT-HARTLEY PLANS.—A plan not described in clause (i) that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and one or more employers and that was established as of September 7, 1993, shall be considered to be a closed plan.

(iii) UNIVERSITY PLANS.—Nothing in this subparagraph shall be construed as preventing a university from offering enrollment, in a closed plan maintained by a university, to students matriculating at the university.

(iv) SMALL EMPLOYERS.—Subject to clause (ii), a plan is not a ''closed'' plan if the plan was formed by one or more small employers or for the benefit of employees of such an employer.

(B) OPEN.—A plan is ''open'' if the plan is not closed (within the meaning of subparagraph (A)).

(c) OTHER TERMS.—In this title and titles II and VI:

(1) HEALTH PLAN.—The term ''health plan'' means a plan that provides health benefits, whether through directly, through insurance, or otherwise, and includes a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).

(2) SMALL EMPLOYER; LARGE EMPLOYER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''small employer'' means an employer that normally employed fewer than 101 employees during a typical business day in the previous year and the term ''large employer'' means an employer that is not a small employer.

(B) SPECIAL RULE FOR LARGE EMPLOYERS.—Subject to subparagraph (C), the Commission shall provide a procedure by which, in the case of an employer that is not a small employer but normally employs fewer than 101 employees (or, in the case of a State making an election described in subparagraph (C)(i), the number of employees specified under the State law) in a HPPC area (or other locality identified by the Commission) during a typical business day, the employer, upon application, would be considered to be a small employer with respect to such employees in the HPPC area (or other locality). Such procedure shall be designed so as to prevent the adverse selection of employees with respect to which the previous sentence is applied.

(C) STATE ELECTION.—

(i) IN GENERAL.—Subject to section 1101(a)(3) and clause (ii), a State may by law, with respect to employers in the State, substitute for ''101'' in subparagraphs (A) and (B) any greater number, so long as—

(I) such number is applied uniformly to all employers (other than

employers described in clause (ii)) in a State, and

(II) the State demonstrates, to the satisfaction of the Commission, that as of the time of enactment of the State law not more than 50 percent of all employees in the State are employees of small employers (as determined based upon such substitution).

(ii) EXCEPTION FOR CERTAIN LARGE MULTI-STATE EMPLOYERS.—Clause (i) shall not apply to an employer that normally employed at least 500 employees during a typical business day in the previous year in each of at least 2 different States.

(3) PREMIUM CLASS.—The term ''premium class'' means a class established under section 1205(a)(2).

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

(5) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Is-

lands, Guam, American Samoa, and the Northern Mariana Islands.

(6) TYPE OF ENROLLMENT.—There are 4 ''types of enrollment'':

(A) Coverage only of an individual (referred to in this title as enrollment ''on an individual basis'').

(B) Coverage of an individual and the individual's spouse.

(C) Coverage of an individual and one child.

(D) Coverage of an individual and more than one eligible family member.

The types of coverage described in subparagraphs (B) through (D) are collectively referred to in this title as enrollment ''on a family basis''.

(7) UNIFORM SET OF EFFECTIVE BENEFITS.—The term ''uniform set of effective benefits'' means, for a year, such set of benefits as recommended by the Commission under section 1302(a), if not disapproved under such section.

TITLE II—LOW-INCOME ASSISTANCE FOR HEALTH COVERAGE

Subtitle A—Low-Income Assistance

SEC. 2001. ELIGIBILITY.

(a) ENROLLEES UNDER ACCOUNTABLE HEALTH PLANS.—Each low-income individual (as defined in section 2009(a)(1)(A)) who is not a medicare-eligible individual is eligible—

(1) for assistance under section 2002(a) with respect to premiums,

(2) for assistance under section 2003(a) with respect to cost-sharing otherwise imposed by the plan, and

(3) in the case of a very low-income individual, for assistance under section 2004 with respect to certain items and services.

(b) MEDICARE-ELIGIBLE INDIVIDUALS.—Each medicare-eligible individual who is a low-income individual is eligible—

(1) for assistance under section 2002(b) with premiums under the medicare program, and

(2) in the case of a very low-income individual, for assistance under section 2003(b) with respect to other medicare cost-sharing and for assistance under

section 2004 with respect to certain items and services.

SEC. 2002. PREMIUM ASSISTANCE.

(a) IN GENERAL.—

(1) VERY LOW-INCOME INDIVIDUALS.—In the case of a very low-income individual (as defined in section 2009(a)(3)) who is enrolled in an AHP, the premium assistance under this section consists of—

(A) an adjustment in premiums charged the individual under the plan, in accordance with section 1205(c)(1); and

(B) payment to the accountable health plan (on behalf of the individual and family members) of the applicable Federal assistance amount (as defined in section 2009(c)(1)) for enrollment under the plan.

(2) MODERATELY LOW-INCOME INDIVIDUALS.—In the case of a moderately low-income individual (as defined in section 2009(a)(2)) who is enrolled in an AHP, the premium assistance under this section consists of—

(A) an adjustment in premiums charged the individual under the plan, in accordance with section 1205(c)(2); and

(B) payment to the accountable health plan (on behalf of the individual and family members) of the applicable Federal assistance amount (as defined in section 2009(c)(1)) for enrollment under the plan.

(b) MEDICARE-ELIGIBLE INDIVIDUALS.—In the case of a medicare-eligible individual described in section 2001(b), the premium assistance under this subsection shall consist of payment for premiums imposed under part A (if any) or part B of title XVIII of the Social Security Act. Such assistance shall be provided in a manner so that no such premium amount is deducted from monthly benefits or transfers under section 1818 or 1840 of such Act.

SEC. 2003. COST-SHARING ASSISTANCE.

(a) NOMINAL COST-SHARING FOR LOW-INCOME INDIVIDUALS.—

(1) IN GENERAL.—In the case of a low-income individual described in section 2001(a) who is enrolled in an AHP in an enrollee unit, the cost-sharing assistance under this subsection shall consist of—

(A) an accountable health plan's reduction, in accordance with section 1202(c), in the cost-sharing otherwise imposed to amounts that are

nominal (as specified by the Commission, consistent with paragraph (2)); and

(B) payment to the accountable health plan (on behalf of the individual and family members) by the Commission of the adjusted per enrollee cost-sharing assistance amount determined under paragraph (3).

(2) NOMINAL.—In establishing what is ''nominal'' for purposes of paragraph (1), the Commission shall consider regulations established to carry out section 1916(a)(3) of the Social Security Act (as in effect before the date of the enactment of this Act).

(3) ADJUSTED PER ENROLLEE COST-SHARING ASSISTANCE AMOUNT.—

(A) IN GENERAL.—For purposes of this section, the term ''adjusted per enrollee cost-sharing assistance amount'' means, for a year, the product of—

(i) the amount determined under subparagraph (B)(i), divided by the number determined under subparagraph (B)(ii); and

(ii) the premium class assistance factor established under subparagraph (C).

(B) DETERMINATION OF AVERAGE PER ENROLLEE COST-SHARING AMOUNT.—Before the beginning of each year the Commission shall estimate—

(i) the total amount of cost-sharing assistance to be provided under this section to enrollee units in the year, and

(ii) the average number of enrollee units (as defined in section 1701(a)(5)) to be provided such assistance in the year.

(C) PREMIUM CLASS ASSISTANCE FACTOR.—The Commission shall establish a factor, for each premium class, that reflects the ratio of the—

(i) the average value of the cost-sharing assistance furnished under this section to individuals within the premium class, to

(ii) the average value of the cost-sharing assistance furnished under this subsection to individuals within all the premium classes.

(b) CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS.—In the case of a very low-income individual described in section 2001(b), the cost-sharing assistance under this

subsection shall consist of payment being made under title XVIII of the Social Security Act—

(1) without regard to coinsurance under such title (including coinsurance described in section 1813 of such title);

(2) without regard to deductibles established under such title (including those described in section 1813 and section 1833(b) of such title); and

(3) as though any reference to ''80 percent'' in section 1833(a) of such title were a reference to ''100 percent''.

(c) APPROPRIATION TO COVER PART A ASSISTANCE.—Section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) is amended by adding at the end the following new sentence: ''In addition to the amounts appropriated under this subsection, there are hereby appropriated to the Trust Fund, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to the reductions in the deductibles and coinsurance established under section 1813 effected under section 2003(b) of the Managed Competition Act of 1993.''.

SEC. 2004. ASSISTANCE FOR CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—In the case of a very low-income individual, the special assistance under this section con-

sists of payment under this section with respect to items and services described in subsection (b), subject to subsection (c).

(b) ITEMS AND SERVICES COVERED.—

(1) IN GENERAL.—Subject to paragraph (2), the items and services described in this subsection are—

(A) prescription drugs,

(B) eyeglasses and hearing aids, and

(C) such other items and services as the Commission determines were commonly provided to individuals described in section 1902(a)(10)(A)(i) of the Social Security Act under State medicaid plans under title XIX of such Act (as in effect as of the date of the enactment of this Act).

(2) EXCLUSIONS.—Items and services described in this subsection shall not include—

(A) items and services included in the uniform set of effective benefits, and

(B) services described in section 2101(c)(1)(A) and similar services.

(c) NOMINAL COPAYMENTS.—The Commission shall provide for cost-sharing under this section in an amount that is nominal (within the meaning of section 1916(a)(3)

of the Social Security Act, as in effect as of the date of the enactment of this Act).

(d) PAYMENT RULES.—The Commission shall provide for such rules relating to—

(1) qualifications of providers of items and services, and

(2) use of carriers in the administration of this section,

as may be appropriate to carry out this section.

