

103<sup>D</sup> CONGRESS  
2<sup>D</sup> 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.

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## 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

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## A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
 5 “Managed Competition Act of 1993”.

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

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### 1 **SEC. 2. FINDINGS; PURPOSES.**

2 (a) FINDINGS.—Congress finds the following:

3 (1) NEED FOR COST CONTAINMENT INCEN-  
4 TIVES.—The current health insurance marketplace is  
5 unable to provide efficient and effective health care  
6 coverage because—

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

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

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

1 (D) health plans frequently manage costs  
2 through underwriting practices and favorable  
3 selection rather than through increased effi-  
4 ciencies in the provision of health care; and

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

8 (2) MANAGED COMPETITION.—

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

14 (B) However, in order to provide for such  
15 a market in health care, there is a need to pro-  
16 vide proper incentives to providers and pur-  
17 chasers in the market for health care.

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

23 (b) PURPOSE.—

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



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

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

8 (3) SPECIFIC MEASURES TO ACHIEVE OBJEC-  
9 TIVES.—In order to—

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

14 (B) promote competition based on cost-ef-  
15 fective care instead of through risk selection,  
16 the Act standardizes benefits, prohibits experi-  
17 ence rating, and adjusts premium payments to  
18 plans based on the risk characteristics of indi-  
19 viduals enrolled in the plan;

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

24 (D) to promote competition based on qual-  
25 ity, 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-in-  
come individuals, the Act offers financial assist-  
ance 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 de-  
fined 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 pre-  
mium amount” is defined in section 2009(c)(2).

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

1           BASE INDIVIDUAL PREMIUM.—The term “base  
2   individual premium” is defined in section  
3   2009(c)(3).

4           BENEFITS, EVALUATIONS, AND DATA STAND-  
5   ARDS BOARD.—The term “Benefits, Evaluations,  
6   and Data Standards Board” refers to the Board es-  
7   tablished under section 1303.

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

11          COMMISSION.—The term “Commission” is de-  
12   fined in section 1701(b)(2).

13          ELIGIBLE EMPLOYEE.—The term “eligible em-  
14   ployee” is defined in section 1701(a)(2).

15          ELIGIBLE FAMILY MEMBER.—The term “eligi-  
16   ble family member” is defined in section 1701(a)(3).

17          ELIGIBLE INDIVIDUAL.—The term “eligible in-  
18   dividual” is defined in section 1701(a)(1).

19          ELIGIBLE RESIDENT.—The term “eligible resi-  
20   dent” is defined in section 1701(a)(4).

21          ENROLLEE UNIT.—The term “enrollee unit” is  
22   defined in section 1701(a)(5).

23          FAMILY ADJUSTED TOTAL INCOME.—The term  
24   “family adjusted total income” is defined in section  
25   2009(b)(1).

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

4 HEALTH OUTCOME.—The term “health out-  
5 come” is defined in section 1302(b)(5)(B).

6 HEALTH PLAN STANDARDS BOARD.—The term  
7 “Health Plan Standards Board” refers to the Board  
8 established under section 1304.

9 HEALTH PLAN.—The term “health plan” is de-  
10 fined in section 1701(c)(1).

11 HPPC; HEALTH PLAN PURCHASING COOPERA-  
12 TIVE.—The terms “health plan purchasing coopera-  
13 tive” and “HPPC” are defined in section  
14 1701(b)(3).

15 INDIVIDUAL RESPONSIBILITY PERCENTAGE.—  
16 The term “individual responsibility percentage” is  
17 defined in section 2009(c)(5).

18 INVESTIGATIONAL TREATMENT.—The term “in-  
19 vestigational treatment” is defined in section  
20 1302(b)(4)(B).

21 LOW-INCOME INDIVIDUAL.—The term “low-in-  
22 come individual” is defined in section 2009(a)(1).

23 MEDICALLY APPROPRIATE.—The term “medi-  
24 cally appropriate” is defined in section 1302(b)(1).

1           MEDICARE BENEFICIARY.—The term “medicare  
2           beneficiary” is defined in section 1701(a)(6).

3           MEDICARE-ELIGIBLE INDIVIDUAL.—The term  
4           “medicare-eligible individual” is defined in section  
5           1701(a)(6).

6           MODERATELY LOW-INCOME INDIVIDUAL.—The  
7           term “moderately low-income individual” is defined  
8           in section 2009(a)(2).

9           MODIFIED FAMILY INCOME.—The term “modi-  
10          fied family income” is defined in section 2009(b)(2).

11          NETWORK PLAN.—The term “network plan” is  
12          defined in section 1208(b)(3)(D) and in section  
13          1222(b)(1).

14          PARTICIPATING PROVIDER.—The term “partici-  
15          pating provider” is defined in section 1222(b)(2).

16          PHYSICIAN INCENTIVE PLAN.—The term “phy-  
17          sician incentive plan” is defined in section  
18          1207(b)(2).

19          POVERTY LINE.—The term “poverty line” is  
20          defined in section 2009(c)(4).

21          PRE-EXISTING CONDITION.—The term “pre-ex-  
22          isting condition” is defined in section  
23          1204(b)(2)(B)(ii).

24          PREMIUM CLASS.—The term “premium class”  
25          is defined in section 1701(c)(3).

1           REFERENCE PREMIUM RATE.—The term “ref-  
2           erence premium rate” is defined in section  
3           2009(c)(4).

4           SECRETARY.—The term “Secretary” is defined  
5           in section 1701(c)(4).

6           SMALL EMPLOYER; LARGE EMPLOYER.—The  
7           terms “small employer” and “large employer” are  
8           defined in section 1701(c)(2).

9           SPECIALIZED CENTER OF CARE.—The term  
10          “specialized center of care” is defined in section  
11          1308(d).

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

15          STATE.—The term “State” is defined in section  
16          1701(c)(5).

17          TREATMENT.—The term “treatment” is defined  
18          in section 1302(b)(5)(A).

19          TYPE OF ENROLLMENT.—The term “type of  
20          enrollment” is defined in section 1701(c)(6).

21          UNIFORM SET OF EFFECTIVE BENEFITS.—The  
22          term “uniform set of effective benefits” is defined in  
23          section 1701(c)(7).

1 UTILIZATION REVIEW PROGRAM.—The term  
 2 “utilization review program” is defined in section  
 3 1223(b).

4 VERY LOW-INCOME INDIVIDUAL.—The term  
 5 “very low-income individual” is defined in section  
 6 2009(a)(3).

7 **TITLE I—MANAGED COMPETI-**  
 8 **TION IN EMPLOYER-BASED**  
 9 **HEALTH PLANS: INCENTIVES**  
 10 **TO CONTROL COSTS**

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

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

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

20 **“SEC. 4980C. EMPLOYER HEALTH PLAN EXPENSES IN EX-**  
 21 **CESS OF ACCOUNTABLE HEALTH PLAN**  
 22 **COSTS.**

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

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

3 “(b) EXCESS HEALTH PLAN EXPENSES.—For pur-  
4 poses of this section—

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

11 “(2) LIMIT TO ACCOUNTABLE HEALTH  
12 PLANS.—Health plan expenses meet the require-  
13 ments of this paragraph only if—

14 “(A) the expenses are attributable to cov-  
15 erage of the covered individual under an ac-  
16 countable health plan, and

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

21 “(3) LIMIT ON PER INDIVIDUAL CONTRIBU-  
22 TION.—

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



1           only to the extent that the amount of such ex-  
2           penses does not exceed the reference premium  
3           rate (as defined in section 2009(c)(4) of the  
4           Managed Competition Act of 1993) for the  
5           month.

6           “(B) USE OF COMMUNITY RATE WITHIN  
7           TYPE OF ENROLLMENT OR ACROSS HPPC AREAS  
8           IN PLACE OF REFERENCE PREMIUM RATE FOR  
9           LARGE EMPLOYERS.—In the case of an em-  
10          ployer that is not a small employer and which  
11          maintains a closed AHP (as defined in section  
12          1701(b)(4)(A)) that elects certain rules to apply  
13          under section 1205(b)(3) of the Managed Com-  
14          petition Act of 1993, the reference premium  
15          rate amount for a covered individual shall be  
16          computed based on the weighted average of  
17          such amounts within the type of enrollment or  
18          across HPPC areas, as elected under such sec-  
19          tion.

20          “(C) TREATMENT OF HEALTH PLANS OUT-  
21          SIDE THE UNITED STATES.—For purposes of  
22          subparagraph (A), in the case of a covered indi-  
23          vidual residing outside the United States, there  
24          shall be substituted for the reference premium  
25          rate such reasonable amounts as the Health

1 Care Standards Commission determines to be  
2 comparable to the limit imposed under subpara-  
3 graph (A) or subparagraph (B) (if applicable).

4 “(4) REQUIREMENT OF LEVEL CONTRIBU-  
5 TION.—Health plan expenses meet the requirements  
6 of this paragraph for any month only if the amount  
7 of the employer contribution (for a premium class)  
8 does not vary based on the accountable health plan  
9 selected.

10 “(c) EXCEPTION FOR MEDICARE-ELIGIBLE RETIR-  
11 EES.—Subsections (a) and (b) shall not apply to health  
12 plan expenses with respect to an individual who is eligible  
13 for benefits under part A of title XVIII of the Social Secu-  
14 rity Act if such expenses are for a health plan that is not  
15 a primary payor under section 1862(b) of such Act.

16 “(d) SPECIAL RULES.—

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

1           “(2) CONTRIBUTIONS TO CAFETERIA PLANS.—  
2       Contributions under a cafeteria plan on behalf of an  
3       employee that are used for a group health plan cov-  
4       erage shall be treated for purposes of this section as  
5       health plan expenses paid or incurred by the em-  
6       ployer.

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

10          “(f) OTHER DEFINITIONS.—For purposes of this sec-  
11       tion—

12           “(1) COVERED INDIVIDUAL.—The term ‘cov-  
13       ered individual’ means any beneficiary of a group  
14       health plan.

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

21           “(3) HEALTH PLAN EXPENSES.—

22           “(A) IN GENERAL.—The term ‘health plan  
23       expenses’ means employer expenses for any  
24       group health plan, including expenses for pre-

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

3 “(B) EXCLUSION OF CERTAIN DIRECT EX-  
 4 PENSES.—Such term does not include expenses  
 5 for direct services which are determined by the  
 6 Health Care Standards Commission to be pri-  
 7 marily aimed at workplace health care and  
 8 health promotion or related population-based  
 9 preventive health activities.

10 “(4) SMALL EMPLOYER.—The term ‘small em-  
 11 ployer’ means, for a taxable year, an employer that  
 12 is a small employer (within the meaning of section  
 13 1701(c)(2) of the Managed Competition Act of  
 14 1993) for the most recent calendar year ending be-  
 15 fore the end of the taxable year.

16 “(5) TYPE OF ENROLLMENT.—The term ‘type  
 17 of enrollment’ is described in section 1701(c)(6) of  
 18 the Managed Competition Act of 1993.”

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

“Sec. 4980C. Employer health plan expenses in excess of account-  
 able health plan costs.”

22 (c) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as otherwise pro-  
 24 vided in this subsection, the amendments made by

1       this section shall apply to expenses incurred for the  
2       provision of health services for periods after Decem-  
3       ber 31, 1994.

4               (2) TRANSITION FOR COLLECTIVE BARGAINING  
5       AGREEMENTS.—The amendments made by this sec-  
6       tion shall not apply to employers with respect to  
7       their employees, insofar as such employees are cov-  
8       ered under a collective bargaining agreement ratified  
9       before the date of the enactment of this Act, earlier  
10      than the date of termination of such agreement (de-  
11      termined without regard to any extension thereof  
12      agreed to after the date of the enactment of this  
13      Act), or January 1, 1997, whichever is earlier.

14   **SEC. 1002. INCREASE IN DEDUCTION FOR HEALTH PLAN**  
15                   **PREMIUM EXPENSES OF SELF-EMPLOYED IN-**  
16                   **DIVIDUALS.**

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

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

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

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

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

10 (d) EFFECTIVE DATE.—

11 (1) IN GENERAL.—Except as otherwise pro-  
12 vided in this subsection, the amendments made by  
13 this section shall apply to taxable years beginning  
14 after December 31, 1994.

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

18 **SEC. 1003. DEDUCTION FOR HEALTH PLAN PREMIUM EX-**  
19 **PENSES OF INDIVIDUALS.**

20 (a) IN GENERAL.—Section 213 of the Internal Reve-  
21 nue Code of 1986 (relating to medical, dental, etc., ex-  
22 penses) is amended by adding at the end the following new  
23 subsection:

24 “(g) SPECIAL RULES FOR HEALTH PLAN PREMIUM  
25 EXPENSES.—

1           “(1) IN GENERAL.—The deduction under sub-  
2       section (a) shall be determined without regard to the  
3       limitation based on adjusted gross income with re-  
4       spect to amounts paid for premiums for coverage  
5       under an accountable health plan.

6           “(2) LIMITS.—

7               “(A) LIMIT IN AMOUNT.—The amount al-  
8       lowed as a deduction under paragraph (1) with  
9       respect to the cost of providing coverage for any  
10      individual shall not exceed the applicable limit  
11      specified in section 4980C(b)(3) reduced by the  
12      aggregate amount paid by all other entities (in-  
13      cluding any employer or any level of govern-  
14      ment) for coverage of such individual under any  
15      health plan.

16          “(B) LIMIT TO HPPC PLANS.—

17               “(i) IN GENERAL.—The deduction  
18      under this subsection shall be allowed only  
19      in the case of an individual who obtains  
20      coverage under an accountable health plan  
21      through a health plan purchasing coopera-  
22      tive.

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

1                   erage in an accountable health plan by vir-  
 2                   tue of the individual's (or other person's)  
 3                   employment by a large employer.

4                   “(3) DEDUCTION ALLOWED AGAINST GROSS IN-  
 5                   COME.—The deduction under this subsection shall  
 6                   be taken into account in determining adjusted gross  
 7                   income under section 62(a).

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

13                  (b) EFFECTIVE DATE.—The amendment made by  
 14                  subsection (a) shall apply to amounts paid after December  
 15                  31, 1994, and taxable years ending after such date.

16   **SEC. 1004. EXCLUSION FROM GROSS INCOME FOR CON-**  
 17                   **TRIBUTIONS BY A PARTNERSHIP OR S COR-**  
 18                   **PORATION TO A HEALTH PLAN COVERING ITS**  
 19                   **PARTNERS OR SHAREHOLDERS.**

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

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



1 shall not apply to coverage under a subsidized accident  
2 or health plan maintained by the S corporation for its em-  
3 ployees.”

4 (b) PARTNERSHIPS.—Section 707 of such Code (re-  
5 lating to transactions between partner and partnership)  
6 is amended by adding at the end thereof the following new  
7 subsection:

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

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

18 **SEC. 1005. EMPLOYER OBLIGATIONS.**

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

21 (1) have in effect an agreement described in  
22 section 1103 with the health plan purchasing cooper-  
23 ative (requiring the offering to employees of cov-  
24 erage through accountable health plans) for the

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

3 (2) comply with such agreement.

4 (b) OTHER EMPLOYERS.—

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

7 (A) offer to each employee (in a time and  
8 manner specified by the Health Care Standards  
9 Commission) enrollment in a qualifying ac-  
10 countable health plan (as defined in paragraph  
11 (3)) both on an individual basis, and, if applica-  
12 ble and at the employee's option, on a family  
13 basis; and

14 (B) provide, at the option of the employee,  
15 for deduction from wages or other compensa-  
16 tion (in the manner specified in section  
17 1103(c)) of amount of any premiums due for  
18 such enrollment (taking into account the  
19 amount of any employer contribution).