SEC. 2005. COMPUTATION OF BASE FEDERAL PREMIUM AMOUNT.

(a) FORMULA.—

(1) IN GENERAL.—For purposes of this Act, the ''base Federal premium amount'' for an individual residing in a HPPC area is equal to the product of—

(A) reference premium rate (as defined in section 2009(c)(4)) for the individual, and

(B) the national subsidy percentage (computed under paragraph (2)).

(2) NATIONAL SUBSIDY PERCENTAGE.—In paragraph (1)(B), the term ''national subsidy percentage'' means, for a year—

(A) the amount specified under subsection (b)(1), divided by

(B) the total amount of low-income assistance that would be provided if the national subsidy percentage were equal to 100 percent;

expressed as a percentage.

(b) COMPUTATION OF TOTAL FEDERAL AMOUNT AVAILABLE FOR LOW-INCOME ASSISTANCE.—

(1) IN GENERAL.—The amount specified in this paragraph for a year is—

(A) the sum determined under paragraph (2) for the year, reduced by

(B) the total amount of reductions under paragraph (3) for the year.

(2) AVAILABLE FEDERAL FUNDS.—

(A) 1995 THROUGH 1999.—The Health Care Standards Commission shall compute, in consultation with the Secretary of Health and Human Services and the Director of the Office of Management and Budget, before the beginning of each of years 1995, 1996, 1997, 1998, and 1999, the sum of—

(i) the total dollar amount of Federal financial participation that would have been payable to States under section 1903 of the Social Security Act (including such a plan operating under a waiver under sec-

tion 1115 of such Act) for calendar quarters during the year, based on their plans in effect as of the date of the enactment of this Act, taking into account changes scheduled to occur in such a plan as of such date; and

(ii) subject to paragraph (4)(A), the total net amount of additional revenues estimated by the Secretary of the Treasury to be received during the year due to the amendments made by subtitle A of title I and subtitle C of this title.

(B) AFTER 1999.—The Health Care Standards Commission shall compute, in consultation with the Secretary of Health and Human Services and the Director of the Office of Management and Budget, before the beginning of 2000 and each subsequent year the sum of—

(i) the total dollar amount computed under subparagraph (A)(i) (or this clause) for the previous year, increased by the percentage increase in the gross domestic product (as determined by the Secretary of Commerce) for the 4-quarter period ending in June of the previous year; and

(ii) subject to paragraph (4)(A), the total net amount of additional revenues estimated by the Secretary of the Treasury to be received during the year due to the amendments made by subtitle A of title I and subtitle C of this title.

(3) REDUCTIONS.—Subject to paragraph (4)(B), the total amount of reductions described in this paragraph for a year are the sum of the following:

(A) LONG-TERM CARE PHASE-DOWN ASSISTANCE.—The total amount of long-term care phase-down assistance to which States are entitled under section 2101 for calendar quarters during the year.

(B) MEDICARE LOW-INCOME ASSISTANCE.—The total amount, estimated by the Commission, of the assistance to be provided under sections 2002(b) and 2003(b) during the year.

(C) COST-SHARING.—The total amount, estimated by the Commission, of the cost-sharing assistance to be provided under section 2003(a) during the year.

(D) SPECIAL LOW-INCOME ASSISTANCE.—The total amount, estimated by the Commission, of the special assistance to be provided under section 2004 during the year.

(E) GRANTS AND OTHER EXPENDITURES.—In order to provide for grants under section 2006(g) and additional expenditures under subtitle E of title I, subtitle B of title III, subtitle A of title IV, and title V, $523,000,000.

(4) ADJUSTMENT FOR OVER- AND UNDER-ESTIMATES.—

(A) FUNDS AVAILABLE.—The amounts determined under subparagraphs (A)(ii) and (B)(ii) of paragraph (2) for a year shall be increased or decreased by the amount by which the amount estimated under such respective subparagraph for the preceding year was below, or above, the actual amount of revenues for such year.

(B) REDUCTIONS.—The amounts specified in subparagraphs (A) through (D) of paragraph (3) for a year shall be increased or decreased by the amount by which the respective amount estimated under such subparagraph for the pre-

ceding year was below, or above, the actual amount described in such subparagraph for such year.

SEC. 2006. APPLICATIONS FOR ASSISTANCE.

(a) IN GENERAL.—Subject to section 2008, any individual who seeks assistance under this subtitle (with respect to himself or herself or a family member) shall submit a written application, by person or mail, to the Commission.

(b) BASIS FOR DETERMINATION.—Subject to section 2008 and reconciliation under section 2007(b), eligibility for assistance under this subtitle shall be based on 4 times the family adjusted total income (as defined in section 2009(b)(1)) during the 3 months preceding the month in which the application is filed.

(c) FORM AND CONTENTS.—An application for assistance under this subtitle shall be in a form and manner specified by the Commission and shall require—

(1) the provision of information necessary to make the determinations described in subsection (b),

(2) the provision of information respecting the AHP in which the individual is enrolled (or is in the process of enrolling), and

(3) the individual to assign rights to assistance under section 2003 to such plan.

Such form also shall include notice that the subsidies under this subtitle will be made as a direct reduction of premiums and cost-sharing under the AHP involved.

(d) FREQUENCY OF APPLICATIONS.—

(1) IN GENERAL.—An application for assistance under this subtitle may be filed at any time during the year and may be resubmitted (but, except as provided in paragraph (3), not more frequently than once every 3 months) based upon a change of income or family composition.

(2) NEED TO REAPPLY.—In the case of an individual who—

(A) is entitled to assistance under this subtitle in September of a year, and

(B) wishes to remain eligible for assistance for months beginning with January of the following year,

the individual (or a family member) must file with the Commission in October of that preceding year a new application for assistance. If a new application under this paragraph is not filed with respect to an individual, an application for such assistance with respect to the individual may not be filed during November or December of that preceding year.

(3) CORRECTION OF INCOME.—Nothing in paragraph (1) shall be construed as preventing an individual or family from, at any time, submitting an application to reduce the amount of assistance under this subtitle based upon an increase in income from that stated in the previous application.

(e) TIMING OF ASSISTANCE.—

(1) IN GENERAL.—If an application for assistance under this subtitle is filed—

(A) on or before the 15th day of a month, assistance under this subtitle shall be available for premiums for months after such month and, with respect to the cost-sharing, for expenses incurred after such month, and, with respect to special assistance, for items and services furnished after such month; or

(B) after the 15th day of a month, assistance under this subtitle shall be available for premiums for months after the month following such month and, with respect to the cost-sharing, for expenses incurred after such following month, and, with respect to special assistance, for items and services furnished after such following month.

(2) WELFARE RECIPIENTS.—In the case of an individual or family with respect to whom an application for assistance is not required because of section 2008, in applying paragraph (1), the date of approval of aid or benefits described in such section shall be considered the date of filing of an application for assistance under this subtitle.

(f) VERIFICATION.—The Commission shall provide for verification, on a sample basis or other basis, of the information supplied in applications under this subtitle. This verification shall be separate from the reconciliation provided under section 2007.

(g) HELP IN COMPLETING APPLICATIONS.—The Commission shall provide, from funds appropriated to carry out this subtitle, for grants to public or private nonprofit entities that will make available assistance to individuals and families in filing applications for assistance under this subtitle. The Commission shall make grants in a manner that provides such assistance at a variety of sites (such as low-income housing projects and shelters for homeless individuals) that are readily accessible to individuals and families eligible for assistance under this subtitle. The total amount of the funds provided in any fiscal year under grants under this subsection may not exceed $10,000,000.

(h) PENALTIES FOR INACCURATE INFORMATION.—

(1) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application for assistance under this subtitle or otherwise makes a material misrepresentation of information in such an application shall be liable to the Health Care Standards Commission for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Commission.

(2) PENALTIES FOR MISREPRESENTATION.—Each individual who knowingly misrepresents material information in an application for assistance under this subtitle shall be liable to the Health Care Standards Commission for $1,000 or, if greater, three times the excess payments made based on such misrepresentation.

(i) FILING OF APPLICATION DEFINED.—Except as provided in subsection (e)(2), for purposes of this subtitle, an application under this subtitle is considered to be ''filed'' on the date on which the complete application, including all documentation required to act on the application, has been filed with the Commission.

SEC. 2007. RECONCILIATION OF PREMIUM ASSISTANCE THROUGH USE OF INCOME STATEMENTS.

(a) REQUIREMENT FOR FILING OF INCOME STATEMENT.—

(1) IN GENERAL.—Subject to section 2008, in the case of a family which is receiving low-income assistance under this subtitle for any month in a year, a member of the family shall file with the Commission, by not later than April 15 of the following year, a statement that verifies the family's total adjusted family income for the taxable year ending during the previous year. Such a statement shall provide information necessary to determine the family adjusted total income during the year and the number of family members in the family as of the last day of the year.

(2) USE OF INCOME TAX RETURN.—The Commission shall provide a process under which the filing of a Federal income tax return shall constitute the filing of a income statement under paragraph (2).

(3) EXTENSION.—The Commission shall permit the extension of the filing deadline under paragraph (1) in such cases as the Commission determines to be appropriate. The Commission shall take into ac-

count the extensions permitted for the filing of Federal income tax returns.

(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the statement filed under subsection (a) with respect to a family or individual, subject to section 2008, the Commission shall compute the amount of assistance that should have been provided under section 2002 with respect to premiums for the family in the year involved. If the amount of such assistance computed is—

(1) greater than the amount of premium assistance provided, the Commission shall provide for payment to the family or individual involved of an amount equal to the amount of the deficit, or

(2) less than the amount of assistance provided, the Commission shall require the family or individual to pay to the Commission (to the credit of the program under this subtitle) an amount equal to the amount of the excess payment.