20 (2) OPEN ENROLLMENT PERIODS.—For pur-  
21 poses of paragraph (1)(A), the Commission shall  
22 provide for—

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

1           dividuals are offered enrollment under a quali-  
2           fying accountable health plan;

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

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

15          (3) QUALIFYING ACCOUNTABLE HEALTH  
16          PLAN.—For purposes of this subsection, the term  
17          “qualifying accountable health plan” means, with re-  
18          spect to an employee, an accountable health plan—

19                (A) that serves the area in which the em-  
20                ployee resides, and

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

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

3       Nothing in this subsection shall be construed as pre-  
4       venting an employer from offering, or an employee  
5       from electing enrollment in, a health plan that  
6       serves the area in which the employee is employed,  
7       rather than the area in which the employee resides.

8           (4) SPECIAL RULE FOR CERTAIN CLOSED AHPS  
9       ELECTING SPECIAL COMMUNITY RATING.—In the  
10      case of a closed AHP offered to an employee, if the  
11      plan has made an election described in section  
12      1205(b)(3), paragraph (3)(B) shall be applied to the  
13      plan based on the weighted average of premiums de-  
14      termined without regard to age, HPPC area, or both  
15      (as elected under such section), rather than on the  
16      basis of premium class.

17      (c) NONDISCRIMINATION UNDER GROUP HEALTH  
18      PLANS.—

19           (1) APPLICATION OF RULES SIMILAR TO MEDI-  
20      CARE NONDISCRIMINATION RULES.—Subject to  
21      paragraph (2), the provisions of paragraphs (1)(A),  
22      (1)(D), (1)(E), (3)(A), and (3)(C) of section  
23      1862(b) of the Social Security Act shall apply to an  
24      individual eligible for low-income assistance under  
25      subtitle A of title II in the same manner as such

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

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

6 (A) in applying clauses (ii) and (iii) of sec-  
7 tion 1862(b)(1)(A) of the Social Security Act,  
8 any reference to “20 or more employees” is  
9 deemed a reference to “5 or more employees”;

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

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

15 (d) ENFORCEMENT.—

16 (1) CIVIL MONEY PENALTIES.—

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

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

1           ject to a civil monetary penalty (not to exceed  
2           \$500) for each day in which the violation con-  
3           tinues.

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

10          (2) DIRECT ENFORCEMENT.—

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

19           (B) OFFER.—The obligation to offer cov-  
20           erage under subsection (b) with respect to an  
21           employee is directly enforceable by civil action  
22           by the employee. In any such action, if the em-  
23           ployee substantially prevails, the employee is  
24           entitled to reasonable attorneys' fees.

1 **SEC. 1006. ENCOURAGING GROUP PURCHASING FOR LARGE**  
2 **EMPLOYER BY ELIMINATING COMMONALITY**  
3 **OF INTEREST OR GEOGRAPHIC LOCATION**  
4 **REQUIREMENT FOR TAX EXEMPT TRUST STA-**  
5 **TUS.**

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

9 (1) by inserting “(A)” after “(9)”; and

10 (2) by adding at the end the following:

11 “(B) Any determination of whether a health  
12 plan maintained by one or more large employers  
13 (within the meaning of section 1701(c)(2) of the  
14 Managed Competition Act of 1993) is a voluntary  
15 employees’ beneficiary association meeting the re-  
16 quirements of this paragraph shall be made without  
17 regard to any determination of commonality of inter-  
18 est or geographic location if the plan is an account-  
19 able health plan (as defined in section 1701(b)(1) of  
20 such Act).”

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

1 **SEC. 1007. SIMPLIFYING FILING OF REPORTS BY PERMIT-**  
2 **TING SINGLE ANNUAL FILING FOR ALL EM-**  
3 **PLOYERS COVERED UNDER AN INSURED**  
4 **MULTIPLE EMPLOYER HEALTH PLAN.**

5 (a) IN GENERAL.—Section 110 of the Employee Re-  
6 tirement Income Security Act of 1974 (29 U.S.C. 1030)  
7 is amended by adding at the end the following new sub-  
8 section:

9 “(c) The Secretary shall prescribe by regulation or  
10 otherwise an alternative method providing for the filing  
11 of a single annual report (as referred to in section  
12 104(a)(1)(A)) with respect to all employers who are cov-  
13 ered under the same fully insured multiple employer wel-  
14 fare arrangement under which benefits consist solely of  
15 medical care described in section 607(1) (disregarding  
16 such incidental benefits as the Secretary shall specify by  
17 regulations).”.

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



1                   **Subtitle B—Health Plan**  
2                   **Purchasing Cooperatives (HPPCs)**

3   **SEC. 1101. ESTABLISHMENT AND ORGANIZATION; HPPC**  
4                   **AREAS.**

5           (a) HPPC AREAS.—

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

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

12               (A) all portions of each metropolitan sta-  
13           tistical area in a State are within the same  
14           HPPC area, and

15               (B) the number of eligible individuals re-  
16           siding within a HPPC area is not less than  
17           250,000.

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

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

4 (b) ESTABLISHMENT OF HPPCs.—

5 (1) IN GENERAL.—Each State shall provide, by  
6 legislation or otherwise, for the establishment by not  
7 later than July 1, 1994, as a not-for-profit corpora-  
8 tion, with respect to each HPPC area (specified  
9 under subsection (a)) of a health plan purchasing  
10 cooperative (each in this title referred to as a  
11 “HPPC”).

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

16 (c) COOPERATIVE BOARD.—

17 (1) ESTABLISHMENT.—Each HPPC shall be  
18 governed by a Cooperative Board which shall be ini-  
19 tially appointed by the Governor or other chief exec-  
20 utive officer of the State (or as otherwise provided  
21 under State law or by the Health Care Standards  
22 Commission in the case of a HPPC described in sub-  
23 section (b)(2)). The Cooperative Board for a HPPC  
24 shall be responsible for ensuring the performance of  
25 the duties of the HPPC under subsection (d).

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

11          (3) LIMITATION ON COMPENSATION.—A HPPC  
12          shall not provide compensation to members of the  
13          Cooperative Board other than reimbursement for  
14          reasonable and necessary expenses incurred in the  
15          performance of their duties as members of the Coop-  
16          erative Board.

17          (d) DUTIES OF HPPCs.—

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

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

22                       (B) enter into agreements with small em-  
23                       ployers under section 1103;

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

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

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

10 (F) provide for establishment of a com-  
11 plaint process and appointment of an ombuds-  
12 man, in accordance with section 1107;

13 (G) conduct and analyze surveys of en-  
14 rollee satisfaction and monitor enrollee  
15 disenrollment, in accordance with section 1108;  
16 and

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

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

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

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

1 activity (including review, approval, or enforce-  
2 ment) relating to premium rates for health  
3 plans;

4 (C) perform any activity (including reg-  
5 istration or enforcement) relating to compliance  
6 of accountable health plans with the require-  
7 ments of part 1 of subtitle C (other than as re-  
8 quired to carry out its specific duties under this  
9 subtitle or under section 1305(c)(2));

10 (D) discriminate among such plans, other  
11 than on the basis of the performance of such  
12 plans under this title, as determined in accord-  
13 ance with standards established by the Health  
14 Care Standards Commission under this title;

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

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

21 (e) PERFORMANCE OF DUTIES.—

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

1 the HPPC, and the Governor (or other chief execu-  
2 tive officer) of each State in which the HPPC oper-  
3 ates, of such finding and permit the Board an op-  
4 portunity to take such action as may be necessary  
5 for the HPPC to carry out such duties.

6 (2) CORRECTIVE ACTION.—If, after such an op-  
7 portunity, the deficiency has not been corrected, the  
8 Health Care Standards Commission may—

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

11 (B) take such other action as may be ap-  
12 propriate in order to assure the performance of  
13 such duties.

14 (3) PERFORMANCE CRITERIA.—

15 (A) DEVELOPMENT.—The Health Care  
16 Standards Commission shall develop criteria re-  
17 lating to HPPC performance of duties. Such  
18 criteria shall include criteria relating to the fol-  
19 lowing:

20 (i) OVERHEAD.—The HPPC overhead  
21 percentage (computed under section  
22 1105(b)(2)) for the HPPC.

23 (ii) FLOAT.—The average period (de-  
24 scribed in section 1102(d)(2)) between the

1 HPPC's receipt and payment of funds re-  
2 ceived.

3 (iii) SATISFACTION OF ELIGIBLE INDIVIDUALS.—The satisfaction of eligible indi-  
4 VIDUALS.—The satisfaction of eligible indi-  
5 viduals with the performance of the HPPC  
6 (as measured under surveys under section  
7 1108).

8 (iv) ENROLLMENT OF AT RISK INDIVIDUALS.—The effectiveness of the  
9 VIDUALS.—The effectiveness of the  
10 HPPC's activities under section  
11 1102(b)(3) in enrolling individuals who are  
12 eligible for low-income assistance or who  
13 reside in medically underserved areas.

14 (B) REPORT.—Each HPPC shall report to  
15 the Health Care Standards Commission, at  
16 such time and in such manner as the Commis-  
17 sion specifies, such information as the Commis-  
18 sion may require in order to evaluate the per-  
19 formance of the HPPC in accordance with the  
20 criteria developed under subparagraph (A).

21 (C) PUBLICATION.—The Health Care  
22 Standards Commission shall publish annually a  
23 report that provides a comparison of the rel-  
24 ative performance of each HPPC, based on  
25 such criteria.

1 (f) EDUCATION AND DEVELOPMENT GRANTS.—  
2 There are authorized to be appropriated \$25,000,000 for  
3 fiscal year 1994 for grants to assist States in the develop-  
4 ment of HPPCs.

5 **SEC. 1102. AGREEMENTS WITH ACCOUNTABLE HEALTH**  
6 **PLANS (AHPS).**

7 (a) AGREEMENTS.—

8 (1) OPEN AHPS.—Each HPPC for a HPPC  
9 area shall enter into an agreement under this section  
10 with each open accountable health plan (described in  
11 section 1701(b)(4)(B)) that serves residents of the  
12 area. Each such agreement under this section shall  
13 include (as specified by the Health Care Standards  
14 Commission) provisions consistent with the require-  
15 ments of the succeeding subsections of this section.  
16 A HPPC may not terminate such an agreement ex-  
17 cept as provided in paragraph (3)(A).

18 (2) CLOSED AHPS.—Each HPPC for a HPPC  
19 area shall enter into a special agreement under this  
20 paragraph with each closed AHP that serves resi-  
21 dents of the area, in order to carry out subsection  
22 (e). Except as otherwise specifically provided, any  
23 reference in this Act to an agreement under this sec-  
24 tion shall not be considered to be a reference to an  
25 agreement under this paragraph.



1           (3) TERMINATION OF AGREEMENT.—In accord-  
2           ance with regulations of the Health Care Standards  
3           Commission—

4                   (A) the HPPC may terminate an agree-  
5                   ment under paragraph (1) or (2) if—

6                           (i) the AHP's registration under part  
7                           1 of subtitle C is revoked, or

8                           (ii) the AHP is determined (in accord-  
9                           ance with rules established by the Commis-  
10                          sion) substantially to have violated the con-  
11                          ditions of such agreement; and

12                   (B) the AHP may terminate either such  
13                   agreement only upon sufficient notice in order  
14                   to provide for the orderly enrollment of enroll-  
15                   ees under other AHPs.

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

18           (b) OFFER OF ENROLLMENT OF INDIVIDUALS.—

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

1           (2) TIMING OF OFFER.—The offer of enroll-  
2       ment shall be available—

3           (A) to eligible individuals who are employ-  
4       ees of small employers, during the 30-day pe-  
5       riod beginning on the date of commencement of  
6       employment, and

7           (B) to other eligible individuals, at such  
8       time (including an annual open enrollment pe-  
9       riod specified by the Health Care Standards  
10      Commission) as the HPPC shall specify, con-  
11     sistent with section 1104(b).

12          (3) OUTREACH.—In carrying out the respon-  
13     sibilities under paragraph (1), a HPPC shall per-  
14     form such activities, including outreach, as may be  
15     necessary to seek actively the enrollment of eligible  
16     individuals, including individuals who are eligible for  
17     low-income assistance or who reside in medically un-  
18     derserved areas.

19          (c) RECEIPT OF GROSS PREMIUMS.—

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

1           (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-  
2           miums shall be payable on a monthly basis (or, at  
3           the option of an eligible individual described in para-  
4           graph (2)(B), on a quarterly basis). The HPPC may  
5           provide for penalties and grace periods for late pay-  
6           ment.

7           (3) AHPs RETAIN RISK OF NONPAYMENT.—  
8           Nothing in this subsection shall be construed as  
9           placing upon a HPPC any risk associated with fail-  
10          ure to make prompt payment of premiums (other  
11          than the portion of the premium representing the  
12          HPPC overhead amount). Each eligible individual  
13          who enrolls with an AHP through the HPPC is lia-  
14          ble to the AHP for premiums.

15          (d) FORWARDING OF ADJUSTED PREMIUMS.—

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

22                       (A) the standard premium rate (estab-  
23                       lished under section 1205) received for the pre-  
24                       mium class, and

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

6 (2) PAYMENTS.—Payments shall be made by  
7 the HPPC under this subsection within a period  
8 (specified by the Health Care Standards Commission  
9 and not to exceed 3 business days) after the time of  
10 receipt of the premium from the employer of the eli-  
11 gible individual or the eligible individual, as the case  
12 may be, based on estimates of applicable risk-adjust-  
13 ment factors. Subsequent payments shall be ad-  
14 justed as appropriate to reflect differences between  
15 the payments that were made based on estimates  
16 and the payments that should have been made based  
17 on reported (and audited) information.

18 (3) ADJUSTMENTS FOR DIFFERENCES IN  
19 NONPAYMENT RATES.—In accordance with rules es-  
20 tablished by the Health Care Standards Commis-  
21 sion, each agreement between an AHP and a HPPC  
22 under this section shall provide that, if a HPPC de-  
23 termines that the rates of nonpayment of premiums  
24 during grace periods established under subsection  
25 (c)(2) vary appreciably among AHPs, the HPPC

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

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

7 (1) IN GENERAL.—Each agreement between an  
8 AHP and a HPPC under this section (including a  
9 special agreement entered into under subsection  
10 (a)(2)) shall provide for such payments from the  
11 AHP to the HPPC, and such payments from the  
12 HPPC to the AHP, as the Health Care Standards  
13 Commission determines is necessary in order to as-  
14 sure the equitable distribution among all AHPs, na-  
15 tionwide, of reductions in premiums and cost-sharing  
16 under section 1205(c) and section 1202(c), respec-  
17 tively.

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

21 (f) NOTICE OF DISENROLLMENT.—Within 3 business  
22 days after receiving a notice of disenrollment of an individ-  
23 ual from an AHP offered by a HPPC, the HPPC shall  
24 notify the AHP of such notice.

1 (g) LIMITATION ON EMPLOYMENT.—An AHP agrees  
2 not to employ (or enter into a consulting or similar con-  
3 tract with) any individual who was, within the previous  
4 2 years, an employee of the HPPC with which the AHP  
5 has an agreement in effect under this section.

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

11 **SEC. 1103. AGREEMENTS WITH SMALL EMPLOYERS.**

12 (a) IN GENERAL.—Each HPPC for a HPPC area  
13 shall enter into an agreement under this section with each  
14 small employer that employs individuals in the area. Each  
15 agreement under this section, between a small employer  
16 and a HPPC shall include (as specified by the Health Care  
17 Standards Commission) provisions consistent with the re-  
18 quirements specified in the succeeding subsections of this  
19 section.

20 (b) FORWARDING INFORMATION ON ELIGIBLE EM-  
21 PLOYEES.—

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

1 information required by the HPPC) of each em-  
2 ployee (including part-time and seasonal employees).

3 (2) APPROPRIATE HPPC.—In this subsection,  
4 the term “appropriate HPPC” means the HPPC for  
5 the principal place of business of the employer or (at  
6 the option of an employee) the HPPC serving the  
7 place of residence of the employee.