(c) DISQUALIFICATION FOR FAILURE TO FILE.—Subject to section 2008, in the case of any individual with respect to whom an information statement under subsection (a) is required to be filed in a year and that fails to file such a statement by the deadline specified in such subsection, the individual is not eligible for assistance

under this subtitle after May 1 of such year. The Commission shall waive the application of this subsection if there is established, to the satisfaction of the Commission, good cause for the failure to file the statement on a timely basis.

(d) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under subsection (a) is subject to a criminal penalty to the same extent as a criminal penalty may be imposed under section 1128B(a) of the Social Security Act with respect to a person described in clause (ii) of such section.

(e) NOTICE OF REQUIREMENT.—The Commission shall provide for written notice, in March of each year, of the requirement of subsection (a) to each family which received assistance under this subtitle in any month during the preceding year and to which such requirement applies.

(f) TRANSMITTAL OF INFORMATION.—The Commission of the Treasury shall transmit annually to the Commission such information relating to the adjusted total income of individuals for the taxable year ending in the previous year as may be necessary to verify the reconciliation of assistance under this section.

(g) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of assistance pro-

vided with respect to cost-sharing assistance under section 2003 or special assistance under section 2004.

SEC. 2008. TREATMENT OF CERTAIN CASH ASSISTANCE RECIPIENTS.

In the case of a family that has been determined to be eligible for aid under part A or E of title IV of the Social Security Act or an individual who has been determined to be eligible for supplemental security income benefits under title XVI of such Act—

(1) the family or individual is deemed, without the need to file an application for assistance under section 2006, to have adjusted total income below 100 percent of the State-adjusted poverty level for the State,

(2) the family or individual need not file a statement under section 2007(a), and

(3) the assistance received by the family is not subject to reconciliation under section 2007(b).

SEC. 2009. DEFINITIONS.

(a) DEFINITIONS RELATING TO LOW-INCOME INDIVIDUALS.—In this subtitle:

(1) LOW-INCOME INDIVIDUAL.—

(A) IN GENERAL.—The term ''low-income individual'' means, in the case of—

(i) a medicare-eligible individual residing in a State, such an individual whose family adjusted total income (as defined in subsection (b)(1)) is less than 120 percent of the State-adjusted poverty level for the State; or

(ii) an individual who is not a medicare-eligible individual and who resides in a State, an eligible individual (as defined in section 1701(a)(1)) whose family adjusted total income is less than 200 percent of the State-adjusted poverty level for the State.

(2) MODERATELY LOW-INCOME INDIVIDUAL.—The term ''moderately low-income individual'' means a low-income individual (as defined in paragraph (1)) who is not a very low-income individual (as defined in paragraph (3).

(3) VERY LOW-INCOME INDIVIDUAL.—The term ''very low-income individual'' means, with respect to an individual residing in a State, a low-income individual whose family adjusted total income is less than 100 percent of the State-adjusted poverty level for the State.

(b) DEFINITIONS RELATING TO INCOME AND POVERTY LINE.—In this subtitle:

(1) FAMILY ADJUSTED TOTAL INCOME.—The term ''family adjusted total income'' means, with respect to an individual, the sum of the modified total income for the individual and all the other eligible family members.

(2) MODIFIED FAMILY INCOME.—The term ''modified family income'' means the sum of—

(A) the adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986) of the taxpayer and family members for the taxable year determined without regard to sections 911, 931, and 933 of such Code, determined without the application of paragraphs (6) and (7) of section 62(a) of such Code and without the application of section 162(l) of such Code, plus

(B) the interest received or accrued by the taxpayer and family members during such taxable year which is exempt from income, plus

(C) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income of the tax-

payer and family members under section 86 of such Code.

(3) STATE-ADJUSTED POVERTY LEVEL DEFINED.—

(A) IN GENERAL.—The term ''State-adjusted poverty level'' means, with respect to an individual resident in a State, the poverty line (as defined in paragraph (4)) multiplied by the State adjustment factor (established under subparagraph (B)) for the State.

(B) STATE ADJUSTMENT FACTORS.—The Health Care Standards Commission shall establish, for each State, a State adjustment factor that reflects the relative cost-of-living in the State compared to the cost-of-living in the continental United States (including Alaska) and Hawaii. The weighted average of such factors shall be 1. Such factors shall be updated annually.

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

(5) FAMILY SIZE.—The family size to be applied under this subtitle, with respect to family adjusted total income, is the number of eligible family members (as defined in section 1701(a)(3)).

(c) DEFINITIONS RELATING TO ASSISTANCE AND PREMIUM AMOUNTS.—In this Act:

(1) APPLICABLE FEDERAL ASSISTANCE AMOUNT.—The term ''applicable Federal assistance amount'' means, with respect to—

(A) a very low-income individual, the base Federal premium amount (as determined under section 2005(a)(1)), or

(B) a moderately low-income individual, the amount by which (i) the applicable low-income premium amount (as defined in paragraph (2)), exceeds (ii) the base individual premium (as defined in paragraph (3)),

reduced by the amount of any contribution made by an employer with respect to coverage of the individual.

(2) APPLICABLE LOW-INCOME PREMIUM AMOUNT.—The term ''applicable low-income premium amount'' means, with respect to a low-income individual, the base Federal premium amount (deter-

mined under section 2005(a)(1)) plus the product of—

(A) the individual responsibility percentage (as defined in paragraph (5)), and

(B) the amount by which (i) the reference premium rate (as defined in paragraph (4)), exceeds (ii) the base Federal premium amount.

(3) BASE INDIVIDUAL PREMIUM.—The term ''base individual premium'' means, with respect to an individual, the product of—

(A) the individual responsibility percentage (as defined in paragraph (5)), and

(B) the reference premium rate (as defined in paragraph (4)).

(4) REFERENCE PREMIUM RATE.—The term ''reference premium rate'' means, with respect to an individual residing in a HPPC area, the lowest premium—

(A) established by an open AHP which enrolls at least such proportion of eligible individuals in the HPPC area as the Commission shall specify, and

(B) offered in the area for the premium class applicable to such individual (including

the HPPC overhead amount established under section 1105(b)(3)).

(5) INDIVIDUAL RESPONSIBILITY PERCENTAGE.—The term ''individual responsibility percentage'' means—

(A) with respect to a very low-income individual, 0 percentage points,

(B) with respect to a moderately low-income individual, the number of percentage points by which the family's family adjusted total income (expressed as a percent of the applicable poverty line) exceeds 100 percentage points, and

(C) with respect to any other individual, 100 percentage points.

Subtitle B—Long-Term Care Phase-Down Assistance to States

SEC. 2101. LONG-TERM CARE PHASE-DOWN ASSISTANCE.

(a) IN GENERAL.—Subject to subsection (b), if the excess percentage (as defined in subsection (c)(3)) for a State is greater than 0 percentage points, the State is entitled for each calendar quarter in 1995 through 1998 to payment equal to ¼ of the product of—

(1) such excess percentage,

(2) the applicable phase-down percentage for the year, described in subsection (c)(4)), and

(3) ½ of the amount described in subsection (c)(1)(B).

(b) MAINTENANCE OF EFFORT REQUIRED.—A State is not eligible for assistance under subsection (a) for a calendar quarter unless the State provides assurances satisfactory to the Commission that the State is incurring expenses (for services described in subsection (c)(1)(A)) in an amount not less than the sum of—

(1) the amount of assistance under subsection (a), and

(2) ¼ of the product of—

(A) the State's effective State medicaid percentage (as defined in subsection (c)(2)), and

(B) ½ of the amount described in subsection (c)(1)(B).

(c) DEFINITIONS.—For purposes of this section:

(1) LONG-TERM CARE PERCENTAGE.—The ''long-term care percentage'' for a State is—

(A) the portion of the amount described in subparagraph (B) that is are attributable to medical assistance for nursing facility services, intermediate care facility services for the men-

tally retarded, home health care services, and home and community-based services, divided by

(B) the total amount of Federal and State expenditures for medical assistance under the State plan under title XIX of the Social Security Act for calendar quarters during fiscal years 1992 and 1993;

expressed as a percentage.

(2) EFFECTIVE STATE MEDICAID PERCENTAGE.—The ''effective State medicaid percentage'' for a State is—

(A)(i) the amount described in subparagraph (B), reduced by (ii) the sum of the amount of the Federal financial participation under section 1903(a) of the Social Security Act paid to the State for calendar quarters during fiscal years 1992 and 1993 and the amount of health-care related taxes (as defined in section 1903(w)(3)(A) of such Act) received by the State during such fiscal years, divided by

(B) the total amount of the Federal and State expenditures under its plan under title XIX of the Social Security Act during calendar quarters in fiscal years 1992 and 1993.

(3) EXCESS PERCENTAGE.—The term ''excess percentage'' means, for a State, percentage by which (A) the long-term care percentage (as defined in paragraph (1)) exceeds (B) 2 percentage points plus the effective State medicaid percentage (as defined in paragraph (2)).

(4) APPLICABLE PHASE-DOWN PERCENTAGE.—The ''applicable phase-down percentage'' for—

(A) 1995, is 80 percent,

(B) 1996, is 60 percent,

(C) 1997, is 40 percent, and

(D) 1998, is 20 percent.