8 (c) PAYROLL DEDUCTION.—

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

14 (A) the deduction, from the employee’s  
15 wages or other compensation, of the amount of  
16 the premium due (less the amount of any em-  
17 ployer contribution), and

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

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

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

5 (2) ADDITIONAL PREMIUMS.—If the sum of the  
6 amount of the employer contribution and the  
7 amount withheld under paragraph (1) is not suffi-  
8 cient to cover the entire cost of the premiums, the  
9 employee shall be responsible for paying directly to  
10 the HPPC the difference between the amount of  
11 such premiums and such sum.

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

14 (1) requiring an employer to provide directly for  
15 enrollment of eligible employees under an account-  
16 able health plan or other health plan,

17 (2) requiring an employer to make, or prevent-  
18 ing an employer from making, information about  
19 such plans available to such employees, or

20 (3) requiring an employer to make, or prevent-  
21 ing an employer from making, an employer contribu-  
22 tion for coverage of such individuals under such a  
23 plan.



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

3 (a) OFFER OF ENROLLMENT.—

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

8 (2) FREEZING ENROLLMENT IN INSOLVENT  
9 PLANS.—If a State superintendent of insurance,  
10 State insurance commissioner, or other State official  
11 with regulatory authority over an AHP has deter-  
12 mined that the AHP is insolvent, a HPPC may dis-  
13 continue offering enrollment in the AHP to individ-  
14 uals not previously enrolled in the plan.

15 (b) ENROLLMENT PROCESS.—

16 (1) IN GENERAL.—Each HPPC shall establish  
17 an enrollment (and disenrollment) process in accord-  
18 ance with rules established by the Health Care  
19 Standards Commission consistent with this sub-  
20 section.

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

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

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

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

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

14      each HPPC shall provide for a special enrollment  
15      period in which the individual is permitted to change  
16      the individual or family basis of coverage or the  
17      AHP in which the individual is enrolled. The cir-  
18      cumstances under which such special enrollment pe-  
19      riods are required and the duration of such periods  
20      shall be specified by the Health Care Standards  
21      Commission.

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

1 Commission) during which eligible individuals may  
2 first enroll.

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

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

12 (c) ANALYSIS AND DISTRIBUTION OF COMPARATIVE  
13 INFORMATION.—

14 (1) ANALYSIS OF INFORMATION.—Each HPPC  
15 shall analyze the information reported under section  
16 1203(a) on AHPs for which the HPPC is offering  
17 enrollment (and may analyze such information on  
18 closed AHPs serving residents of the HPPC area) in  
19 order to distribute the information under paragraph  
20 (2) in a form, consistent with section 1307(a)(2),  
21 that permits the direct comparison of different  
22 AHPs on the basis of the ability of the AHPs—

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

25 (B) to satisfy enrolled individuals.

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

3 (2) DISTRIBUTION OF INFORMATION.—

4 (A) IN GENERAL.—Each HPPC shall dis-  
5 tribute, to eligible individuals and employers,  
6 information, in comparative form, on the prices,  
7 health outcomes, and enrollee satisfaction of the  
8 different AHPs for which it is offering enroll-  
9 ment and may provide other information per-  
10 taining to the quality of such AHPs. Such dis-  
11 tribution shall occur at least annually before  
12 each general enrollment period. Each HPPC  
13 also shall make such information available to  
14 other interested persons.

15 (B) ADDITIONAL INFORMATION.—Such in-  
16 formation shall include—

17 (i) a summary of the analysis of infor-  
18 mation collected under paragraph (1) and  
19 information collected under section  
20 1108(a)(2), and

21 (ii) a breakdown of the portion of  
22 AHP premiums attributable to the HPPC  
23 overhead amount (specified under section  
24 1105(b)(3)).

25 (d) PERIOD OF COVERAGE.—

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

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

15           (3) SPECIAL ENROLLMENT PERIODS.—

16           (A) IN GENERAL.—In the case of an eligi-  
17 ble individual who enrolls with an AHP during  
18 a special enrollment period described in sub-  
19 section (b)(4), coverage under the plan shall  
20 begin on such date (not later than the first day  
21 of the first month that begins at least 15 days  
22 after the date of enrollment) as the Commission  
23 shall specify, except that coverage of family  
24 members shall begin as soon as possible on or

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

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

9 (4) MINIMUM PERIOD OF ENROLLMENT.—In  
10 order to avoid adverse selection, each HPPC may re-  
11 quire, consistent with rules of the Health Care  
12 Standards Commission, that enrollments with AHPs  
13 be for not less than a specified minimum enrollment  
14 period (with exceptions permitted for such excep-  
15 tional circumstances as the Commission may recog-  
16 nize).

17 **SEC. 1105. RECEIPT OF PREMIUMS.**

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

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

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

4           (b) HPPC OVERHEAD AMOUNT.—

5           (1) HPPC BUDGET.—Each HPPC shall estab-  
6           lish a budget for each year for each HPPC area in  
7           accordance with regulations established by the  
8           Health Care Standards Commission.

9           (2) HPPC OVERHEAD PERCENTAGE.—The  
10          HPPC shall compute for each HPPC area an over-  
11          head percentage which, when applied for each en-  
12          rollee unit (whether enrolled on a family or individ-  
13          ual basis) to the weighted average of the standard  
14          premium amounts for premium classes for enroll-  
15          ment on an individual basis (taking into account any  
16          reduction in premiums attributable to low-income as-  
17          sistance under section 2002), will provide for reve-  
18          nues equal to the budget for the HPPC area for the  
19          year. Such percentage may in no case exceed 1 per-  
20          centage point.

21          (3) HPPC OVERHEAD AMOUNT.—The HPPC  
22          overhead amount for enrollment, whether on an indi-  
23          vidual or family basis, in an AHP for a HPPC area  
24          for a month is equal to the applicable HPPC over-  
25          head percentage (computed under paragraph (2))

1 multiplied by the weighted average of the standard  
2 premium amounts for premium classes for enroll-  
3 ment on an individual basis under the AHP for the  
4 month (taking into account any reduction in pre-  
5 miums attributable to low-income assistance under  
6 section 2002).

7 **SEC. 1106. COORDINATION AMONG HPPCS.**

8 (a) IN GENERAL.—The Health Care Standards Com-  
9 mission shall establish rules consistent with this section  
10 for—

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

16 (2) coordination among HPPCs in the low-in-  
17 come assistance reconciliation processes under sec-  
18 tion 1102(e)(1).

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

22 (b) COORDINATION RULES.—Under the rules estab-  
23 lished under subsection (a)(1)—



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

4                   (A) for providing information to the em-  
5                   ployer’s employees on AHPs for areas in which  
6                   employees reside;

7                   (B)(i) for enrolling employees under the  
8                   AHP selected (even if the AHP selected is not  
9                   in the same HPPC area as the HPPC) and (ii)  
10                  if the AHP chosen is not in the same HPPC  
11                  area as the HPPC, for forwarding the enroll-  
12                  ment information to the HPPC for the area in  
13                  which the AHP selected is located; and

14                  (C) in the case of premiums to be paid  
15                  through payroll deduction, or employer con-  
16                  tribution, or both, to receive such premiums  
17                  and forward them to the HPPC for the area in  
18                  which the AHP selected is located.

19           (2) HPPC FOR EMPLOYEE RESIDENCE.—The  
20           HPPC for the HPPC area in which an employee re-  
21           sides shall be responsible for providing other HPPCs  
22           with information concerning AHPs being offered in  
23           such HPPC area.

24           (c) COORDINATION OF RECONCILIATION OF LOW-IN-  
25           COME ASSISTANCE.—Under the rules established under

1 subsection (a)(2), the Commission shall provide for such  
2 payments among the different HPPCs as the Commission  
3 determines is necessary in order to assure the equitable  
4 distribution among AHPs in different HPPC areas of ad-  
5 justments in premiums and cost-sharing under section  
6 1205(c) and section 1202(c), respectively.

7 **SEC. 1107. COMPLAINT PROCESS; OMBUDSMAN.**

8 (a) COMPLAINT PROCESS.—Each HPPC shall estab-  
9 lish a process for the receipt and disposition of complaints  
10 regarding the performance of its duties.

11 (b) OMBUDSMAN.—

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

13 (A) for the appointment of an ombudsman,  
14 and

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

17 (2) DUTIES AND AUTHORITIES.—Each ombuds-  
18 man shall have the duty and authority to do the fol-  
19 lowing:

20 (A) RELATING TO HPPCS.—(i) To inves-  
21 tigate complaints regarding the failure of a  
22 HPPC to perform its duties.

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

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

4 (B) RELATING TO AHPS.—(i) To inves-  
 5 tigate complaints concerning the failure of an  
 6 AHP to meet the applicable requirements of  
 7 part 1 of subtitle C.

8 (ii) To assist enrollees in AHPs in resolv-  
 9 ing grievances with such plans.

10 (iii) To issue public reports and reports to  
 11 the Health Care Standards Commission on any  
 12 finding that an AHP has failed to meet the ap-  
 13 plicable requirements of part 1 of subtitle C.

14 (3) ACCESS TO INFORMATION.—The HPPC  
 15 shall provide the ombudsman and the ombudsman's  
 16 staff with access to such information as may be nec-  
 17 essary to carry out such duties.

18 **SEC. 1108. ENROLLEE SATISFACTION SURVEYS; MONITOR-**  
 19 **ING ENROLLEE DISENROLLMENT.**

20 (a) ENROLLEE SATISFACTION SURVEYS.—

21 (1) IN GENERAL.—Each HPPC, using a stand-  
 22 ard survey instrument prescribed by the Health Care  
 23 Standards Commission, shall collect information on  
 24 the satisfaction of eligible individuals with—

25 (A) the performance of the HPPC, and

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

3 (2) ANALYSIS.—Each HPPC shall—

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

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

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

11 (b) MONITORING ENROLLEE DISENROLLMENT.—  
12 Each HPPC shall monitor enrollee disenrollment from  
13 AHPs in order to determine whether there is a pattern  
14 of disenrollment which does not reflect the distribution of  
15 age, income, health condition, place of residence, and other  
16 potential risk characteristics of their enrollees. If a HPPC  
17 determines that such a pattern exists, the HPPC shall  
18 provide the Health Care Standards Commission with such  
19 information on such pattern as the Commission may speci-  
20 fy and may petition under section 1305(c)(2) for the rev-  
21 ocation of the registration of the AHP.

1     **Subtitle C—Accountable Health**  
2                   **Plans (AHPs)**

3     **PART 1—REQUIREMENTS FOR ACCOUNTABLE**  
4                   **HEALTH PLANS**

5     **SEC. 1201. REGISTRATION PROCESS; QUALIFICATIONS.**

6         (a) IN GENERAL.—The Health Care Standards Com-  
7 mission shall provide a process whereby a health plan (as  
8 defined in section 1701(c)(1)) may be registered with the  
9 Commission by its sponsor as an accountable health plan.  
10 Such a registered AHP is authorized to allocate its re-  
11 sources (except as otherwise specifically required under  
12 this subtitle) to maximize the health of its enrollees.

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

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

21             (2) provide, in accordance with section 1203,  
22 for the collection and provision to the Commission  
23 and HPPCs of certain information regarding its en-  
24 rollees and provision of services;

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

3           (4) establish standard premiums for the uni-  
4           form set of effective benefits, in accordance with sec-  
5           tion 1205;

6           (5) meet financial solvency requirements, in ac-  
7           cordance with section 1206;

8           (6) meet requirements relating to grievance pro-  
9           cedures, physician incentive plans, advance direc-  
10          tives, and agent commissions, in accordance with  
11          section 1207;

12          (7) in the case of an open plan (as defined in  
13          section 1701(b)(4)(B)), meet certain additional re-  
14          quirements under section 1208 (relating to offering  
15          of plans, acceptance of enrollees, and participation  
16          as a plan under the medicare program and under  
17          the Federal employees health benefits program);

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

21          (9) provide for any required medicare adjust-  
22          ment payments, in accordance with section 1210;

23          (10) pay certain premiums to the National  
24          Medical Education Fund, in accordance with section  
25          1211; and

1           (11) pay registration fees imposed under sec-  
2       tions 1303(d)(1) and 1304(d).

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

8       **SEC. 1202. SPECIFIED UNIFORM SET OF EFFECTIVE BENE-**  
9                       **FITS; REDUCTION IN COST-SHARING FOR**  
10                      **LOW-INCOME INDIVIDUALS; QUALITY STAND-**  
11                      **ARDS.**

12       (a) BENEFITS.—The Health Care Standards Com-  
13       mission shall not accept the registration of a health plan  
14       as an AHP unless, subject to subsection (b), the plan—

15           (1) offers only the uniform set of effective bene-  
16       fits, established under section 1302(a)(1);

17           (2) has entered into arrangements with a suffi-  
18       cient number, distribution, and variety of providers  
19       to assure that the uniform set of effective benefits  
20       is—

21           (A) available and accessible to each en-  
22       rollee, within the area served by the plan, with  
23       reasonable promptness and in a manner which  
24       assures continuity, and

1 (B) when medically necessary, available  
2 and accessible twenty-four hours a day and  
3 seven days a week,  
4 without imposing cost-sharing in excess of the cost-  
5 sharing described in paragraph (4);

6 (3) provides for the application of coverage  
7 standards, with respect to the uniform set of effec-  
8 tive benefits, which are disclosed by the plan to plan  
9 enrollees (in a manner specified by the Commission)  
10 and which are consistent with coverage criteria  
11 under section 1302(b) (as interpreted by the Com-  
12 mission);

13 (4) if it is a network plan (as defined in section  
14 1222(b)(1)), (A) selects providers of each type of  
15 good or service offered by the plan based on a com-  
16 petitive criteria, including price, quality, and services  
17 offered, and (B) publicizes and makes available,  
18 upon request, before the selection of participating  
19 providers such competitive criteria;

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

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



1 included in the uniform set of effective benefits serv-  
2 ices amounts in excess of such cost-sharing; and

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

7 (b) TREATMENT OF ADDITIONAL BENEFITS.—

8 (1) IN GENERAL.—Subject to paragraphs (2)  
9 and (3), subsection (a) shall not be construed as  
10 preventing an AHP from offering benefits in addi-  
11 tion to the uniform set of effective benefits, if such  
12 additional benefits are offered, and priced, sepa-  
13 rately from the benefits described in subsection (a).

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

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

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

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

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

8       (d) LIMITATION ON IMPOSITION OF COST-SHAR-  
9 ING.—In order to assure that providers of services for  
10 which benefits are available through an AHP do not im-  
11 pose cost-sharing in excess of that permitted under sub-  
12 section (a)(5), each AHP may not provide payment for  
13 services (other than emergency services) furnished by a  
14 provider with an arrangement described in subsection  
15 (a)(2) to meet the uniform set of effective benefits unless  
16 the provider has agreed (in a manner specified by the  
17 Health Care Standards Commission) not to impose cost-  
18 sharing in excess of that so specified.

19       (e) QUALITY STANDARDS.—The Health Care Stand-  
20 ards Commission shall establish standards relating to the  
21 minimum level of acceptable quality for an AHP's provi-  
22 sion of the uniform set of effective benefits. In order for  
23 a plan to be registered under this subtitle, the plan must  
24 agree to provide benefits in a manner that complies with  
25 such standards.

1 **SEC. 1203. COLLECTION AND PROVISION OF STANDARD-**  
2 **IZED INFORMATION.**

3 (a) PROVISION OF INFORMATION.—

4 (1) IN GENERAL.—Each AHP must provide the  
5 applicable HPPC and the Health Care Standards  
6 Commission (at a time, not less frequently than an-  
7 nually, and in an electronic, standardized form and  
8 manner specified by the Commission) such informa-  
9 tion as the Commission determines to be necessary,  
10 consistent with this subsection and sections 1104(c)  
11 and 1307, to forward payments to AHPs under sec-  
12 tion 1102(d) and to evaluate the performance of the  
13 AHP in providing the uniform set of effective bene-  
14 fits to enrollees in each HPPC area.

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

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

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

1 (C) Information on health care expendi-  
2 tures, volume and prices of procedures, and use  
3 of specialized centers of care (for which infor-  
4 mation is submitted under section 1308).

5 (D) Information on the flexibility per-  
6 mitted by plans to enrollees in their selection of  
7 providers.

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

14 (b) CONDITIONING CERTAIN PROVIDER PAY-  
15 MENTS.—

16 (1) IN GENERAL.—In order to assure the collec-  
17 tion of all information required from the direct pro-  
18 viders of services for which benefits are available  
19 through an AHP, each AHP may not provide pay-  
20 ment for services (other than emergency services)  
21 furnished by a provider to meet the uniform set of  
22 effective benefits unless the provider has given the  
23 AHP (or has given directly to the Health Care  
24 Standards Commission and the applicable HPPC)

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

3 (2) FORWARDING INFORMATION.—If informa-  
4 tion under paragraph (1) is given to the AHP, the  
5 AHP is responsible for forwarding the information  
6 to the Commission and the applicable HPPC.

7 (c) AUDITING.—Each AHP shall provide, in accord-  
8 ance with standards established by the Commission, for  
9 the auditing of information provided under this section.

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

14 (a) IN GENERAL.—Except as provided under sub-  
15 section (b), an AHP may not deny, limit, or condition the  
16 coverage under (or benefits of) the plan based on the  
17 health status of an individual, claims experience of an indi-  
18 vidual, receipt of health care by an individual, medical his-  
19 tory of an individual, receipt of public subsidies by an indi-  
20 vidual, lack of evidence of insurability of an individual, or  
21 any other characteristic of the individual that may relate  
22 to the need for health care services.

23 (b) TREATMENT OF PREEXISTING CONDITION EX-  
24 CLUSIONS FOR SERVICES.—

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

9           (2) CREDITING OF PREVIOUS COVERAGE.—

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

19           (B) DEFINITIONS.—As used in this para-  
20           graph:

21                   (i) PERIOD OF CONTINUOUS COV-  
22                   ERAGE.—

23                   (I) IN GENERAL.—The term “pe-  
24                   riod of continuous coverage” means  
25                   the period beginning on the date an

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

5 (II) TRANSITIONAL AMNESTY AT  
6 TIME OF INITIAL ENROLLMENT.—For  
7 purposes of this clause, each individ-  
8 ual who enrolls in an AHP before  
9 July 1, 1995, is considered to have  
10 had a period of continuous coverage  
11 during the 6 months ending January  
12 1, 1995.

13 (ii) PREEXISTING CONDITION.—The  
14 term “preexisting condition” means, with  
15 respect to coverage under an AHP, a con-  
16 dition which has been diagnosed or treated  
17 during the 3-month period ending on the  
18 day before the first date of such coverage  
19 (without regard to any waiting period).

20 (3) LIMITATION TO UNIFORM SET OF EFFEC-  
21 TIVE BENEFITS.—This subsection shall not apply to  
22 treatment which is not within the uniform set of ef-  
23 fective benefits.

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

1 nance organization that is an AHP shall not be con-  
2 sidered as failing to meet the requirements of sec-  
3 tion 1301 of the Public Health Service Act notwith-  
4 standing that it provides for an exclusion of the type  
5 described in paragraph (1) so long as such exclusion  
6 is applied consistent with the previous provisions of  
7 this subsection.

8 **SEC. 1205. USE OF STANDARD PREMIUMS.**

9 (a) STANDARD PREMIUMS FOR OPEN AHPs.—

10 (1) IN GENERAL.—

11 (A) ESTABLISHMENT.—Subject to sub-  
12 section (c), each open AHP shall establish a  
13 standard premium for the uniform set of effec-  
14 tive benefits within each HPPC area in which  
15 the plan is offered.

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

23 (C) UNIFORMITY WITHIN A YEAR.—Within  
24 a HPPC area for individuals within a premium  
25 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

1 for an average class. The weighted average  
2 of the premium class factors shall be 1.  
3 Such premium class factors shall be com-  
4 puted based on the actuarial value of bene-  
5 fits for such population group within the  
6 class (which shall include the population el-  
7 igible to enroll with open AHPs through  
8 HPPCs) as the Commission determines to  
9 be appropriate.

10 (ii) LIMIT ON VARIATION IN PREMIUM  
11 CLASS FACTORS WITHIN A TYPE OF EN-  
12 ROLLMENT.—The highest premium class  
13 factor within a type of enrollment may not  
14 exceed twice the lowest premium class fac-  
15 tor for that type of enrollment. The pre-  
16 vious sentence shall not apply to premiums  
17 imposed pursuant to a risk-sharing con-  
18 tract under section 1876 of the Social Se-  
19 curity Act.

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

23 (b) STANDARD PREMIUMS FOR CLOSED AHPs.—

24 (1) ESTABLISHMENT.—Subject to subsection

25 (c) and paragraph (3), each closed AHP shall estab-

1       lish a standard premium for the uniform set of ef-  
2       fective benefits within each HPPC area in which the  
3       plan is offered.

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

6               (A) the amount of premium applicable for  
7       all individuals within a premium class is the  
8       standard premium amount multiplied by the  
9       premium class factor specified by the Commis-  
10      sion for that class under subsection (a)(2)(B),  
11      and

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

16              (3) COMMUNITY RATING PERMITTED.—

17              (A) SAME RATES WITHIN TYPE OF EN-  
18      ROLLMENT WITHOUT REGARD TO AGE.—A  
19      closed AHP may elect (in a manner specified by  
20      the Health Care Standards Commission) to  
21      apply this subsection on the basis of type of en-  
22      rollment rather than premium class. In such  
23      case, all references in this subsection to pre-  
24      mium class are deemed a reference to type of  
25      enrollment and the reference to premium class

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

4 (B) COMMUNITY RATING ACROSS HPPC  
5 AREAS.—A closed AHP may elect (in a manner  
6 specified by the Commission) to apply this sub-  
7 section by treating two or more HPPC areas as  
8 a single HPPC area. In such case, subject to  
9 subparagraph (A), the premium class factor to  
10 be applied shall be the weighted average of such  
11 factors for the plan for the HPPC areas in-  
12 volved.

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

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

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

22 (i) the base Federal premium amount  
23 (as defined in section 2005(a)(1)) for en-  
24 rollment under the plan, and

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

6                   (B) the AHP shall credit against the pre-  
7                   mium owed the applicable Federal assistance  
8                   amount (as defined in section 2009(c)(1)) pro-  
9                   vided the plan under section 2002(a)(1)(B).

10               (2) MODERATELY LOW-INCOME INDIVIDUALS.—

11               In the case of a moderately low-income individual  
12               (as defined in section 2009(a)(2)) eligible for pre-  
13               mium assistance under section 2002 and enrolled  
14               with an AHP—

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

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

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

1            ual is enrolled exceeds (II) the reference  
2            premium rate (as defined in section  
3            2009(c)(4)) for the individual; and

4            (B) the AHP shall credit against the pre-  
5            mium owed the applicable Federal assistance  
6            amount (as defined in section 2009(c)(1)) pro-  
7            vided the plan under section 2002(a)(2)(B).

8            If the premium reduction under subparagraph (A) is  
9            not a multiple of \$1, the Commission may provide  
10          for the rounding of such reduction to a multiple of  
11          \$1.

12    **SEC. 1206. FINANCIAL SOLVENCY REQUIREMENTS.**

13          (a) SOLVENCY PROTECTION.—

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

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

1 under the plan are protected with respect to poten-  
2 tial insolvency of the plan.

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

13 **SEC. 1207. GRIEVANCE MECHANISMS; ENROLLEE PROTEC-**  
14 **TIONS; WRITTEN POLICIES AND PROCE-**  
15 **DURES RESPECTING ADVANCE DIRECTIVES;**  
16 **AGENT COMMISSIONS.**

17 (a) EFFECTIVE GRIEVANCE PROCEDURES.—

18 (1) IN GENERAL.—Each AHP shall provide for  
19 effective procedures for hearing and resolving griev-  
20 ances between the plan and individuals enrolled  
21 under the plan, which procedures meet standards  
22 specified by the Health Care Standards Commission.

23 (2) ACCESS OF OMBUDSMAN TO INFORMA-  
24 TION.—Each AHP shall provide the ombudsman,  
25 appointed under section 1107(b) for the HPPC area

1 in which the AHP operates, and the ombudsman's  
2 staff with access to such information as may be nec-  
3 essary for the ombudsman to carry out duties under  
4 such section.

5 (b) RESTRICTION ON CERTAIN PHYSICIAN INCEN-  
6 TIVE PLANS.—

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

14 (2) PHYSICIAN INCENTIVE PLAN DEFINED.—In  
15 this subsection, the term “physician incentive plan”  
16 means any compensation or other financial arrange-  
17 ment between the AHP and a physician or physician  
18 group that may directly or indirectly have the effect  
19 of reducing or limiting services provided with respect  
20 to individuals enrolled under the plan.

21 (c) WRITTEN POLICIES AND PROCEDURES RESPECT-  
22 ING ADVANCE DIRECTIVES.—A health plan may not be  
23 registered as an AHP unless the plan meets the require-  
24 ments of section 1866(f) of the Social Security Act (relat-  
25 ing to maintaining written policies and procedures respect-



1 ing advance directives), insofar as such requirements  
2 would apply to the plan if the plan were an eligible organi-  
3 zation.

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

5 (1) may pay a commission or other remunera-  
6 tion to an agent or broker in marketing the plan to  
7 individuals or groups, but

8 (2) may not vary such remuneration based, di-  
9 rectly or indirectly, on the anticipated or actual  
10 claims experience associated with the group or indi-  
11 viduals to which the plan was sold.

12 **SEC. 1208. ADDITIONAL REQUIREMENTS OF OPEN AHPS.**

13 (a) REQUIREMENT OF AGREEMENT WITH HPPC.—

14 In the case of a health plan which is an open plan (as  
15 defined in section 1701(b)(4)(B)), in order to be reg-  
16 istered as an AHP the plan must have in effect an agree-  
17 ment (described in section 1102) with each HPPC for  
18 each HPPC area in which it is offered.

19 (b) REQUIREMENT OF OPEN ENROLLMENT.—

20 (1) IN GENERAL.—In the case of a health plan  
21 which is an open health plan, in order to be reg-  
22 istered as an AHP the plan must, subject to para-  
23 graph (3), not reject the enrollment of any eligible  
24 individual whom a HPPC is authorized to enroll  
25 under an agreement referred to in subsection (a) if

1 the individual applies for enrollment during an en-  
2 rollment period.

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

7 (A) nonpayment of premiums,

8 (B) fraud or misrepresentation, or

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

13 (3) TREATMENT OF NETWORK PLANS.—

14 (A) GEOGRAPHIC LIMITATIONS.—

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

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

1 plans of service areas in order to prevent  
2 discrimination based on health status of  
3 individuals or their need for health serv-  
4 ices.

5 (B) SIZE LIMITS.—Subject to subpara-  
6 graph (C), an AHP which is a network plan  
7 may apply to the Commission to cease enrolling  
8 eligible individuals under the AHP (or in a  
9 service area of the plan) if—

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

12 (ii) it can demonstrate that its finan-  
13 cial or administrative capacity to serve pre-  
14 viously covered groups or individuals (and  
15 additional individuals who will be expected  
16 to enroll because of affiliation with such  
17 previously covered groups or individuals)  
18 will be impaired if it is required to enroll  
19 other eligible individuals.

20 (C) FIRST-COME-FIRST-SERVED.—A net-  
21 work plan is only eligible to exercise the limita-  
22 tions provided for in subparagraphs (A) and  
23 (B) if it provides for enrollment of eligible indi-  
24 viduals on a first-come-first-served basis, except  
25 that the plan, under rules of the Commission,

1           shall provide preference for eligible individuals  
2           who are not eligible to enroll in another net-  
3           work plan.

4           (D) NETWORK PLAN.—In this paragraph,  
5           the term “network plan” means an eligible or-  
6           ganization (as defined in section 1876(b) of the  
7           Social Security Act) and includes a similar or-  
8           ganization, specified in regulations of the Com-  
9           mission, that requires a limitation on enroll-  
10          ment of employer groups or individuals due to  
11          the manner in which the organization provides  
12          health care services.

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

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

23               (2) EXPANSION OF MEDICARE SELECT PRO-  
24               GRAM.—Subsection (c) of section 4358 of the Omni-  
25               bus Budget Reconciliation Act of 1990 (104 Stat.

1       1388–137) is amended by striking “only apply in 15  
2       States” and all that follows through the end and in-  
3       serting “on and after January 1, 1992.”.

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

7       (d) PARTICIPATION IN FEHBP.—

8           (1) IN GENERAL.—In the case of a health plan  
9       which is an open health plan, in order to be reg-  
10      istered as an AHP the plan must have entered into  
11      an agreement with the Office of Personnel Manage-  
12      ment to offer a health plan to Federal employees  
13      and annuitants, and family members, under the  
14      Federal Employees Health Benefits Program under  
15      chapter 89 of title 5, United States Code, under the  
16      same terms and conditions (other than the amount  
17      of premiums) offered by the AHP for enrollment of  
18      eligible individuals through HPPCs.

19          (2) CHANGE IN CONTRIBUTION AND OTHER  
20      FEHBP RULES.—Notwithstanding any other provi-  
21      sion of law, effective January 1, 1995—

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

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

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

5 (ii) for any individual in a premium  
6 class shall not exceed the base individual  
7 premium (as defined in section  
8 2009(c)(3)), and

9 (iii) in the aggregate for any fiscal  
10 year shall be equal to the aggregate  
11 amount of Government contributions that  
12 would have been made but for this sub-  
13 section.

14 **SEC. 1209. COORDINATION OF BENEFITS WITH LOW-IN-**  
15 **COME ASSISTANCE.**

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

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

21 (2) an adjustment, in accordance with sections  
22 1202(c) and 1205(c), in the cost-sharing or pre-  
23 mium amounts otherwise imposed to reflect the cost-  
24 sharing and premium assistance provided under  
25 such subtitle, and

1           (3) such reconciliation payments as may be re-  
2           quired under section 1102(e).

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

9   **SEC. 1210. ADDITIONAL REQUIREMENT OF CERTAIN AHPS.**

10          (a) MEDICARE ADJUSTMENT PAYMENT RE-  
11 QUIRED.—Each AHP which is not described in section  
12 1208(c)(1) shall provide for payment to the Health Care  
13 Standards Commission of such amounts as may be re-  
14 quired as to put the plan in the same financial position  
15 as the AHP would be in if it was required to meet the  
16 requirement of such section.

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

1 **SEC. 1211. FUNDING FOR APPROVED MEDICAL RESIDENCY**  
2 **TRAINING PROGRAMS AND PHYSICIAN RE-**  
3 **TRAINING PROGRAMS.**

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

8 (b) PAYMENT METHOD.—

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

13 (2) CLOSED AHPS.—In the case of a closed  
14 AHP, the payment under subsection (a) shall be  
15 made on a monthly (or other basis) as specified by  
16 the Commission. Failure of a closed AHP to make  
17 such a payment on a timely basis is grounds for rev-  
18 ocation of the registration of the AHP under this  
19 part.