Subtitle C—Financing

PART 1—MEDICARE SAVINGS

SEC. 2201. REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by section 13501(a)(1) of the Omnibus Budget Reconciliation Act of 1993 (hereafter in this part referred to as ''OBRA–1993''), is amended—

(1) in subclause (XII), by striking ''fiscal year 1997, the market basket percentage increase minus 0.5 percentage point'' and inserting ''each of the fiscal years 1997, 1998, and 1999, the market basket

percentage increase minus 2.5 percentage points''; and

(2) in subclause (XIII), by striking ''fiscal year 1998'' and inserting ''fiscal year 2000''.

(b) PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(B)(ii)(V) of such Act (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)), as amended by section 13502(a)(1) of OBRA–1993, is amended by striking ''through 1997'' and inserting ''through 1999''.

SEC. 2202. 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)), as amended by section 13511(a)(1) of OBRA–1993, 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 1996

THROUGH 1999.—In applying clause (i) for services furnished during the period beginning January 1, 1996, and ending December 31, 1999, the percentage increase in the appropriate update index shall be reduced by such percent as the Secretary determines will result in a reduction in aggregate payments for physicians' services under this part during such period of at least $6,300,000,000 from the amount of aggregate payments for such services that would otherwise have been made during the period.''.

SEC. 2203. REDUCTION IN HOSPITAL OUTPATIENT SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that

for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1995, such amount shall be equal to 90 percent of the amount that would otherwise have been determined;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1994, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1995.

SEC. 2204. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

''PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

''SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed

by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

''(b) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for any taxable year if—

''(1) such individual is covered under Medicare part B for any month during such year, and

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

''(1) IN GENERAL.—The Medicare part B premium tax for any month is the applicable percentage (as defined in paragraph (2)) of the amount equal to the excess of—

''(A) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(B) the total monthly premium under section 1839 of the Social Security Act (deter-

mined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) PHASE-IN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by—

''(A) less than $25,000, the applicable percentage under this paragraph is 33⅓ percent;

''(B) at least $25,000, but less than $50,000, the applicable percentage under this paragraph is 66⅔ percent,

''(C) at least $50,000, but less than $75,000, the applicable percentage under this paragraph is 65/75 (expressed as a percent), or

''(D) at least $75,000, the applicable percentage under this paragraph is 100 percent.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $75,000,

''(B) $100,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

''(ii) does not live apart from his spouse at all times during the taxable year.

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1993 in taxable years ending after December 31, 1993.

SEC. 2205. PHASED-IN ELIMINATION OF MEDICARE HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.

Section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i), by inserting ''and before September 30, 1998,'' after ''1986,'';

(2) in clause (ii), by striking ''The amount of such payment'' and inserting ''Subject to clause (ix), the amount of such payment''; and

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

''(ix) The amount of the additional payment made under this paragraph for a discharge shall be equal to—

''(I) for discharges occurring during fiscal year 1995, 80 percent of the amount otherwise determined for the discharge under clause (ii);

''(II) for discharges occurring during fiscal year 1996, 60 percent of the amount otherwise determined for the discharge under clause (ii);

''(III) for discharges occurring during fiscal year 1997, 40 percent of the amount otherwise determined for the discharge under clause (ii); and

''(IV) for discharges occurring during fiscal year 1998, 20 percent of the amount otherwise determined for the discharge under clause (ii).''.

SEC. 2206. REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

Section 1861(v)(1)(L)(i) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III)—

(A) by inserting ''and before July 1, 1995,'' after ''1977,'', and

(B) by adding ''or'' at the end; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) July 1, 1995, 103 percent,''.

SEC. 2207. REDUCTION IN ROUTINE COST LIMITS FOR EXTENDED CARE SERVICES.

(a) IN GENERAL.—Section 1888(a) of the Social Security Act (42 U.S.C. 1395yy(a)) is amended—

(1) by striking ''112 percent'' and inserting ''102 percent'' each place it appears.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1994.

SEC. 2208. REDUCTIONS IN PAYMENTS FOR HOSPICE SERVICES.

Section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)(ii)), as amended by section 13504 of OBRA–1993, is amended—

(1) in subclause (III), by striking ''1.5 percentage points'' and inserting ''2.5 percentage points'';

(2) in subclause (IV), by striking ''1.5 percentage points'' and inserting ''2.5 percentage points'';

(3) in subclause (V), by striking ''0.5 percentage point'' and inserting ''1.5 percentage points'' and by striking ''and'' at the end;

(4) by redesignating subclause (VI) as subclause (VIII) ; and

(5) by inserting after subclause (V) the following new subclauses:

''(VI) for fiscal year 1998, the market basket percentage increase for the fiscal year minus 1.0 percentage point;

''(VII) for fiscal year 1999, the market basket percentage increase for the fiscal year minus 1.0 percentage point; and''.

PART 2—OTHER SAVINGS

SEC. 2211. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term ''agency'' means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term ''health benefits plan'' means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term ''health-benefits coverage'' means coverage under a health benefits plan'';

(4) an individual shall be considered to be an ''annuitant of an agency'' if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term ''Office'' means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a ''pay-as-you-go'' basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or

who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be pay-

able in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

Subtitle D—Repeal of Medicaid Program

SEC. 2301. REPEAL OF MEDICAID PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act is repealed.

(b) REPORT ON CONFORMING CHANGES.—By not later than May 1, 1994, the Health Care Standards Commission shall submit to Congress a report on—

(1) changes in laws that should be made in order to conform those laws to the repeal in the medicaid program effected under subsection (a), and

(2) the need for any special or transitional provisions that should be made in order to ensure con-

tinuous assistance for the medical needs of the medicaid population.

(c) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to items and service furnished on or after January 1, 1995.

TITLE III—TRAINING AND EDUCATION OF HEALTH CARE PROFESSIONALS

Subtitle A—Reform of Federal Funding for Medical Residency Training

SEC. 3001. DEFINITIONS.

In this subtitle, the following definitions shall apply:

(1) The term ''entry position'' means, with respect to a medical residency training program, a position as a resident in the initial year of study in the program.

(2) The term ''Fund'' means the National Medical Education Fund established under section 3005.

(3) The term ''medical residency training program'' means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training

programs in geriatric medicine approved by the Health Care Standards Commission.

(4) The term ''primary care resident'' means a resident enrolled in a medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(5) The term ''resident'' includes any participant in a medical residency training program (or, for purposes of section 3003, a physician retraining program).

(6) The term ''United States medical graduate'' means a resident who is a graduate of —

(A) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association (or approved by such Committee as meeting the standards necessary for such accreditation); or

(B) a school of osteopathy accredited by the American Osteopathic Association (or approved by such Association as meeting the standards necessary for such accreditation).

SEC. 3002. APPROVAL OF MEDICAL RESIDENCY TRAINING POSITIONS.

(a) IN GENERAL.—The Health Care Standards Commission shall approve a resident training position in a medical residency training program for purposes of funding under section 3003(a) if—

(1) the program submits an application for approval of the position to the Commission (at such time and in such manner as the Commission may require); and

(2) the Commission determines that the entry position relating to such resident training position in the program has been allocated to the program under subsection (b).

(b) ALLOCATION OF ENTRY POSITIONS AMONG PROGRAMS.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the Commission shall establish a process for the allocation of entry positions among medical residency training programs consistent with this subsection.

(2) TOTAL NUMBER OF FUNDED POSITIONS.—

(A) IN GENERAL.—In consultation with accountable health plans, medical societies, and medical specialty societies, the Commission shall determine the appropriate total number of

entry positions that will be allocated to medical residency training programs under this subsection in the United States for each residency year. In this subsection, the term ''residency year'' means a 12-month period beginning with July of the year in which the program begins.

(B) BASIS FOR TOTAL NUMBER OF ENTRY POSITIONS.—Subject to subparagraph (C), such total number of entry positions shall be based on the need for health care professionals to provide cost effective health care services in the United States. In determining such number the Commission shall take into account the population-to-physician ratio, consistent with demand for health care services.

(C) LIMIT ON TOTAL NUMBER OF ENTRY POSITIONS.—The total number of entry positions determined under this paragraph for any residency year shall not exceed 110 percent of the number of United States medical graduates who complete undergraduate medical education in the previous year.

(D) NO APPLICATION TO RESIDENTS WHO HAVE COMPLETED ANOTHER TRAINING PROGRAM.—The total number determined under

this paragraph shall only apply to residents who may enroll in a program without having previously completed another medical residency training program.

(3) GENERAL DISTRIBUTION OF POSITIONS AMONG SPECIALITIES.—

(A) IN GENERAL.—In consultation with accountable health plans, medical societies, and medical specialty societies, the Commission shall determine the appropriate distribution of the total number of entry positions determined under paragraph (2) among the various medical specialties.

(B) BASIS FOR DISTRIBUTION.—Such distribution shall be based on the need for health care professionals in different medical specialities to provide cost effective health care services in the United States. In determining such distribution the Commission shall take into account the population-to-physician ratio with respect to each medical specialty, consistent with demand for health care services, and the specific needs of accountable health plans.

(4) ALLOCATION AMONG PROGRAMS.—

(A) IN GENERAL.—The Commission shall allocate entry positions, distributed among medical specialties under paragraph (3), among specific medical residency training programs.

(B) BASIS FOR ALLOCATION.—Such allocation shall be based on the recommendations (if any) submitted by the Accreditation Council for Graduate Medical Education and the Residency Review Committees of such Council and the following objectives:

(i) Allocating positions among programs on the basis of quality.

(ii) Allocating positions among programs to avoid an inappropriate geographic distribution of physicians.