20 (c) GROSS PREMIUM RECEIPTS DEFINED.—In this  
21 section, the term “gross premium receipts” means, with  
22 respect to—

23 (1) an open AHP, the payment amounts other-  
24 wise payable by a HPPC to the AHP, or

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



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

4 **PART 2—PREEMPTION OF STATE LAWS FOR**  
5 **ACCOUNTABLE HEALTH PLANS**

6 **SEC. 1221. PREEMPTION FROM STATE BENEFIT MANDATES.**

7 Effective as of January 1, 1995, no State shall estab-  
8 lish or enforce any law or regulation that—

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

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

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

18 **SEC. 1222. PREEMPTION OF STATE LAW RESTRICTIONS ON**  
19 **NETWORK PLANS.**

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

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

1           (2) a State may not prohibit or limit a network  
2           plan from limiting coverage of services to those pro-  
3           vided by a participating provider;

4           (3) a State may not prohibit or limit the nego-  
5           tiation of rates and forms of payments for providers  
6           under a network plan;

7           (4) a State may not prohibit or limit a network  
8           plan from limiting the number of participating pro-  
9           viders;

10          (5) a State may not prohibit or limit a network  
11          plan from requiring that services be provided (or au-  
12          thorized) by a practitioner selected by the enrollee  
13          from a list of available participating providers; and

14          (6) a State may not prohibit or limit the cor-  
15          porate practice of medicine.

16          (b) DEFINITIONS.—In this section:

17               (1) NETWORK PLAN.—The term “network  
18               plan” means an AHP—

19                       (A) which—

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

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

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

4           (B) which has a sufficient number and dis-  
5           tribution of participating providers to assure  
6           that the uniform set of effective benefits (i) is  
7           available and accessible to each enrollee, within  
8           the area served by the plan, with reasonable  
9           promptness and in a manner which assures con-  
10          tinuity, and (ii) when medically necessary, is  
11          available and accessible twenty-four hours a day  
12          and seven days a week; and

13          (C) which provides benefits for the uniform  
14          set of effective benefits not furnished by partici-  
15          pating providers if the services are medically  
16          necessary and immediately required because of  
17          an unforeseen illness, injury, or condition.

18          (2) PARTICIPATING PROVIDER.—The term  
19          “participating provider” means an entity or individ-  
20          ual which provides, sells, or leases health care serv-  
21          ices under a contract with a network plan, which  
22          contract does not permit—

23                (A) cost-sharing in excess of the cost-shar-  
24                ing permitted under the uniform set of effective  
25                benefits, and

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

4 **SEC. 1223. PREEMPTION OF STATE LAWS RESTRICTING UTI-**  
5 **LIZATION REVIEW PROGRAMS.**

6 (a) IN GENERAL.—Effective January 1, 1995, no  
7 State law or regulation shall prohibit or regulate activities  
8 under a utilization review program (as defined in sub-  
9 section (b)).

10 (b) UTILIZATION REVIEW PROGRAM DEFINED.—In  
11 this section, the term “utilization review program” means  
12 a system of reviewing the medical necessity and appro-  
13 priateness of patient services (which may include inpatient  
14 and outpatient services) using specified guidelines. Such  
15 a system may include preadmission certification, the appli-  
16 cation of practice guidelines, continued stay review, dis-  
17 charge planning, preauthorization of ambulatory proce-  
18 dures, and retrospective review.

19 **PART 3—ANTITRUST PROVISIONS**

20 **SEC. 1231. PUBLICATION OF GUIDELINES FOR ACCOUNT-**  
21 **ABLE HEALTH PLANS.**

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

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

3 (b) REVIEW PROCESS.—The Attorney General shall  
4 establish a review process under which an AHP (or organi-  
5 zation that proposes to establish an AHP) may obtain a  
6 prompt opinion from the Department of Justice on the  
7 plan’s conformity with the Federal antitrust laws.

8 (c) ANTITRUST LAWS DEFINED.—In this section, the  
9 term “antitrust laws” has the meaning given it in sub-  
10 section (a) of the first section of the Clayton Act (15  
11 U.S.C. 12(a)), except that such term includes section 5  
12 of the Federal Trade Commission Act (15 U.S.C. 45) to  
13 the extent such section applies to unfair methods of com-  
14 petition.

15 **SEC. 1232. ISSUANCE OF HEALTH CARE CERTIFICATES OF**  
16 **PUBLIC ADVANTAGE.**

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

1 date). Such venture, and the parties to such venture, shall  
2 not be liable under any of the antitrust laws for conduct  
3 described in such certificate and engaged in by such ven-  
4 ture if such conduct occurs while such certificate is in ef-  
5 fect.

6 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF  
7 CERTIFICATES.—

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

12 (A) the benefits that are likely to result  
13 from carrying out the venture outweigh the re-  
14 duction in competition (if any) that is likely to  
15 result from the venture, and

16 (B) such reduction in competition is rea-  
17 sonably necessary to obtain such benefits.

18 (2) FACTORS TO BE CONSIDERED.—

19 (A) WEIGHING OF BENEFITS AGAINST RE-  
20 Duction IN COMPETITION.—For purposes of  
21 making the finding described in paragraph  
22 (1)(A), the Attorney General shall consider  
23 whether the venture is likely —

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

1 (ii) to increase access to health care,  
2 (iii) to achieve cost efficiencies that  
3 will be passed on to health care consumers,  
4 such as economies of scale, reduced trans-  
5 action costs, and reduced administrative  
6 costs,

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

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

12 (vi) to reduce inefficient health care  
13 resource duplication.

14 (B) NECESSITY OF REDUCTION IN COM-  
15 PETITION.—For purposes of making the finding  
16 described in paragraph (1)(B), the Attorney  
17 General shall consider—

18 (i) the ability of the providers of  
19 health care services that are (or likely to  
20 be) affected by the health care joint ven-  
21 ture and the entities responsible for mak-  
22 ing payments to such providers to nego-  
23 tiate societally optimal payment and serv-  
24 ice arrangements,

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

5                   (iii) the availability of equally effi-  
6                   cient, less restrictive alternatives to achieve  
7                   the benefits that are intended to be  
8                   achieved by carrying out the venture.

9           (c) ESTABLISHMENT OF CRITERIA AND PROCE-  
10 DURES.—Subject to subsections (d) and (e), not later than  
11 1 year after the date of the enactment of this Act, the  
12 Attorney General and the Secretary shall establish jointly  
13 by rule the criteria and procedures applicable to the issu-  
14 ance of certificates under subsection (a). The rules shall  
15 specify the form and content of the application to be sub-  
16 mitted to the Attorney General to request a certificate,  
17 the information required to be submitted in support of  
18 such application, the procedures applicable to denying and  
19 to revoking a certificate, and the procedures applicable to  
20 the administrative appeal (if such appeal is authorized by  
21 rule) of the denial and the revocation of a certificate. Such  
22 information may include the terms of the health care joint  
23 venture (in the case of a venture in existence as of the  
24 time of the application) and implementation plan for the  
25 joint venture.



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

6           (1) an agreement by the parties to the venture  
7 that the venture will not foreclose competition by en-  
8 tering into contracts that prevent health care provid-  
9 ers from providing health care in competition with  
10 the venture,

11          (2) an agreement that the venture will submit  
12 to the Attorney General annually a report that de-  
13 scribes the operations of the venture and informa-  
14 tion regarding the impact of the venture on health  
15 care and on competition in health care, and

16          (3) an agreement that the parties to the ven-  
17 ture will notify the Attorney General and the Sec-  
18 retary of the termination of the venture not later  
19 than 30 days after such termination occurs.

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

1 ration of such 30-day period, the Attorney General fails  
2 to issue or deny the issuance of such certificate, the Attor-  
3 ney General shall be deemed to have issued such certifi-  
4 cate.

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

10 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

11 (1) DENIAL AND REVOCATION OF CERTIFI-  
12 CATES.—If the Attorney General denies an applica-  
13 tion for a certificate or revokes a certificate, the At-  
14 torney General shall include in the notice of denial  
15 or revocation a statement of the reasons relied upon  
16 for the denial or revocation of such certificate.

17 (2) JUDICIAL REVIEW.—

18 (A) AFTER ADMINISTRATIVE PROCEED-  
19 ING.—(i) If the Attorney General denies an ap-  
20 plication submitted or revokes a certificate is-  
21 sued under this section after an opportunity for  
22 hearing on the record, then any party to the  
23 health care joint venture involved may com-  
24 mence a civil action, not later than 60 days  
25 after receiving notice of the denial or revoca-

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

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

11          (B) DENIAL OR REVOCATION WITHOUT AD-  
12          MINISTRATIVE PROCEEDING.—If the Attorney  
13          General denies an application submitted or re-  
14          vokes a certificate issued under this section  
15          without an opportunity for hearing on the  
16          record, then any party to the health care joint  
17          venture involved may commence a civil action,  
18          not later than 60 days after receiving notice of  
19          the denial or revocation, in an appropriate dis-  
20          trict court of the United States for de novo re-  
21          view of such denial or revocation.

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

1           (1) to prepare, agree to prepare, or attempt to  
2           agree to prepare an application to request a certifi-  
3           cate under this section, or

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

7           (i) DEFINITIONS.—In this section:

8           (1) The term “antitrust laws”—

9                   (A) has the meaning given it in subsection  
10                  (a) of the first section of the Clayton Act (15  
11                  U.S.C. 12(a)), except that such term includes  
12                  section 5 of the Federal Trade Commission Act  
13                  (15 U.S.C. 45) to the extent such section ap-  
14                  plies to unfair methods of competition; and

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

17           (2) The term “certificate” means a certificate  
18           of public advantage authorized to be issued under  
19           subsection (a).

20           (3) The term “health care joint venture” means  
21           an agreement (whether existing or proposed) be-  
22           tween 2 or more providers of health care services  
23           that is entered into solely for the purpose of sharing  
24           in the provision of health care services and that in-  
25           volves substantial integration or financial risk-shar-

1       ing between the parties, but does not include the ex-  
2       changing of information, the entering into of any  
3       agreement, or the engagement in any other conduct  
4       that is not reasonably required to carry out such  
5       agreement.

6           (4) The term “health care services” includes  
7       services related to the delivery or administration of  
8       health care services.

9           (5) The term “liable” means liable for any civil  
10      or criminal violation of the antitrust laws.

11          (6) The term “provider of health care services”  
12      means any individual or entity that is engaged in the  
13      delivery of health care services in a State and that  
14      is required by State law or regulation to be licensed  
15      or certified by the State to engage in the delivery of  
16      such services in the State.

17      **Subtitle D—Health Care Standards**  
18                      **Commission**

19      **SEC. 1301. ESTABLISHMENT OF HEALTH CARE STANDARDS**  
20                      **COMMISSION.**

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

25          (b) COMPOSITION AND TERMS.—

1           (1) APPOINTMENT.—The Commission shall be  
2       composed of 5 members appointed by the President  
3       by and with the advice and consent of the Senate.  
4       In appointing members to the Commission, the  
5       President shall provide that all members shall dem-  
6       onstrate experience with and knowledge of the health  
7       care system.

8           (2) CHAIRMAN.—The President shall designate  
9       one of the members to be Chairman of the Commis-  
10      sion.

11          (3) TERMS.—Each member of the Commission  
12      shall be appointed for a term of 7 years, except that,  
13      of the members first appointed, 1 shall each be ap-  
14      pointed for terms of 3, 4, 5, 6, and 7 years, as des-  
15      ignated by the President at the time of appointment.  
16      Members appointed to fill vacancies shall serve for  
17      the remainder of the terms of the vacating members.

18          (4) PARTY AFFILIATION.—Not more than 3  
19      members of the Commission shall be of the same po-  
20      litical party.

21          (5) OTHER EMPLOYMENT PROHIBITED.—A  
22      member of the Commission may not, during the  
23      term as a member, engage in any other business, vo-  
24      cation, profession, or employment.

1           (6) QUORUM.—Three members of the Commis-  
2       sion shall constitute a quorum, except that 2 mem-  
3       bers may hold hearings.

4           (7) MEETINGS.—The Commission shall meet at  
5       the call of the Chairman or 3 members of the Com-  
6       mission.

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

12      (c) PERSONNEL.—

13           (1) IN GENERAL.—The Commission shall ap-  
14      point an Executive Director and such additional offi-  
15      cers and employees as it considers necessary to carry  
16      out its functions under this Act. Except as otherwise  
17      provided in any other provision of law, such officers  
18      and employees shall be appointed, and their com-  
19      pensation shall be fixed, in accordance with title 5,  
20      United States Code.

21           (2) EXPERTS AND CONSULTANTS.—The Com-  
22      mission may procure the services of experts and con-  
23      sultants in accordance with the provisions of section  
24      3109 of title 5, United States Code.

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

5 **SEC. 1302. SPECIFICATION OF UNIFORM SET OF EFFECTIVE**  
6 **BENEFITS.**

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

9 (1) TRANSMITTAL OF RECOMMENDATIONS TO  
10 CONGRESS.—

11 (A) FOR 1995.—The Commission shall  
12 transmit to Congress, by not later than July 1,  
13 1994, recommendations for the uniform set of  
14 effective benefits to apply under this title for  
15 1995 and, subject to subparagraph (B), subse-  
16 quent years.

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

24 (C) CONGRESSIONAL CONSIDERATION.—



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

16 (ii) JOINT RESOLUTION OF DIS-  
17 APPROVAL.—A joint resolution described in  
18 this clause means only a joint resolution  
19 which is introduced within the 10-day pe-  
20 riod beginning on the date on which the  
21 Commission transmits recommendations  
22 under subparagraph (A) or (B) and—

23 (I) which does not have a pre-  
24 amble;

1 (II) the matter after the resolv-  
2 ing clause of which is as follows:  
3 “That Congress disapproves the rec-  
4 ommendations of the Health Care  
5 Standards Commission concerning the  
6 uniform set of effective benefits as  
7 transmitted by the Commission on  
8 \_\_\_\_\_.”, the blank space  
9 being filled in with the appropriate  
10 date; and

11 (III) the title of which is as fol-  
12 lows: “Joint resolution disapproving  
13 the recommendations of the Health  
14 Care Standards Commission concern-  
15 ing the uniform set of effective bene-  
16 fits as transmitted by the Commission  
17 on \_\_\_\_\_.”, the blank  
18 space being filled in with the appro-  
19 priate date.

20 (iii) PROCEDURES FOR CONSIDER-  
21 ATION OF RESOLUTION OF DIS-  
22 APPROVAL.—Subject to clause (iv), the  
23 provisions of section 2908 (other than sub-  
24 section (a)) of the Defense Base Closure  
25 and Realignment Act of 1990 shall apply

1 to the consideration of a joint resolution  
2 described in clause (ii) in the same manner  
3 as such provisions apply to a joint resolu-  
4 tion described in section 2908(a) of such  
5 Act.

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

9 (I) any reference to the Commit-  
10 tee on Armed Services of the House of  
11 Representatives shall be deemed a ref-  
12 erence to the Committee on Energy  
13 and Commerce of the House of Rep-  
14 resentatives and any reference to the  
15 Committee on Armed Services of the  
16 Senate shall be deemed a reference to  
17 the Committee on Finance of the Sen-  
18 ate; and

19 (II) any reference to the date on  
20 which the President transmits a re-  
21 port shall be deemed a reference to  
22 the date on which the Commission  
23 transmits a recommendation under  
24 subparagraph (A) or (B).

25 (D) TREATMENT OF DISAPPROVAL.—

1 (i) FOR 1995.—If recommendations  
2 transmitted under subparagraph (A) are  
3 disapproved by joint resolution under sub-  
4 paragraph (C), then the Commission shall  
5 transmit to Congress, by not later than 15  
6 days after the date of adoption of the reso-  
7 lution, recommendations for the uniform  
8 set of effective benefits to apply under this  
9 title for 1995 and, subject to subparagraph  
10 (B), subsequent years. The provisions of  
11 subparagraph (C) shall apply to such new  
12 recommendations in the same manner as  
13 they applied to the recommendations pre-  
14 viously transmitted under subparagraph  
15 (A), except that any time period specified  
16 in such subparagraph shall be half the pe-  
17 riod otherwise provided.