(iii) Allocating positions among programs to assure a sufficient number of residents in outpatient settings.

SEC. 3003. FUNDING FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS AND PHYSICIAN RETRAINING PROGRAMS.

(a) IN GENERAL.—In the case of an entry position in a medical residency training program that is approved by the Commission under section 3002(a) and in the case of an entry position in a physician retraining program de-

scribed in subsection (d)(1) for a residency year, the Commission shall provide a payment to the program on the first day of each month of the year from the National Medical Education Fund established under section 3005 in the amount determined under subsection (b). This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to make payments to such programs in accordance with this subtitle. No payment shall be made under this subsection for a month before July 1995.

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—Subject to subsection (e), the amount of payment made to an approved medical residency training program or a physician retraining program for each approved entry position for a full-time equivalent resident, shall be equal to the applicable percentage (as defined in paragraph (3)) of the base per resident amount established by the Commission for the year under paragraph (2) for that resident.

(2) BASE PER RESIDENT AMOUNT.—The Commission shall establish a base per resident amount for each year (beginning with 1995) that reflects an appropriate measure of the salary and benefits paid to residents in medical residency training programs

during the year. The Commission may vary such amount for residents to take into account—

(A) increases provided in the salaries and benefits of residents on the basis of the length of service in the program; and

(B) the relative wages and other costs of goods and services among the various geographic areas in which such programs are operated.

(3) APPLICABLE PERCENTAGE DEFINED.—In paragraph (1), the ''applicable percentage'' with respect to a resident is equal to—

(A) 175 percent, in the case of a primary care resident; and

(B) 150 percent, in the case of a resident who is not a primary care resident.

(c) LIMIT ON LENGTH OF SERVICE OF RESIDENT.—

(1) IN GENERAL.—No payment shall be made under subsection (a) for any resident who has completed 4 years of medical residency training in any program.

(2) EXCEPTION.—Paragraph (1) shall not apply to a resident enrolled in a physician retraining program described in subsection (d)(1).

(d) FUNDING OF PHYSICIAN RETRAINING PROGRAMS.—

(1) PROGRAM DESCRIBED.—A physician retraining program described in this paragraph is a program that—

(A) provides training over a period of not to exceed 2 years for primary care residents for physicians who have completed training in a medical residency training program (other than as a primary care resident); and

(B) meets such other requirements as the Commission (in consultation with the Accreditation Council for Graduate Medical Education) may impose.

(2) FUNDING FOR PILOT PROGRAMS.—The Health Care Standards Commission shall make payments from the Fund to assist the development of physician retraining programs described in paragraph (1).

(e) LIMIT ON EXPENDITURES FOR PROGRAMS.—The amounts otherwise payable under this section shall be reduced, in a pro rata manner, to the extent necessary to assure that the total amount expended by the Health Care Standards Commission during a year for payments under this section do not exceed the Commission's estimate of

the amount of funds available for expenditure from the Fund in the year.

SEC. 3004. FINANCING.

(a) ASSESSMENT AGAINST PREMIUMS OF ACCOUNTABLE HEALTH PLANS.—For requirement of payment by accountable health plans to the National Medical Education Fund of 1 percent of gross premium receipts, see section 1211.

(b) PAYMENTS FROM MEDICARE.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1889 the following new section:

''PAYMENTS TO NATIONAL MEDICAL EDUCATION FUND

''SEC. 1890. (a) ANNUAL PAYMENT REQUIRED.—For each month (beginning with July 1995), the Secretary shall make a payment to the National Medical Education Fund established under section 3005 of the Managed Competition Act of 1993 in an amount that is equal, for a month in a fiscal year, to 1/12 of 1 percent of the Secretary's estimate of the total expenditures made by the Secretary under this title during the preceding fiscal year, adjusted to the extent of any overpayment or underpayment which the Secretary determines was made under this section for any prior fiscal year and with respect to which adjustment has not already been made under this subsection.

''(b) ALLOCATION AMONG TRUST FUNDS.—The Secretary shall provide for an allocation of the payment made under subsection (a) between the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a proportion that reasonably reflects the proportion of medical education costs of hospitals for which payment was made under this title for cost reporting periods during fiscal year 1993 that are associated with the provision of services under part A and part B.''.

SEC. 3005. NATIONAL MEDICAL EDUCATION FUND.

(a) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund to be known as the ''National Medical Education Fund'', which shall consist of—

(1) amounts paid into the Fund by (or on behalf of) accountable health plans pursuant to section 1211;

(2) amounts paid into the Fund by the Secretary of Health and Human Services under section 1890 of the Social Security Act (as added by section 3004(b)); and

(3) such other amounts that may otherwise be deposited in or appropriated to the Fund.

(b) USE OF AMOUNTS IN FUND.—Amounts in the Fund shall be used by the Health Care Standards Commission to make payments to medical residency training programs and physician retraining programs under section 3003(b).

(c) MANAGEMENT OF FUND.—

(1) IN GENERAL; REPORTS ON OPERATION.—The Secretary of the Treasury shall, in consultation with the Health Care Standards Commission, manage the Fund, and shall report to Congress each year on the financial condition and the results of the operation of the Fund during the preceding year and on the expected condition and operations of the Fund during the next 5 years.

(2) INVESTMENT.—The Secretary of the Treasury shall invest the portion of the Fund that is not, in the judgment of the Secretary and of the Health Care Standards Commission, required to meet current withdrawals. Any investments of monies in the Fund may be made only in interest-bearing obligations of the United States.

SEC. 3006. REPEAL OF SEPARATE MEDICAL EDUCATION PAYMENTS UNDER MEDICARE.

(a) PROHIBITING RECOGNITION OF MEDICAL EDUCATION COSTS UNDER PART B.—Section 1861(v)(1) of

the Social Security Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs, the Secretary may not include any costs incurred by a provider for graduate medical education.''.

(b) REPEAL OF ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION COSTS.—Section 1886(d)(5) of such Act (42 U.S.C. 1395ww(d)(5)) is amended by striking subparagraph (B).

(c) REPEAL OF PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—Section 1886 of such Act (42 U.S.C. 1395ww) is amended by striking subsection (h) and redesignating subsection (i) as subsection (h).

(d) CONFORMING AMENDMENTS.—Section 1886(d) of such Act (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (3)(C)(ii)—

(A) by inserting ''and before October 1, 1994,'' after ''September 30, 1986,''; and

(B) by inserting ''and on or before September 30, 1994,'' after ''October 1, 1986,''; and

(2) in paragraph (9)(D), by striking clause (ii) and redesignating clauses (iii) and (iv) as clauses (ii) and (iii).

(e) EFFECTIVE DATES.—

(1) REASONABLE COSTS.—The amendment made by subsection (a) shall apply to costs incurred on or after July 1, 1995.

(2) INDIRECT MEDICAL EDUCATION ADJUSTMENT.—The amendments made by subsections (b) and (d) shall apply to discharges occurring on or after July 1, 1995.

(3) DIRECT MEDICAL EDUCATION.—The amendment made by subsection (c) shall apply to portions of cost reporting periods beginning on or after July 1, 1995.

Subtitle B—Other Medical Education Grants and Programs

SEC. 3101. SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS OF NATIONAL HEALTH SERVICE CORPS.

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

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

(2) by striking ''through 2000.'' and inserting ''through 1994, $150,000,000 for fiscal year 1995, $175,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $225,000,000 for fiscal year 1998, and $250,000,000 for fiscal year 1999.''.

SEC. 3102. AREA HEALTH EDUCATION CENTERS.

Section 746(i)(1)(A) of the Public Health Service Act (42 U.S.C. 293j(i)(1)(A)) is amended by striking ''through 1995'' and inserting ''through 1994 and $30,000,000 for each of the fiscal years 1995 through 1999''.

SEC. 3103. PUBLIC HEALTH AND PREVENTIVE MEDICINE.

Section 765(a) of the Public Health Service Act (42 U.S.C. 294c(a)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3104. FAMILY MEDICINE.

Section 747(d)(1) of the Public Health Service Act (42 U.S.C. 293k(d)(1)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3105. GENERAL INTERNAL MEDICINE AND PEDIATRICS.

Section 748(c) of the Public Health Service Act (42 U.S.C. 293l(c)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3106. PHYSICIAN ASSISTANTS.

Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3107. ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3108. NURSE ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 3109. NURSE PRACTITIONER AND NURSE MIDWIFE PROGRAMS.

Section 822(d) of the Public Health Service Act (42 U.S.C. 296m(d)) is amended by striking ''and 1994'' and inserting ''through 1999''.

SEC. 3110. USE OF HEALTH CARE POLICY AND RESEARCH FUNDS FOR PRIMARY CARE.

Section 926 of the Public Health Service Act (42 U.S.C. 299c–5), as amended by section 10 of Public Law 102–410 (106 Stat. 2101), is amended by adding at the end the following subsection:

''(f) ALLOCATION REGARDING PRIMARY CARE.—Of the amounts made available for a fiscal year for carrying out this title, the Secretary shall obligate not less than 15 percent for carrying out section 902 with respect to primary care.''.

TITLE IV—PREVENTIVE HEALTH AND INDIVIDUAL RESPONSIBILITY

Subtitle A—Expansion of Public Health Programs

SEC. 4001. IMMUNIZATIONS AGAINST VACCINE-PREVENTABLE DISEASES.

Section 317(j)(1)(A) of the Public Health Service Act (42 U.S.C. 247b(j)(1)(A)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 4002. PREVENTION, CONTROL, AND ELIMINATION OF TUBERCULOSIS.

Section 317(j)(2) of the Public Health Service Act (42 U.S.C. 247b(j)(2)) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 4003. LEAD POISONING PREVENTION.–

Section 317A(l)(1) of the Public Health Service Act (42 U.S.C. 247b–1(l)(1)) is amended by striking ''through 1997'' and inserting ''through 1999''.

SEC. 4004. PREVENTIVE HEALTH MEASURES WITH RESPECT TO BREAST AND CERVICAL CANCERS.

Section 1509(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended—

(1) by striking ''and'' after ''1991,'', and

(2) by striking ''1993.'' and inserting ''1993, $100,000,000 for each of the fiscal years 1994 through 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999.''.

SEC. 4005. OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION.

(a) IN GENERAL.—Section 1701(b) of the Public Health Service Act (42 U.S.C. 300u(b)) is amended by striking ''through 1996'' and inserting ''through 1999''.

(b) PROMOTION OF INDIVIDUAL RESPONSIBILITY.—Section 1701(a)(11) of such Act (42 U.S.C. 300u(a)(11)) is amended—

(1) by striking ''and'' at the end of subparagraph (C),

(2) by redesignating subparagraph (D) as subparagraph (E), and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) promote individual responsibility in personal health care and in the use of valuable health care resources; and''.

(c) MINORITY HEALTH.—Section 1707(f) of such Act (42 U.S.C. 300u–6(f)) is amended by striking ''1993.'' and inserting ''1993, $35,000,000 for each of the fiscal

years 1994 through 1996, and such sums as may be necessary for each of the fiscal years 1997 through 1999.''.

SEC. 4006. PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.

Section 1901(a) of the Public Health Service Act (42 U.S.C. 300w(a)) is amended by striking ''through 1997'' and inserting ''through 1999''.

SEC. 4007. CATEGORICAL GRANTS FOR EARLY INTERVENTION REGARDING ACQUIRED IMMUNE DEFICIENCY SYNDROME.

Section 2655 of the Public Health Service Act (42 U.S.C. 300ff–55) is amended by striking ''through 1995'' and inserting ''through 1999''.

SEC. 4008. PROGRAMS OF OFFICE OF SMOKING AND HEALTH.

In addition to any other authorization of appropriations that is available for programs of the Centers for Disease Control regarding the smoking of tobacco products, there is authorized to be appropriated for such programs $10,000,000 for each of the fiscal years 1995 through 1999.

Subtitle B—Medicare

PART 1—COVERAGE OF PREVENTIVE SERVICES

SEC. 4101. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS AND SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

''(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to screening fecal-occult blood tests provided for the purpose of early detection of colon cancer, except as provided by the Secretary under paragraph (3)(A), the payment amount established for tests performed—

''(i) in 1995 shall not exceed $5; and

''(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer—

''(i) if the individual is under 50 years of age; or

''(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for

a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer—

''(i) if the individual is under 50 years of age; or

''(ii) if the procedure is performed within the 59 months after a previous screening flexible sigmoidoscopy.

''(3) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

''(A) REDUCTIONS IN PAYMENT LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 1997, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

''(B) REVISION OF FREQUENCY.—

''(i) REVIEW.—The Secretary, in consultation with the Director of the National

Cancer Institute, shall review periodically the appropriate frequency for performing screening fecal-occult blood tests and screening flexible sigmoidoscopies based on age and such other factors as the Secretary believes to be pertinent.

''(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such revision shall apply to tests or procedures performed before January 1, 1998.

''(4) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

''(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as

defined in subparagraph (B), or, if less, as defined in section 1848(g)(2)).

''(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means 115 percent of the payment limit established under paragraph (2)(A).

''(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).''.

(b) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) of such Act (42 U.S.C. 1395l(a)) are each amended by striking ''subsection (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(2) Section 1833(h)(1)(A) of such Act (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to paragraphs (1) and (3)(A) of section 1834(d), the Secretary''.

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) of such Act (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking ''a service'' and inserting ''a service (other than a screening flexible sigmoidoscopy provided to an in-

dividual for the purpose of early detection of colon cancer)''.

(4) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to screening fecal-occult blood tests and screening flexible sigmoidoscopies performed on or after January 1, 1995.

SEC. 4102. COVERAGE OF CERTAIN IMMUNIZATIONS.

(a) IN GENERAL.—Section 1861(s)(10) of the Social Security Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) in subparagraph (A)—

(A) by striking ‘‘, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,’’, and

(B) by striking ‘‘; and’’ and inserting a comma;

(2) in subparagraph (B), by striking the semicolon at the end and inserting ‘‘, and’’; and

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

‘‘(C) tetanus-diphtheria booster and its administration;’’.

(b) LIMITATION ON FREQUENCY.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by section 4101(b)(4)(A) of this Act, is amended—

(1) in subparagraph (F), by striking ‘‘and’’ at the end;

(2) in subparagraph (G), by striking the semicolon at the end and inserting ‘‘, and’’; and

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

''(H) in the case of an influenza vaccine, which is administered within the 11 months after a previous influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within the 119 months after a previous tetanus-diphtheria booster;''.

(c) CONFORMING AMENDMENT.—Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 4101(b)(4)(B) of this Act, is amended by striking ''or (G)'' and inserting ''(G), or (H)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to influenza vaccines and tetanus-diphtheria boosters administered on or after January 1, 1995.

SEC. 4103. COVERAGE OF WELL-CHILD CARE.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 13553(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

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

(2) by striking the semicolon at the end of subparagraph (Q) and inserting ''; and''; and

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

''(R) well-child services (as defined in subsection (ll)(1)) provided to an individual entitled to benefits under this title who is under 7 years of age;''.

(b) SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) added by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after subsection (kk) (as so redesignated) the following new subsection:

''Well-Child Services

''(ll)(1) The term 'well-child services' means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care, provided in accordance with the periodicity schedule established with respect to the services under paragraph (2).

''(2) The Secretary, in consultation with the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided to healthy children.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1861(s)(2)(O) of such Act (42 U.S.C. 1395x(s)(2)(O)) is amended by striking ''subsection (jj)'' and inserting ''subsection (kk)''.

(2) Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by sections 4101(b)(4)(A) and 4102(b) of this Act, is amended—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in subparagraph (H), by striking the semicolon at the end and inserting '', and''; and

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

''(I) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(ll)(2) for such services;''.

(3) Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by sections 4101(b)(4)(B) and 4102(c) of this Act, is amended by striking ''or (H)'' and inserting ''(H), or (I)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to well-child services provided on or after January 1, 1995.

SEC. 4104. ANNUAL SCREENING MAMMOGRAPHY.

(a) ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the Social Security Act (42 U.S.C. 1395m(b)(2)(A)) is amended—

(1) in clause (iv), by striking ''but under 65 years of age,'', and

(2) by striking clause (v).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to screening mammography performed on or after January 1, 1995.

SEC. 4105. FINANCING OF ADDITIONAL BENEFITS.

(a) PREMIUM FOR 1995.—Section 1839(e)(1)(B)(v) of the Social Security Act (42 U.S.C. 1395r(e)(1)(B)(v)) is amended by striking ''$46.10'' and inserting ''$47.50''.

(b) PREMIUMS FOR 1996–1998.—(1) Section 1839 of such Act (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

''(g) Except as provided in subsections (b) and (f), the monthly premium otherwise determined, without regard to this subsection, for each individual enrolled under this part shall be increased by $1.40 for each month in 1996, 1997, and 1998.''.

(2) Section 1839 of such Act (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (e), and (g)'',

(B) in subsection (a)(3), by striking ''subsection (e)'' and inserting ''subsections (e) and (g)'', and

(C) in subsection (b), by striking ''determined under subsection (a) or (e)'' and inserting ''otherwise determined under this section (without regard to subsection (f))''.

PART 2—NOTICE OF ADVANCE DIRECTIVE RIGHTS

SEC. 4111. 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.

TITLE V—MALPRACTICE REFORM

Subtitle A—Findings; Purpose; Definitions

SEC. 5001. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds that—

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

(2) the Federal Government has a major interest in health care as a direct provider of health care and as a source of payment for health care, and has a demonstrated interest in assessing the quality of

care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

(b) PURPOSE.—It is the purpose of this title to—

(1) provide grants to States to develop alternative dispute resolution procedures to attain a more efficient, expeditious, and equitable resolution of health care malpractice disputes;

(2) enhance general knowledge concerning the benefits of different forms of alternative dispute resolution mechanisms; and

(3) establish uniformity and curb excesses in the State-based medical liability systems through Federally-mandated reforms.

SEC. 5002. DEFINITIONS.

As used in this title:

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

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

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

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

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

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

to engage in the delivery of such services in the State.

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

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

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

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section

201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

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

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

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

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

Subtitle B—Uniform Standards for Malpractice Claims

SEC. 5101. APPLICABILITY.

Except as provided in section 5111, this subtitle shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1995.

SEC. 5102. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 5202(a), or, in the case of a State in which such a system is not in effect

for the year, under the alternative Federal system established under section 5202(b).

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

(3) CLAIMS AGAINST UNITED STATES.—

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

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice

liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

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

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

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

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

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

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

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

previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 5103. PROCEDURAL REQUIREMENTS FOR FILING OF ACTIONS.

(a) CERTIFICATE OF MERIT.—

(1) IN GENERAL.—Each individual who files a medical malpractice liability action shall, not later than 90 days after filing the action—

(A) submit a certificate of merit described in subsection (b); or

(B) post a surety (or equivalent security) bond of $4,000 (or, during the 45-day period that begins on the date the action is filed, a cost bond of $2,000) with the court.