18 (ii) FOR SUBSEQUENT YEARS.—If rec-  
19 ommendations transmitted under subpara-  
20 graph (B) are disapproved by joint resolu-  
21 tion under subparagraph (C), then such  
22 recommendations shall not take effect and  
23 the recommendations not previously dis-  
24 approved under this paragraph shall con-  
25 tinue in effect until otherwise changed.

1           (2) SPECIFICATION OF ALL MEDICALLY APPRO-  
2       PRIATE TREATMENTS.—

3           (A) MEDICALLY APPROPRIATE TREAT-  
4       MENTS.—The uniform set of effective benefits  
5       submitted under paragraph (1) shall include  
6       such categories of health care services that the  
7       Commission determines will provide for the de-  
8       livery of medically appropriate treatment by  
9       AHPs.

10          (B) COVERAGE OF CLINICAL PREVENTIVE  
11       SERVICES.—Such benefits shall include the full  
12       range of effective clinical preventive services  
13       (including appropriate screening, counseling,  
14       and immunization and chemoprophylaxis), spec-  
15       ified by the Commission, appropriate to age and  
16       other risk factors.

17          (C) COVERAGE OF DIAGNOSTIC SERV-  
18       ICES.—Such benefits shall include a full range  
19       of diagnostic services not covered under sub-  
20       paragraph (B).

21          (D) GUIDELINES.—Nothing in this para-  
22       graph shall prohibit the Commission from devel-  
23       oping guidelines that would specify the appro-  
24       priate uses of treatment in greater detail.

1 (D) ADDITIONAL COVERAGE.—Nothing in  
2 this paragraph shall be construed as preventing  
3 a plan from providing coverage of treatment  
4 that has not been determined (under subsection  
5 (b)) by the Commission to be medically appro-  
6 priate for purposes of this paragraph.

7 (3) COST-SHARING.—

8 (A) IN GENERAL.—Subject to subpara-  
9 graph (B), such set shall include uniform cost-  
10 sharing associated with such benefits consistent  
11 with subsection (c).

12 (B) TREATMENT OF NETWORK PLANS.—In  
13 the case of a network plan (as defined in sec-  
14 tion 1222(b)), the plan may provide for charg-  
15 ing cost-sharing in excess of the uniform cost-  
16 sharing under subparagraph (A) in the case of  
17 services provided by providers that are not par-  
18 ticipating providers (as defined in such section).

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

21 (1) IN GENERAL.—An AHP is required to pro-  
22 vide for coverage of the uniform set of effective ben-  
23 efits only for treatments and diagnostic procedures  
24 that are medically appropriate. Subject to the suc-  
25 ceeding provision of this subsection, for purposes of

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

5               (A) TREATMENT OR DIAGNOSIS OF MEDI-  
6       CAL CONDITION.—

7               (i) IN GENERAL.—The treatment or  
8       diagnostic procedure is for a medical con-  
9       dition.

10              (ii) MEDICAL CONDITION DEFINED.—  
11       The term “medical condition” means a dis-  
12       ease, illness, injury, or biological or psycho-  
13       logical condition or status for which treat-  
14       ment is indicated to improve, maintain, or  
15       stabilize a health outcome (as defined in  
16       paragraph (6)(B)) or which, in the absence  
17       of treatment, could lead to an adverse  
18       change in a health outcome.

19              (iii) ADVERSE CHANGE IN HEALTH  
20       OUTCOME DEFINED.—In clause (ii), an ad-  
21       verse change in a health outcome occurs if  
22       there is a biological or psychological  
23       decremental change in a health status or if  
24       the original endowment for a feature lies  
25       outside the normal range.

1 (B) NOT INVESTIGATIONAL.—There must  
2 be sufficient evidence on which to base conclu-  
3 sions about the existence and magnitude of the  
4 change in health outcome resulting from the  
5 treatment or diagnostic procedure compared  
6 with the best available alternative (or with no  
7 treatment or diagnostic procedure if no alter-  
8 native treatment or procedure is available).

9 (C) EFFECTIVE AND SAFE.—The evidence  
10 must demonstrate that the treatment or diag-  
11 nostic procedure can reasonably be expected to  
12 produce the intended health result or provide  
13 intended health information and is safe and the  
14 treatment or diagnostic procedure provides a  
15 clinically meaningful benefit with respect to  
16 safety and effectiveness in comparison to other  
17 available alternatives.

18 (2) TREATMENT OR DIAGNOSTIC PROCEDURE  
19 CONSISTENT WITH PRACTICE GUIDELINES.—A treat-  
20 ment or diagnostic procedure that is provided con-  
21 sistent with a practice guideline established by the  
22 Agency for Clinical Evaluations, established under  
23 section 1309, (or its predecessor) is deemed to be  
24 medically appropriate.

25 (3) RELATIONSHIP TO FDA REVIEW.—



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

3 (i) DRUGS.—A drug that has been  
4 found to be safe and effective under sec-  
5 tion 505 of the Federal Food, Drug, and  
6 Cosmetic Act is deemed to meet the re-  
7 quirements of paragraphs (1)(B) and  
8 (1)(C) (relating to not investigational and  
9 safety and effectiveness).

10 (ii) BIOLOGICALS.—A biological that  
11 has been found to be safe and effective  
12 under section 351 of the Public Health  
13 Service Act is deemed to meet the require-  
14 ments of paragraphs (1)(B) and (1)(C)  
15 (relating to not investigational and safety  
16 and effectiveness).

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

1 not investigational and safety and effec-  
2 tiveness).

3 (B) OTHER DRUGS, BIOLOGICALS, AND DE-  
4 VICES.—A drug, biological, or medical device  
5 not described in subparagraph (A) shall be con-  
6 sidered to be investigational. Nothing shall pro-  
7 hibit a AHP from covering such drugs,  
8 biologicals, and medical devices, including treat-  
9 ment investigational new drugs (IND).

10 (C) OFF-LABEL USE.—An off-label use for  
11 a drug described in subparagraph (A)(i) is pre-  
12 sumed to meet the requirements of paragraph  
13 (1)(C) if the medical indication for which it is  
14 used is listed in one of the following 3 compen-  
15 dia: the American Hospital Formulary Service-  
16 Drug Information, the American Medical Asso-  
17 ciation Drug Evaluations, and the United  
18 States Pharmacopeia-Drug Information.

19 (4) COVERAGE OF INVESTIGATIONAL TREAT-  
20 MENTS IN APPROVED RESEARCH TRIALS.—

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

1           only if the treatment is part of an approved re-  
2           search trial (as defined in subparagraph (D)).

3           (B) INVESTIGATIONAL TREATMENT DE-  
4           FINED.—In subparagraph (A), the term “inves-  
5           tigational treatment” means a treatment for  
6           which there is not sufficient evidence to deter-  
7           mine the health outcome of the treatment com-  
8           pared with the best available alternative treat-  
9           ment (or with no treatment if there is no alter-  
10          native treatment).

11          (C) ROUTINE MEDICAL COSTS DEFINED.—  
12          In subparagraph (A), the term “routine medical  
13          costs” means the cost of health services re-  
14          quired to provide treatment according to the de-  
15          sign of the trial, except those costs normally  
16          paid for by other funding sources (as defined by  
17          the Commission). Such costs do not include the  
18          cost of the investigational agent, devices or pro-  
19          cedures themselves, the costs of any nonhealth  
20          services that might be required for a person to  
21          receive the treatment, or the costs of managing  
22          the research.

23          (D) APPROVED RESEARCH TRIAL DE-  
24          FINED.—In subparagraph (A), the term “ap-  
25          proved research trial” means a trial—

1 (i) conducted for the primary purpose  
2 of determining the safety, effectiveness, ef-  
3 ficacy, or health outcomes of a treatment,  
4 compared with the best available alter-  
5 native treatment, and

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

8 A trial is deemed to be approved under clause  
9 (ii) if it is approved by the National Institutes  
10 of Health, the Food and Drug Administration  
11 (through an investigational new drug exemp-  
12 tion), the Department of Veterans Affairs, or  
13 by a qualified nongovernmental research entity  
14 (as identified in guidelines issued by one or  
15 more of the National Institutes of Health).

16 (5) DOCUMENTATION.—

17 (A) IN GENERAL.—Each AHP is respon-  
18 sible for maintaining documentary evidence sup-  
19 porting the plan's decisions to cover or to deny  
20 coverage based on the criteria specified in this  
21 subsection.

22 (B) REFERENCES.—The evidence that may  
23 be used in making such coverage decisions in-  
24 cludes—

25 (i) published peer-reviewed literature,

- 1                   (ii) opinions of medical specialty  
2                   groups and other medical experts,  
3                   (iii) evidence of general acceptance by  
4                   the medical community, and  
5                   (iv) recommendations of the Commis-  
6                   sion.

7                   (C) DISCLOSURE.—Each AHP shall dis-  
8                   close to its members, in a manner specified by  
9                   the Commission, its coverage decisions and  
10                  must submit information on such decisions to  
11                  the Benefits, Evaluations, and Data Standards  
12                  Board.

13                  (6) TREATMENT AND HEALTH OUTCOME DE-  
14                  FINED.—In this subsection (and subsection (a)(2)):

15                   (A) IN GENERAL.—The term “treatment”  
16                   means any health care intervention undertaken,  
17                   with respect to a specific indication, to improve,  
18                   maintain, or stabilize a health outcome or to  
19                   prevent or mitigate an adverse change in a  
20                   health outcome.

21                   (B) HEALTH OUTCOME DEFINED.—The  
22                   term “health outcome” means an outcome that  
23                   affects the length or quality of an enrollee’s life.

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

4 (1) include only such cost-sharing as will re-  
5 strain consumers from seeking unnecessary services,

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

8 (3) balance the effect of the cost-sharing in re-  
9 ducing premiums and in affecting utilization of ap-  
10 propriate services,

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

14 (5) incorporate, consistent with the previous  
15 provisions, incentives for individuals to control their  
16 utilization of health care services and shall (for this  
17 purpose) consider incorporating the concepts of med-  
18 ical savings accounts and wellness dividends.

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

23 (d) AUTHORITY RESPECTING PROVIDERS.—

24 (1) NO AUTHORITY TO RESTRICT USE OF PRO-  
25 VIDERS.—In the case of treatment included in the

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

3 (A) to restrict the coverage of such treat-  
4 ment only to, or

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

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

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

18 **SEC. 1303. BENEFITS, EVALUATIONS, AND DATA STAND-**  
19 **ARDS BOARD.**

20 (a) ESTABLISHMENT.—The Commission shall pro-  
21 vide for the initial organization, as a nonprofit corporation  
22 in the District of Columbia, of the Benefits, Evaluations,  
23 and Data Standards Board (in this section referred to as  
24 the “BEDS Board”), under the direction of a board of  
25 directors consisting of 5 directors.

1 (b) APPOINTMENT OF DIRECTORS.—

2 (1) SOLICITATION.—The Commission shall so-  
3 licit nominations for the initial board of directors of  
4 the BEDS Board from organizations that represent  
5 the various groups with an interest in the health  
6 care system and the functions of the Board.

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

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

22 (c) FUNCTIONS.—

23 (1) IN GENERAL.—The BEDS Board shall  
24 make recommendations to the Commission concern-  
25 ing each of the following:



1 (A) The uniform set of effective benefits.

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

4 (C) Auditing standards to ensure the accu-  
5 racy of such information.

6 (D) Aggregate data on coverage decisions  
7 made by AHPs and recommendations for eval-  
8 uations of particular technologies.

9 Before making recommendations described in sub-  
10 paragraphs (B) and (D), the BEDS Board shall  
11 consult with the Agency for Clinical Evaluations re-  
12 garding the need for information in performing its  
13 activities.

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

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

19 (B) information provided by AHPs, includ-  
20 ing AHP-specific information on clinical health,  
21 functional status, well-being, and plan satisfac-  
22 tion of enrolled individuals.

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

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

3 (d) FUNDING.—

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

12 (2) AMOUNT OF FUNDS.—The amount specified  
13 in this paragraph for each of fiscal years 1994 and  
14 1995, is \$50,000,000, and, for each succeeding fis-  
15 cal year, is \$25,000,000.

16 **SEC. 1304. HEALTH PLAN STANDARDS BOARD.**

17 (a) ESTABLISHMENT.—The Commission shall pro-  
18 vide for the initial organization, as a nonprofit corporation  
19 in the District of Columbia, of the Health Plan Standards  
20 Board (in this section referred to as the “Plan Standards  
21 Board”), under the direction of a board of directors con-  
22 sisting of 5 directors.

23 (b) APPOINTMENT OF DIRECTORS.—

24 (1) SOLICITATION.—The Commission shall so-  
25 licit nominations for the initial board of directors of

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

4 (2) CONTINUATION.—The by-laws of the Plan  
5 Standards Board shall provide for the board of di-  
6 rectors subsequently to be appointed by the board in  
7 a manner that ensures a broad range of representa-  
8 tion of through groups with an interest in providing  
9 and purchasing health care.

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

19 (c) FUNCTIONS.—

20 (1) IN GENERAL.—The Plan Standards Board  
21 shall make recommendations to the Commission con-  
22 cerning the standards for AHPs (other than stand-  
23 ards relating to the uniform set of effective benefits  
24 and the national health data system) and for  
25 HPPCs.

1           (2) ASSESSMENT OF RISK-ADJUSTMENT FAC-  
2       TORS.—The Plan Standards Board shall provide the  
3       Commission with its assessment of the risk-adjust-  
4       ment factors under section 1306.

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

13   **SEC. 1305. REGISTRATION OF ACCOUNTABLE HEALTH**  
14                   **PLANS.**

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

18      (b) TREATMENT OF STATE CERTIFICATION.—If (and  
19      so long as) the Commission determines that a State super-  
20      intendent of insurance, State insurance commissioner, or  
21      other State official provides for the imposition of stand-  
22      ards that the Commission finds are equivalent to the  
23      standards established under part 1 of subtitle C for reg-  
24      istration of a health plan as an AHP, the Commission may  
25      provide for registration as AHPs of health plans that such

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

5 (c) REVOCATION OF REGISTRATION.—

6 (1) IN GENERAL.—The Commission shall pro-  
7 vide for a process for revocation of such registration  
8 in cases where the Commission finds, after notice to  
9 the plan and appropriate due process specified by  
10 the Commission, that a health plan no longer sub-  
11 stantially meets the standards for such registration  
12 or has failed to comply with a requirement under  
13 section 1402(a).

14 (2) INITIATION OF PROCESS.—Such process  
15 may be initiated upon the petition of a HPPC, the  
16 ombudsman for a HPPC, or by the Commission it-  
17 self. If the process is not initiated by a HPPC or  
18 ombudsman, the Commission shall notify each  
19 HPPC involved that such a process has been initi-  
20 ated. A HPPC may provide notice to enrollees of an  
21 AHP at the time such a process is initiated with re-  
22 spect to the AHP.

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

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

3 **SEC. 1306. SPECIFICATION OF RISK-ADJUSTMENT FAC-**  
4 **TORS.**

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

8 (b) PROCESS.—

9 (1) IDENTIFICATION OF RELATIVE RISK.—The  
10 Commission shall determine risk-adjustment factors  
11 for types of enrollment that are correlated with in-  
12 creased or diminished risk for consumption of the  
13 type of health services included in the uniform set  
14 of effective benefits, taking into account differences  
15 in utilization resulting from low-income cost-sharing  
16 assistance provided under section 2003. To the max-  
17 imum extent practicable, such factors shall be deter-  
18 mined without regard to the methodology used by in-  
19 dividual AHPs in the provision of such benefits. In  
20 determining such factors, with respect to an individ-  
21 ual (in an enrollee unit) identified as having—

22 (A) a lower-than-average risk for consump-  
23 tion of the services, the factor shall be a num-  
24 ber, less than zero, reflecting the degree of such  
25 lower risk;

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

3 (C) a higher-than-average risk for con-  
4 sumption of the services, the factor shall be a  
5 number, greater than zero, reflecting the degree  
6 of such higher risk.