(2) EXTENSION OF DEADLINE.—On the motion of any party to the action or upon a written agreement of the parties filed with the court, the court may extend the deadline specified in paragraph (1) for a period not to exceed 30 days.

(3) DISMISSAL FOR FAILURE TO MEET REQUIREMENT.—If an individual filing a medical malpractice liability action fails to meet the requirements of paragraph (1)—

(A) the court shall dismiss the action without prejudice to the refiling of the action by the individual; and

(B) require the individual to pay any court costs incurred by the defendants as a result of the filing of the action.

(4) WAIVER FOR GOOD CAUSE.—The court may waive the application of paragraph (1) to a plaintiff if the plaintiff shows good cause that such paragraph should not apply.

(5) CERTIFICATE OF MERIT DESCRIBED.—In paragraph (1), a ''certificate of merit'' is, with respect to an individual filing a medical malpractice liability action, an affidavit declaring that the individual (or the individual's attorney) has obtained a written opinion from a medical expert who is knowledgeable of the relevant medical issues involved in the action that the defendant was negligent and the defendant's conduct was a proximate cause of the alleged injury that is the subject of the action.

(b) RESPONSE TO STANDARD INTERROGATORIES AND REQUESTS FOR DOCUMENTS.—

(1) DEADLINE.—Each party to a medical malpractice liability action shall respond to the standard set of interrogatories and requests for production of documents developed pursuant to paragraph (4) as follows:

(A) In the case of a plaintiff, the party shall provide the defendant (or the defendant's attorney) with full and complete responses not later than 45 days after filing the action.

(B) In the case of a defendant, the party shall provide the plaintiff (or the plaintiff's attorney) with full and complete responses not later than 45 days after receiving the plaintiff's responses under subparagraph (A).

(C) In the case of a party who is added to the action after the action is filed, the party shall provide all other parties (or such parties' attorneys) with full and complete responses not later than 45 days after the date of the filing of the pleading by which the party is added to the action.

(2) EXTENSION OF DEADLINE.—On the motion of any party to the action that is supported by good cause, or upon a written agreement of the parties filed with the court, the court shall extend the dead-

line specified in paragraph (1) for a period not to exceed 30 days.

(3) IMPOSITION OF SANCTIONS FOR FAILURE TO RESPOND.—If a party to a medical malpractice liability action fails to respond to the standard set of interrogatories and requests for production of documents as required under paragraph (1), the party shall be subject to sanctions by the court under any applicable laws, rules, and regulations governing the imposition of sanctions by the court.

(4) DEVELOPMENT OF STANDARD INTERROGATORIES AND REQUESTS.—

(A) APPOINTMENT OF EXPERT PANELS.—The Governor of each State shall appoint a panel to develop the standard set of interrogatories and requests for production of documents that will be used for purposes of this subsection in the courts of the State. The set shall be comprehensive and designed to expedite the discovery process in the courts. The Attorney General shall appoint a panel to develop such set that will be used for purposes of this subsection in the Federal courts.

(B) COMPOSITION.—Each panel appointed pursuant to subparagraph (A) shall consist of

not less than 6 and not more than 12 members, of whom an equal number shall be attorneys who customarily represent plaintiffs in medical malpractice liability actions and attorneys who customarily represent defendants in such actions.

(C) DEADLINES.—Not later than October 1, 1994, each panel appointed pursuant to subparagraph (A) shall complete and publish the standard set of interrogatories and requests for production of documents.

SEC. 5104. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

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

(b) NO AWARD OF PUNITIVE DAMAGES AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical

product, no punitive or exemplary damages may be awarded against such manufacturer.

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

(d) ALLOCATION OF PUNITIVE DAMAGE AWARDS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—

(1) IN GENERAL.—The total amount of any punitive damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought (or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided) for the purposes of carrying out the activities described in paragraph (2).

(2) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to paragraph (1) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

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

(B) implementing health care quality assurance programs;

(C) carrying out public education programs to increase awareness of the availability of comparative quality information on accountable health plans;

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

(E) implementing and operating a State alternative dispute resolution system certified by the Secretary under section 5202.

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for the activities described in paragraph (2).

(e) DEVELOPMENT OF ALTERNATIVE LIMITS ON NONECONOMIC DAMAGES.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Health Care Standards Commission shall develop and trans-

mit to Congress alternative limits on the amount of noneconomic damages that may be awarded with respect to medical malpractice liability claims, together with legislative specifications necessary to replace the limit imposed under subsection (a) on the amount of such damages with such alternative limits. The purpose of the development of the limits is to provide certainty and fairness in malpractice awards and to avoid unwarranted disparities among health care providers and health care professionals who have engaged in similar conduct.

(2) ESTABLISHMENT OF SEPARATE LIMITS FOR CATEGORIES OF INJURIES.—In developing limits under paragraph (1), the Commission shall establish separate limits for noneconomic damages resulting from each of the following categories of injuries:

(A) Non-physical injuries.

(B) Insignificant physical injuries.

(C) Temporary minor physical injuries.

(D) Temporary major physical injuries.

(E) Permanent minor physical injuries.

(F) Permanent substantial physical injuries.

(G) Permanent major physical injuries.

(H) Permanent grave physical injuries.

(I) Death.

(3) FACTORS CONSIDERED.—In developing limits under paragraph (1) for each of the categories described in paragraph (2), the Commission shall—

(A) examine the most recent available data on the amount of damages awarded with respect to such claims; and

(B) set specific limits that reasonably compensate most injured parties at the level of compensation currently provided, excluding those levels of compensation that the Commission finds unreasonably large.

(4) CONSULTATION.—In developing limits under this subsection, the Commission shall consult with representatives of each of the following:

(A) Attorneys who represent plaintiffs in medical malpractice liability actions.

(B) Attorneys who represent health care professionals and health care providers in medical malpractice liability actions.

(C) Physicians and other health care professionals and providers.

(D) Individuals who have suffered injury as a result of medical malpractice.

(E) Judges who preside over medical malpractice liability actions.

(F) Medical ethicists.

(G) Health care economists.

(H) Liability insurers.

(5) GUIDANCE TO ENTITIES RESOLVING CLAIMS.—If Congress enacts legislation that imposes the limits developed by the Commission under this subsection on the amount of noneconomic damages that may be awarded with respect to medical malpractice liability claims, the Commission shall prepare and disseminate guidelines to assist courts and other entities resolving such claims in the determination of the particular category of injury specified in paragraph (2) to which a claimant's injury shall be assigned for purposes of applying the appropriate limit on such damages.

SEC. 5105. PERIODIC PAYMENTS FOR FUTURE LOSSES.

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

determined by the court, based upon projections of when such expenses are likely to be incurred.

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

SEC. 5106. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a medical malpractice liability claim may not charge, demand, receive, or collect for services rendered in connection with such claim in excess of the following amount recovered by judgment or settlement under such claim:

(A) 25 percent of the first $150,000 (or portion thereof) recovered, plus

(B) 10 percent of any amount in excess of $150,000 recovered.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be

based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 5102(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action is not greater than the amount

of damages awarded to the party under the ADR system; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not less than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

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

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

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

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

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact

that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(4) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

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

SEC. 5107. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered or the date on which such injury should reasonably have been discovered, whichever is earlier.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may be initiated after the expiration of the period described in subsection (a) if the claim is initiated before the minor attains 8 years of age.

SEC. 5108. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a medical malpractice claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy,

the trier of fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

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

SEC. 5109. UNIFORM STANDARD FOR DETERMINING LIABILITY IN ACTIONS BASED ON NEGLIGENCE.

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

(b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—Subsection (a) shall not apply with respect to a medical malpractice action if (in accordance with applicable State

law) the theory of liability upon which the action is based is a theory of strict liability.

SEC. 5110. JURISDICTION OF FEDERAL COURTS.

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

SEC. 5111. PREEMPTION.

(a) IN GENERAL.—This subtitle supersedes any State law only to the extent that the State law permits the recovery by a claimant or the assessment against a defendant of a greater amount of damages or establishes a less strict standard of proof for determining whether a defendant has committed malpractice, than the provisions of this subtitle.

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

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

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

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

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

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

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

SEC. 5201. BASIC REQUIREMENTS.

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

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

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

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

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

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

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

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

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining

health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

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

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of subtitle B (other than sections 5102 and 5103) shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 5202. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1994), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 5201.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1994, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 5201(a) shall apply to claims brought under the system;

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

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

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

SEC. 5203. GRANTS TO STATES.

(a) IN GENERAL.—The Secretary shall make grants to States for a 2-year period to assist States in implementing and operating alternative dispute resolution systems that meet the requirements of section 5201.

(b) ELIGIBILITY.—A State is eligible to receive a grant under this section if the Secretary has certified the State's alternative dispute resolution system under section 5202(b).

(c) LIMITATION ON AMOUNT OF GRANT.—The amount of funds provided to a State under a grant under this section may not exceed $5,000,000 during the 2-year period of the grant.

SEC. 5204. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this subtitle and the alternative Federal system established under section 5202(b).

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

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

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

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

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

Subtitle D—Grants to States for Development of Practice Guidelines

SEC. 5301. GRANTS TO STATES.

(a) IN GENERAL.—The Secretary shall make grants to States for a 2-year period for the development of medical practice guidelines for health care professionals (including mid-level practitioners) that may be applied to resolve medical malpractice liability claims and actions in the State.

(b) ELIGIBILITY.—A State is eligible to receive a grant under this section if the State submits to the Secretary an application at such time, in such form, and containing such information and assurances as the Secretary may require, including assurances that the State will submit such periodic reports on the development and application of the State's medical practice guidelines as the Secretary may require.

(c) NUMBER OF GRANTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall award not less than 10 grants under this section.

(2) EXCEPTION.—Notwithstanding paragraph (1), the Secretary may award less than 10 grants under this section if the Secretary determines that there are an inadequate number of applications submitted that meet the eligibility and approval requirements of this section.

(d) LIMITATION ON AMOUNT OF GRANT.—The amount of funds provided to a State under a grant under this section may not exceed $5,000,000 during the 2-year period of the grant.

TITLE VI—PAPERWORK REDUCTION AND ADMINISTRATIVE SIMPLIFICATION

SEC. 6001. PREEMPTION OF STATE QUILL PEN LAWS.

After 1994, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form.

SEC. 6002. CONFIDENTIALITY OF ELECTRONIC HEALTH CARE INFORMATION.

(a) PROMULGATION OF REQUIREMENTS.—

(1) IN GENERAL.—The Health Care Standards Commission shall promulgate, and may modify from time to time, requirements to facilitate and ensure the uniform, confidential treatment of individually identifiable health care information in electronic environments.

(2) ITEMS TO BE INCLUDED.—The requirements under this subsection shall—

(A) provide for the preservation of confidentiality and privacy rights in electronic health care claims processing and payment;

(B) apply to the collection, storage, handling, and transmission of individually identifiable health care data (including initial and sub-

sequent disclosures) in electronic form by all accountable health plans, public and private third-party payers, providers of health care, and all other entities involved in the transactions;

(C) not apply to public health reporting required under State or Federal law;

(D) delineate protocols for securing electronic storage, processing, and transmission of health care data;

(E) specify fair information practices that assure a proper balance between required disclosures and use of data, including—

(i) creating a proper balance between what an individual is expected to divulge to a record-keeping organization and what the individual seeks in return,

(ii) minimizing the extent to which information concerning an individual is itself a source of unfairness in any decision made on the basis of such information, and

(iii) creating and defining obligations respecting the uses and disclosures that will be made of recorded information about an individual;

(F) require publication of the existence of health care data banks;

(G) establish appropriate protections for highly sensitive data (such as data concerning mental health, substance abuse, and communicable and genetic diseases);

(H) encourage the use of alternative dispute resolution mechanisms (where appropriate); and

(I) provide for the deletion of information that is no longer needed to carry out the purpose for which it was collected.

(3) CONSULTATION WITH WORKING GROUP.—In promulgating and modifying requirements under this subsection, the Commission shall consult with a working group of knowledgeable individuals representing all interested parties (including third-party payers, providers, consumers, employers, information managers, and technical experts).

(4) DEADLINE.—The Commission shall first promulgate requirements under this subsection by not later than six months after the date of the enactment of this Act.

(b) APPLICATION OF REQUIREMENTS.—

(1) STATE ENFORCEMENT OF SIMILAR REQUIREMENTS.—The requirements promulgated under subsection (a) shall not apply to health care information in a State if—

(A) the State has applied to the Health Care Standards Commission for a determination that the State has in effect a law that provides for the application of requirements with respect to such information (and enforcement provisions with respect to such requirements) consistent with such requirements (and with the enforcement provisions of subsection (c)), and

(B) the Commission determines that the State has such a law in effect.

(2) APPLICATION TO CURRENT INFORMATION.—The Health Care Standards Commission shall specify the extent to which (and manner in which) the requirements promulgated under subsection (a) apply to information collected before the effective date of the requirements.

(c) DEFENSE FOR PROPER DISCLOSURES.—An entity that establishes that is has disclosed health care information in accordance with the requirements promulgated under subsection (a) has established a defense in an action brought for improper disclosure of such information.

(d) PENALTIES FOR VIOLATIONS.—An entity that collects, stores, handles, transmits, or discloses health care information in violation of the requirements promulgated under subsection (a) is liable for civil damages, equitable remedies, and attorneys' fees (if appropriate), in accordance with regulations of the Health Care Standards Commission.

SEC. 6003. STANDARDIZATION FOR THE ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH PLAN INFORMATION.

(a) GOALS.—The Health Care Standards Commission shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in eliminating unnecessary paperwork and achieving appropriate standardization in the areas of electronic receipt and transmission of health care claims and health plan information and eligibility verification (consistent with the requirements promulgated under section 6002(a)).

(b) CONTINGENT REQUIREMENTS.—If the Commission determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Commission under such subsection, the Commission shall promulgate (and may, from time to time, modify) standards and requirements con-

cerning the electronic receipt and transmission of health plan claims forms and other health plan information.

(c) CONSULTATION.—The Commission shall conduct activities under this section in consultation with the Accredited Standards Committee X–12 of the American National Standards Institute, insurers, providers, and others.

SEC. 6004. USE OF UNIFORM HEALTH CLAIMS FORMS AND IDENTIFICATION NUMBERS.

(a) GOALS.—The Health Care Standards Commission shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity—

(1) in the format and content of basic claims forms under health plans, and

(2) in the use of common identification numbers for beneficiaries and providers of health care items or services under health plans.

(b) CONTINGENT REQUIREMENTS.—If the Commission determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Commission under such subsection, the Commission shall promulgate (and may, from time to time, modify) standards and requirements concerning—

(1) the format and content of basic claims forms under health plans, and

(2) the common identification numbers to be used by health plans to identify health plan beneficiaries and health care providers.

(c) CONSULTATION.—The Commission shall conduct activities under this section in consultation with the Workgroup for Electronic Data Interchange and with insurers, providers, and others.

SEC. 6005. PRIORITY AMONG INSURERS.

(a) GOALS.—The Health Care Standards Commission shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity in the rules for determining the liability of insurers when benefits are payable under two or more health plans.

(b) CONTINGENT REQUIREMENTS.—If the Commission determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Commission under such subsection, the Commission shall promulgate (and may, from time to time, modify) rules for determining the liability of health plans when benefits are payable under two or more health plans.

(c) CONSULTATION.—The Commission shall conduct activities under this section in consultation with health plans.

SEC. 6006. FURNISHING OF INFORMATION AMONG HEALTH PLANS.

(a) GOALS.—The Health Care Standards Commission shall establish national goals, and time frameworks, respecting the progress to be made by the health care industry in achieving uniformity in the availability of information among health plans when benefits are payable under two or more health plans.

(b) CONTINGENT REQUIREMENTS.—If the Commission determines that the health care industry has failed to meet the goals established under subsection (a) by the deadlines established by the Commission under such subsection, the Commission shall promulgate (and may, from time to time, modify) requirements concerning the transfer among health plans (and annual updating) of appropriate information (which may include requirements for the use of unique identifiers, and for the listing of all individuals covered under a health plan).

(c) CONSULTATION.—The Commission shall conduct activities under this section in consultation with health plans.

SEC. 6007. FAILURE TO SATISFY CERTAIN HEALTH PLAN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans) is amended by adding at the end the following new section:

"SEC. 5000A. FAILURE TO SATISFY CERTAIN HEALTH PLAN REQUIREMENTS.

''(a) GENERAL RULE.—There is hereby imposed, on any administrator of a health plan, a tax on any failure to comply with an applicable requirement of sections 6003 through 6006 of the Managed Competition Act of 1993. The Health Care Standards Commission shall determine whether any such administrator meets the requirements of those sections.

''(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) for a taxable year in which an administrator fails to comply with a requirement described in that subsection shall be equal to $100 for each such failure.

''(c) CONTROLLED GROUPS.—

''(1) EMPLOYERS.—In the case of an administrator that is an employer, for purposes of this section all persons that are treated as part of the same employer (within the meaning of section 414) as the administrator shall be treated as the same person.

''(2) OTHER ADMINISTRATORS.—In the case of an administrator that is not an employer, for purposes of this section—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or businesses (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(d) LIMITATIONS ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person liable for tax did not know, and by exercising reasonable diligence would not have known, that the failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

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

''(B) the failure is corrected during the 30-day period beginning on the 1st date the person liable for the tax knew, or by exercising reasonable diligence would have known, that the failure existed.

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

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of that Code (relating to nondeductibility of certain taxes) is amended by inserting ''47,'' after ''46,''.

(c) CLERICAL AMENDMENTS.—The table of sections for chapter 47 of that Code is amended by adding at the end the following new item:

''5000A. Failure to satisfy certain health plan requirements.''.

SEC. 6008. DEFINITIONS.

For purposes of this title—

(1) The term ''health plan'' means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract (including any closed accountable health plan), but does not include (except for purposes of sections 6005 and 6006)—

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

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

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

(2) The term ''provider'' means a physician, hospital, pharmacy, laboratory, or other person licensed or otherwise authorized under applicable State laws to furnish health care items or services.

TITLE VII—ADDITIONAL BENEFITS ON A PAY-AS-YOU-GO BASIS

SEC. 7001. SENSE OF CONGRESS.

It is the sense of Congress that additional benefits should be provided by the Federal Government to the extent that additional financing is made available for such benefits on a pay-as-you-go basis, including the following benefits:

(1) Providing tax preferences for expenses for long-term care, including tax deductibility of employer contributions for long-term care insurance.

(2) Providing direct Federal subsidies for expenses for long-term care.

(3) Expanding coverage under the medicare program, including coverage of outpatient prescription drugs and coverage of long-term care services.

(4) Increasing the income threshold for eligibility for premium assistance (under section 2002).

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