7 For an enrollee unit, the factor to be applied (pursu-  
8 ant to section 1402(b)) shall reflect the factors ap-  
9 plicable to all covered individuals in the unit.

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

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

1 **SEC. 1307. NATIONAL HEALTH DATA SYSTEM.**

2 (a) STANDARDIZATION OF INFORMATION.—

3 (1) IN GENERAL.—The Commission shall estab-  
4 lish standards for the periodic provision by AHPs of  
5 information under section 1203(a) and the auditing  
6 of the information so provided.

7 (2) PATIENT CONFIDENTIALITY.—The stand-  
8 ards shall be established in a manner that protects  
9 the confidentiality of individual enrollees, but may  
10 provide for the disclosure of information which dis-  
11 closes particular providers within an AHP.

12 (b) ANALYSIS OF INFORMATION.—

13 (1) IN GENERAL.—The Commission shall ana-  
14 lyze the information provided to the Commission  
15 under section 1203(a) with respect to AHPs for  
16 which a HPPC is not performing an analysis under  
17 section 1104(c)(1).

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

21 (3) DISTRIBUTION OF ANALYSES.—The Com-  
22 mission shall distribute the analyses in a form, con-  
23 sistent with subsection (a)(2), that reports, on a na-  
24 tional, State, and community basis, the levels and  
25 trends of health care expenditures, the rates and  
26 trends in the provision of individual procedures, and



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

6 (c) DISTRIBUTION OF INFORMATION.—

7 (1) ANNUAL REPORT ON EXPENDITURES.—The  
8 Commission shall publish annually (beginning with  
9 1996) a report on expenditures on procedures, vol-  
10 umes of procedures, and, to the extent such proce-  
11 dures are priced separately, the prices of procedures.  
12 Such report shall be distributed to each AHP, each  
13 HPPC, each Governor, and each State legislature.

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

17 (A) procedures for which, as reflected in  
18 variations in use or rates of increase, there ap-  
19 pear to be the greatest need to develop valid  
20 clinical protocols for clinical decision-making  
21 and review,

22 (B) procedures for which, as reflected in  
23 price variations and price inflation, there ap-  
24 pear to be the greatest need for strengthening  
25 competitive purchasing, and

1 (C) States and localities for which, as re-  
2 flected in expenditure levels and rates of in-  
3 crease, there appear to be the greatest need for  
4 additional cost control measures.

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

8 (A) to an AHP of such information relat-  
9 ing to the plan as may be appropriate in order  
10 to encourage the plan to improve its delivery of  
11 care, and

12 (B) to business, consumer, and other  
13 groups and individuals of such information as  
14 may improve their ability to effect improve-  
15 ments in the outcomes, quality, and efficiency  
16 of health services.

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

22 **SEC. 1308. MEASURES OF QUALITY OF CARE OF SPECIAL-**  
23 **IZED CENTERS OF CARE.**

24 (a) COLLECTION OF INFORMATION.—The Commis-  
25 sion shall provide a process whereby a specialized center

1 of care (as defined in subsection (d)) may submit to the  
2 Commission such clinical and other information bearing  
3 on the quality of care provided with respect to the uniform  
4 set of effective benefits at the center as the Commission  
5 may specify. Such information shall include sufficient in-  
6 formation to take into account outcomes and the risk fac-  
7 tors associated with individuals receiving care through the  
8 center. Such information shall be provided at such fre-  
9 quency (not less often than annually) as the Commission  
10 specifies.

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

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

16 (2) rate the performance of such a center with  
17 respect to a class of services relative to the perform-  
18 ance of other specialized centers of care and relative  
19 to the performance of AHPs generally, and

20 (3) publish such ratings.

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

1 1946, and the Commission shall apply for the registration  
2 of such service mark under such Act. For purposes of such  
3 Act, such service mark shall be deemed to be used in com-  
4 merce. For purposes of this subsection, the “Trademark  
5 Act of 1946” refers to the Act entitled “An Act to provide  
6 for the registration and protection of trademarks used in  
7 commerce, to carry out the provisions of international con-  
8 ventions, and for other purposes”, approved July 5, 1946  
9 (15 U.S.C. 1051 and following).

10 (d) SPECIALIZED CENTER OF CARE DEFINED.—In  
11 this section, the term “specialized center of care” means  
12 an institution or other organized system for the provision  
13 of specific services, which need not be multi-disciplinary,  
14 and does not include (except as the Commission may pro-  
15 vide) individual practitioners.

16 **SEC. 1309. AGENCY FOR CLINICAL EVALUATIONS.**

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

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

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

3 (c) DUTIES.—

4 (1) IN GENERAL.—The Administrator shall as-  
5 sume the following responsibilities:

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

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

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

16 (D) Responsibilities of the Director of the  
17 Office of Research and Demonstrations of the  
18 Health Care Financing Administration, insofar  
19 as such responsibilities relate to clinical evalua-  
20 tions.

21 (2) SPECIFIC DUTIES.—In carrying out respon-  
22 sibilities under paragraph (1), the Administrator  
23 shall—

24 (A) set priorities for the research commu-  
25 nity to strengthen the research base;

1 (B) support research and evaluation (both  
2 on a contract and investigator-initiated basis)  
3 on medical effectiveness through technology as-  
4 sessment, consensus development, outcomes re-  
5 search practice guidelines, and other appro-  
6 priate activities;

7 (C) conduct effectiveness trials in collabo-  
8 ration with medical specialty societies, medical  
9 educators, and AHPs;

10 (D) maintain a clearinghouse and other  
11 registries on clinical trials and outcomes re-  
12 search data;

13 (E) assure the systematic evaluation of ex-  
14 isting as well as new treatments and diagnostic  
15 technologies in a constant, continuous effort to  
16 upgrade the knowledge base for clinical deci-  
17 sionmaking and policy choice; and

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

22 (3) ASSISTANCE.—The Administrator shall pro-  
23 vide the Benefits, Evaluations, and Data Standards  
24 Board with such information, on evaluations related  
25 to the uniform set of effective benefits and any other

1 information developed in the scope of carrying out  
2 the Administrator's responsibilities, as may be ap-  
3 propriate.

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

11 (d) REFERENCES.—Any reference in any law to the  
12 Administrator for Health Care Policy and Research or to  
13 the Agency for Health Care Policy and Research is  
14 deemed a reference to the Administrator and Agency, re-  
15 spectively, under this section.

16 (e) TRANSFERS.—There are hereby transferred to  
17 the Agency the staff, funds, and other assets of the agen-  
18 cies for which the Agency is assuming responsibilities  
19 under subsection (c)(1).

20 (f) ADDITIONAL AUTHORIZATION OF APPROPRIA-  
21 TIONS.—In addition to the amounts transferred under  
22 subsection (e), there are authorized to be appropriated to  
23 the Agency \$250,000 for each fiscal year (beginning with  
24 fiscal year 1995).

1 **SEC. 1310. REPORT AND RECOMMENDATIONS ON ACHIEV-**  
2 **ING UNIVERSAL COVERAGE.**

3 (a) FACTORS AFFECTING COVERAGE.—

4 (1) COLLECTION OF INFORMATION.—The Com-  
5 mission, on a continuing basis, shall collect informa-  
6 tion concerning and analyze the number and charac-  
7 teristics of eligible individuals (as defined in sub-  
8 section (c)) who are not enrolled with AHPs com-  
9 pared to such number and characteristics of individ-  
10 uals enrolled. Such characteristics shall include age,  
11 sex, race, ethnicity, family status, employment sta-  
12 tus, whether the individual is an eligible employee,  
13 income, health status, health risk factors, geography,  
14 whether the individual resides in a rural or medically  
15 underserved area, and such other factors as may af-  
16 fect the election of an eligible individual to obtain  
17 health coverage.

18 (2) REPORT.—By not later than April 1 of each  
19 year (beginning with 1996), the Commission shall  
20 submit to Congress a report analyzing the informa-  
21 tion collected under paragraph (1). Such report shall  
22 include a description of the primary factors contrib-  
23 uting to lack of coverage of identifiable groups of eli-  
24 gible individuals.

25 (b) RECOMMENDATIONS FOR INCREASING COV-  
26 ERAGE.—



1           (1) IN GENERAL.—By not later than January  
2           1, 1997, the Commission shall submit to Congress  
3           recommendations on the feasibility, cost-effective-  
4           ness, and the economic impact of using different vol-  
5           untary and other methods for increasing the cov-  
6           erage of eligible individuals.

7           (2) INDIVIDUAL MANDATE.—The Commission  
8           shall specifically make recommendations under para-  
9           graph (1) regarding establishing a requirement that  
10          all eligible individuals obtain health coverage  
11          through enrollment with an AHP.

12          (c) ELIGIBLE INDIVIDUAL DEFINED.—In this sec-  
13          tion, the term “eligible individual”—

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

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

19   **SEC. 1311. NO AUTHORITY TO IMPOSE CONTROLS RELAT-**  
20                   **ING TO HEALTH CARE SPENDING.**

21          The Commission is not authorized to establish or en-  
22          force any controls (such as global budgets, price controls,  
23          or premium limitations) on health care spending.

1 **SEC. 1312. MONITORING REINSURANCE MARKET.**

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

4 (b) PERIODIC REPORTS.—The Commission shall pe-  
5 riodically report to Congress respecting the availability of  
6 reinsurance for AHPs at reasonable rates and the impact  
7 of such availability on the establishment of new plans and  
8 on the financial solvency of current plans.

9 **SEC. 1313. AUTHORIZATION OF APPROPRIATIONS; SUNSET.**

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

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

18 **Subtitle E—Managed Competition**  
19 **in Rural and Urban Under-**  
20 **served Areas**

21 **PART 1—SPECIAL TREATMENT OF DESIGNATED**  
22 **UNDERSERVED AREAS**

23 **SEC. 1401. DESIGNATION OF UNDERSERVED AREAS.**

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

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

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

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

8 (b) REVIEW BY COMMISSION.—No designation under  
9 subsection (a) shall take effect under this subsection un-  
10 less the Commission—

11 (1) has been notified of the proposed designa-  
12 tion, and

13 (2) has not, within 60 days after the date of re-  
14 ceipt of the notice, disapproved the designation.

15 (c) CONSTRUCTION.—An area need not be designated  
16 as a medically underserved area (under section 330(b)(3)  
17 of the Public Health Service Act) or as a health profes-  
18 sional shortage area (under section 332(a) of such Act)  
19 in order to be designated as an underserved area under  
20 this section.

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

1 **SEC. 1402. SPECIAL TREATMENT.**

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

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

17 (c) DIRECT STATE SUBSIDIES.—The HPPC shall in-  
18 crease the amount of the payments made to AHPs serving  
19 individuals residing in an area designated under section  
20 1401 by such amounts as the State makes available for  
21 this purpose.

22 (d) TECHNICAL ASSISTANCE IN ANTITRUST MAT-  
23 TERS.—The Department of Justice shall provide ongoing  
24 technical assistance to organizations in relation to the ap-  
25 plication of the Federal antitrust laws to the establishment  
26 of an AHP in an area designated under section 1401.

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

3 **PART 2—TRANSITIONAL SUPPORT FOR DEVEL-**  
4 **OPMENT OF ACCOUNTABLE HEALTH PLANS**  
5 **IN UNDERSERVED AREAS**

6 **SEC. 1411. TECHNICAL ASSISTANCE FUNDING.**

7 (a) IN GENERAL.—The Secretary of Health and  
8 Human Services shall make funds available under this sec-  
9 tion to provide technical assistance and advice for entities  
10 (including Federally qualified health centers and rural  
11 health clinics) seeking to establish a network plan (as de-  
12 fined in section 1222(b)(1)) in an underserved rural or  
13 urban area.

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

16 (1) assistance in network development, utilizing  
17 existing local providers and facilities where appro-  
18 priate;

19 (2) advice on obtaining the proper balance of  
20 primary and secondary facilities for the local popu-  
21 lation;

22 (3) assistance in coordinating arrangements for  
23 tertiary care;

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

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

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

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

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

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

20       **SEC. 1412. RURAL DEVELOPMENT GRANTS.**

21       (a) IN GENERAL.—The Secretary of Health and  
22       Human Services shall provide financial assistance to eligi-  
23       ble entities in order to provide for the development and  
24       implementation of AHPs in rural areas.

25       (b) ELIGIBLE ENTITIES.—

1           (1) IN GENERAL.—An entity is eligible to re-  
2       ceive financial assistance under this section only if  
3       the entity—

4           (A) is based in a rural area, and

5           (B) is undertaking to develop and imple-  
6       ment an AHP in a rural area with the active  
7       participation of at least 3 health care providers  
8       or facilities in the area.

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

14      (c) USE OF FUNDS.—

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

18           (A) For development and implementation.

19           (B) For information systems, including  
20      telecommunications.

21           (C) For meeting solvency requirements for  
22      an AHP.

23           (D) For recruiting health care providers.

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

4                   (A) For a telecommunications system un-  
5                   less such system is coordinated with, and does  
6                   not duplicate, such a system existing in the  
7                   area.

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

10          (d) APPLICATION.—

11               (1) IN GENERAL.—No financial assistance shall  
12               be provided under this section to an entity unless  
13               the entity has submitted to the Secretary, in a time  
14               and manner specified by the Secretary, and had ap-  
15               proved by the Secretary an application.

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

18                   (A) a description of the proposed AHP, in-  
19                   cluding service area and capacity,

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

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



1 (e) AUTHORIZATION OF APPROPRIATIONS.—

2 (1) IN GENERAL.—There are authorized to be  
3 appropriated \$75,000,000 for each of fiscal years  
4 1995 through 1999 to carry out this section.  
5 Amounts appropriated under this section shall be  
6 available until expended.

7 (2) INTEGRATION OF OTHER AUTHORIZA-  
8 TIONS.—In order to provide for the authorization of  
9 appropriations under paragraph (1), notwithstanding  
10 any other provision of law, no funds are authorized  
11 to be appropriated to carry out the following pro-  
12 grams in fiscal years after fiscal year 1994:

13 (A) The rural health transition grant pro-  
14 gram (under section 4005(e) of the Omnibus  
15 Budget Reconciliation Act of 1987).

16 (B) The rural health outreach program  
17 (for which appropriations were annually pro-  
18 vided under the Departments of Labor, Health  
19 and Human Services, and Education, and Re-  
20 lated Agencies Appropriation Acts).

21 **SEC. 1413. MIGRANT HEALTH CENTERS.**

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

24 (1) in paragraph (1)(A), by striking “through  
25 1994” and inserting “through 1999”,

1           (2) in paragraph (2)(A), by striking “through  
2       1994” and inserting “through 1999”, and

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

6       “(3)(A) For the purpose of carrying out subpara-  
7       graph (B), there are authorized to be appropriated  
8       \$11,500,000 for each of the fiscal years 1995 through  
9       1999.

10       “(B) The Secretary may make grants to migrant  
11       health centers for the purpose of assisting such centers  
12       in integrating with AHPs and in providing (and coordinat-  
13       ing the provision of) the uniform set of effective benefits  
14       under such a plan.”.

15       **SEC. 1414. COMMUNITY HEALTH CENTERS.**

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

18           (1) in paragraph (1)(A), by striking “through  
19       1994” and inserting “through 1999”,

20           (2) in paragraph (2)(A), by striking “through  
21       1994” and inserting “through 1999”, and

22           (3) by redesignating paragraph (3) as para-  
23       graph (4) and by inserting after paragraph (2) the  
24       following new paragraph:

1       “(3)(A) For the purpose of carrying out subpara-  
 2 graph (B), there are authorized to be appropriated  
 3 \$88,500,000 for each of the fiscal years 1995 through  
 4 1999.

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

10           **PART 3—ESTABLISHMENT OF RURAL**

11           **EMERGENCY ACCESS CARE HOSPITALS**

12       **SEC. 1421. RURAL EMERGENCY ACCESS CARE HOSPITALS**

13           **DESCRIBED.**

14       Section 1861 of the Social Security Act (42 U.S.C.  
 15 1395x) is amended by adding at the end the following new  
 16 subsection:

17       “Rural Emergency Access Care Hospital; Rural  
 18       Emergency Access Care Hospital Services

19       “(oo)(1) The term ‘rural emergency access care hos-  
 20 pital’ means, for a fiscal year, a facility with respect to  
 21 which the Secretary finds the following:

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

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

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

9           “(D) The facility has entered into (or plans to  
10          enter into) an agreement with a hospital with a par-  
11          ticipation agreement in effect under section 1866(a),  
12          and under such agreement the hospital shall accept  
13          patients transferred to the hospital from the facility  
14          and receive data from and transmit data to the facil-  
15          ity.

16          “(E) There is a practitioner who is qualified to  
17          provide advanced cardiac life support services (as de-  
18          termined by the State in which the facility is lo-  
19          cated) on-site at the facility on a 24-hour basis.

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

22          “(G) The facility meets such staffing require-  
23          ments as would apply under section 1861(e) to a  
24          hospital located in a rural area, except that—

1           “(i) the facility need not meet hospital  
2 standards relating to the number of hours dur-  
3 ing a day, or days during a week, in which the  
4 facility must be open, except insofar as the fa-  
5 cility is required to provide emergency care on  
6 a 24-hour basis under subparagraphs (E) and  
7 (F) of this paragraph; and

8           “(ii) the facility may provide any services  
9 otherwise required to be provided by a full-time,  
10 on-site dietician, pharmacist, laboratory techni-  
11 cian, medical technologist, or radiological tech-  
12 nologist on a part-time, off-site basis.

13           “(H) The facility meets the requirements appli-  
14 cable to clinics and facilities under subparagraphs  
15 (C) through (J) of paragraph (2) of section  
16 1861(aa) and of clauses (ii) and (iv) of the second  
17 sentence of such paragraph (or, in the case of the  
18 requirements of subparagraph (E), (F), or (J) of  
19 such paragraph, would meet the requirements if any  
20 reference in such subparagraph to a ‘nurse practi-  
21 tioner’ or to ‘nurse practitioners’ was deemed to be  
22 a reference to a ‘nurse practitioner or nurse’ or to  
23 ‘nurse practitioners or nurses’); except that in deter-  
24 mining whether a facility meets the requirements of  
25 this subparagraph, subparagraphs (E) and (F) of

1       that paragraph shall be applied as if any reference  
2       to a ‘physician’ is a reference to a physician as de-  
3       fined in section 1861(r)(1).

4       “(2) The term ‘rural emergency access care hospital  
5       services’ means medical and other health services fur-  
6       nished by a rural emergency access care hospital.”.

7       **SEC. 1422. COVERAGE OF AND PAYMENT FOR SERVICES.**

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

11               (1) by striking “and” at the end of subpara-  
12       graph (I);

13               (2) by striking the period at the end of sub-  
14       paragraph (J) and inserting “; and”; and

15               (3) by adding at the end the following new sub-  
16       paragraph:

17               “(K) rural emergency access care hospital  
18       services (as defined in section 1861(oo)(2)).”.

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

21               (1) IN GENERAL.—Section 1833(a)(6) of the  
22       Social Security Act (42 U.S.C. 1395l(a)(6)) is  
23       amended by striking “services,” and inserting “serv-  
24       ices and rural emergency access care hospital serv-  
25       ices,”.

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

4           (A) in the heading, by striking “SERV-  
5       ICES” and inserting “SERVICES AND RURAL  
6       EMERGENCY ACCESS CARE HOSPITAL SERV-  
7       ICES”;

8           (B) in paragraph (1), by striking “during  
9       a year before 1993” and inserting “during a  
10      year before the prospective payment system de-  
11      scribed in paragraph (2) is in effect”;

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

14      “The amount of payment shall be determined under  
15      either method without regard to the amount of the  
16      customary or other charge.”;

17          (D) in paragraph (2), by striking “Janu-  
18      ary 1, 1993,” and inserting “January 1,  
19      1996,”; and

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

22      “(3) APPLICATION OF METHODS TO PAYMENT  
23      FOR RURAL EMERGENCY ACCESS CARE HOSPITAL  
24      SERVICES.—The amount of payment for rural emer-  
25      gency access care hospital services provided during

1 a year shall be determined using the applicable  
2 method provided under this subsection for determin-  
3 ing payment for outpatient rural primary care hos-  
4 pital services during the year.”.

5 **SEC. 1423. EFFECTIVE DATE.**

6 The amendments made by this part shall apply to fis-  
7 cal years beginning on or after October 1, 1994.

8 **PART 4—TRANSITIONAL ASSISTANCE FOR**  
9 **SAFETY NET HOSPITALS**

10 **SEC. 1431. PAYMENTS TO HOSPITALS.**

11 (a) IN GENERAL.—The Secretary of Health and  
12 Human Services shall make payments for transitional as-  
13 sistance to eligible hospitals whose applications for assist-  
14 ance have been approved under this part.

15 (b) GENERAL ELIGIBILITY REQUIREMENTS FOR AS-  
16 SISTANCE.—

17 (1) HOSPITALS DESCRIBED.—

18 (A) IN GENERAL.—A hospital shall be gen-  
19 erally eligible for assistance under this part if  
20 the hospital—

21 (i) receives an additional payment  
22 under section 1886(d)(5)(F) of the Social  
23 Security Act and is described in clause  
24 (i)(II) or clause (vii)(I) of such section, or  
25 is deemed a disproportionate share hospital



1 under a State plan for medical assistance  
2 under title XIX of such Act on the basis  
3 described in section 1923(b)(1) of such  
4 Act; or

5 (ii) is a hospital that the Secretary  
6 otherwise determines to be an appropriate  
7 recipient of assistance under this part on  
8 the basis of the existence of a patient care  
9 operating deficit, a demonstrated inability  
10 to secure or repay financing for a qualify-  
11 ing project on reasonable terms, or such  
12 other criteria as the Secretary considers  
13 appropriate.

14 (B) DEVELOPMENT OF CRITERIA.—For  
15 purposes of subparagraph (A)(ii), with respect  
16 to rural hospitals which are at risk or critical  
17 to health care access, the Prospective Payment  
18 Review Commission, not later than 6 months  
19 after the date of the enactment of this Act,  
20 shall develop criteria to assist the Secretary in  
21 deciding which such hospitals deserve assist-  
22 ance.

23 (2) OWNERSHIP REQUIREMENTS.—In order to  
24 qualify for assistance under this part, a hospital  
25 must—

1 (A) be owned or operated by a unit of  
2 State or local government;

3 (B) be a quasi-public corporation, defined  
4 as a private, nonprofit corporation or public  
5 benefit corporation which is formally granted  
6 one or more governmental powers by legislative  
7 action through (or is otherwise partially funded  
8 by) the State legislature, city or county council;  
9 or

10 (C) be a private nonprofit hospital which  
11 has contracted with, or is otherwise funded by,  
12 a governmental agency to provide health care  
13 services to low income individuals not eligible  
14 for benefits under title XVIII or title XIX of  
15 the Social Security Act, where revenue from  
16 such contracts constitute at least 10 percent of  
17 the hospital's operating revenues over the prior  
18 3 fiscal years.

19 (c) MEETING ADDITIONAL SPECIFIC CRITERIA.—  
20 Hospitals that are generally eligible for assistance under  
21 this part under subsection (b) may apply for the specific  
22 programs described in this part and must meet any addi-  
23 tional criteria for participation in such programs.

1 **SEC. 1432. APPLICATION FOR ASSISTANCE.**

2 (a) IN GENERAL.—No hospital may receive assist-  
3 ance for a project under this part unless the hospital—

4 (1) has filed with the Secretary, in a form and  
5 manner specified by the Secretary an application for  
6 assistance under this part;

7 (2) establishes in its application (for its most  
8 recent cost reporting period) that it meets the cri-  
9 teria for general eligibility under this part;

10 (3) includes a description of the project, includ-  
11 ing the community in which it is located, and de-  
12 scribes utilization and services characteristics of the  
13 project and the hospital, and the patient population  
14 that is to be served;

15 (4) describes the extent to which the project  
16 will include the financial participation of State and  
17 local governments, and all other sources of financing  
18 sought for the project; and

19 (5) establishes, to the satisfaction of the Sec-  
20 retary, that the project meets the additional criteria  
21 for assistance under this part.

22 (b) CRITERIA FOR APPROVAL.—The Secretary shall  
23 determine for each application for assistance under this  
24 part—

25 (1) whether the hospital meets the general eligi-  
26 bility criteria under section 1431(b);

1           (2) whether the hospital meets any additional  
2           eligibility criteria;

3           (3) whether the project for which assistance is  
4           being requested meets the requirements of this part;  
5           and

6           (4) whether funds are available, pursuant to the  
7           limitations of each program, to fully fund the re-  
8           quest for assistance.

9   **SEC. 1433. PUBLIC SERVICE RESPONSIBILITIES.**

10          (a) IN GENERAL.—Any hospital accepting assistance  
11          under this part shall agree—

12               (1) to make the services of the facility or por-  
13               tion thereof to be constructed, acquired, or modern-  
14               ized available to all persons residing in the territorial  
15               area of the applicant; and

16               (2) to provide a significant volume of services to  
17               persons unable to pay therefore, consistent with  
18               other provisions of this Act.

19          (b) ENFORCEMENT.—The Director of the Office of  
20          Civil Rights of the Department of Health and Human  
21          Services shall be given the power to enforce the public  
22          service responsibilities described in this section.

1 **SEC. 1434. AUTHORIZATION OF APPROPRIATIONS.**

2       There is authorized to be appropriated \$50,000,000  
3 for each of the fiscal years 1995 through 1999 to carry  
4 out this part.

5                   **Subtitle F—Treatment of**  
6                   **Chronically Underserved Areas**

7 **SEC. 1501. PROMOTING STATE ACTION.**

8       (a) STANDARDS FOR IDENTIFICATION OF CHRON-  
9 ICALLY UNDERSERVED AREAS.—The Health Care Stand-  
10 ards Commission shall develop, not later than 2 years  
11 after the date of the enactment of this Act, standards for  
12 the identification of chronically underserved areas in  
13 which the special treatment provided under subsection (b)  
14 may be appropriate. Such standards shall be based on—

15               (1) inadequate access in an area to services in-  
16 cluded within the uniform set of effective benefits,

17               (2) insufficient price competition for such serv-  
18 ices in an area, and

19               (3) poor quality of such services in an area.

20       (b) STATE IDENTIFICATION OF AREAS AND PLAN.—  
21 On and after 3 years after the date of the enactment of  
22 this Act, a State may submit to the Commission—

23               (1) a finding that an area within the State  
24 meets the standards developed under subsection (a)  
25 to be identified as a chronically underserved area,  
26 and

1           (2) a plan for addressing the problem of health  
2       care delivery in such area.

3 No plan may be submitted under paragraph (2) for an  
4 area unless the plan has been developed in cooperation  
5 with each HPPC serving any portion of the area.

6       (c) CONTENTS OF PLAN.—A plan under subsection  
7 (b)(2) for a chronically underserved area may provide for  
8 the limitation of agreements under section 1102 to a sin-  
9 gle AHP, with such contract awarded on a competitive  
10 basis.

11       (d) REVIEW.—With respect to submissions under  
12 subsection (b), the Commission shall review—

13           (1) each finding described in subsection (b)(1),  
14       and

15           (2) each plan submitted under subsection  
16       (b)(2).

17 The Commission shall approve or disapprove such a find-  
18 ing and such a plan within 60 days of the date of its sub-  
19 mission and shall notify the State of its decision. If the  
20 Commission disapproves the finding or the plan, the Com-  
21 mission shall provide the State with the reasons for the  
22 disapproval. If the Commission does not act within such  
23 period, the Commission is deemed to have approved the  
24 finding and the plan.

**Subtitle G—Repeal of COBRA  
Continuation Requirements**

**SEC. 1601. REPEAL OF COBRA CONTINUATION REQUIRE-  
MENTS.**

(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

1 amended by striking “paragraph (1) or (4) of sec-  
2 tion 606 or”.

3 (c) PUBLIC HEALTH SERVICE ACT.—Title XXII of  
4 the Public Health Service Act is repealed.

5 (d) EFFECTIVE DATE.—The repeals and amend-  
6 ments made by this section shall apply to health plans of  
7 employers as of the January 1, 1995.

8 (e) NOTICE OF BENEFITS.—In the case of continu-  
9 ation coverage which is in effect on January 1, 1995,  
10 under a provision of law repealed by this section, such con-  
11 tinuation may not be discontinued without 30-day notice  
12 to the individual of such discontinuation. Such notice shall  
13 include such information with respect to continuation of  
14 coverage through a health plan purchasing cooperative as  
15 the Health Care Standards Commission shall specify.

## 16 **Subtitle H—Definitions**

### 17 **SEC. 1701. DEFINITIONS.**

18 (a) ELIGIBILITY.—In this title and title II:

19 (1) ELIGIBLE INDIVIDUAL.—The term “eligible  
20 individual” means, with respect to a HPPC area, an  
21 individual who—

22 (A) is an eligible employee,

23 (B) is an eligible resident, or

24 (C) an eligible family member of an eligible  
25 employee or eligible resident.



1           (2) ELIGIBLE EMPLOYEE.—The term “eligible  
2       employee” means, with respect to a HPPC area, an  
3       individual residing in the area who is the employee  
4       of a small employer.

5           (3) ELIGIBLE FAMILY MEMBER.—The term “el-  
6       igible family member” means, with respect to an eli-  
7       gible employee or other principal enrollee, an individ-  
8       ual who—

9                   (A)(i) is the spouse of the employee or  
10                  principal enrollee, or

11                  (ii) is an unmarried dependent child under  
12                  22 years of age, including—

13                           (I) an adopted child or recognized  
14                           natural child, and

15                           (II) a stepchild or foster child but  
16                           only if the child lives with the employee or  
17                           principal enrollee in a regular parent-child  
18                           relationship,

19                  or such an unmarried dependent child regard-  
20                  less of age who is incapable of self-support be-  
21                  cause of mental or physical disability which ex-  
22                  isted before age 22;

23                  (B) is a citizen or national of the United  
24                  States, an alien lawfully admitted to the United  
25                  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-

1            cipal enrollee pursuant to such an  
2            offer if such offer had been accepted.

3            (ii) EXCEPTION FOR PART-TIME, SEA-  
4            SONAL, AND TEMPORARY EMPLOYEES.—  
5            Subclause (II) of clause (i) shall not apply  
6            to an individual who is offered coverage  
7            under an AHP by an employer and who is  
8            only a part-time, seasonal, or temporary  
9            employee of that employer. For purposes of  
10          the previous sentence, the term “part-  
11          time” means employment for an average of  
12          less than 25 hours a week on a monthly  
13          basis and an employee who is employed for  
14          more than 8 weeks in a 12-month period  
15          for an employer shall not be considered to  
16          be seasonal or temporary employee.

17          (C) TREATMENT OF MEDICARE BENE-  
18          FICIARIES.—The term “eligible resident” does  
19          not include a medicare-eligible beneficiary.

20          (5) ENROLLEE UNIT.—The term “enrollee  
21          unit” means one unit in the case of coverage on an  
22          individual basis or in the case of coverage on a fam-  
23          ily basis.

24          (6) MEDICARE BENEFICIARY.—The term “med-  
25          icare beneficiary” means an individual who is enti-

1 tled to benefits under part A of title XVIII of the  
2 Social Security Act, including an individual who is  
3 entitled to such benefits pursuant to an enrollment  
4 under section 1818 or 1818A of such Act.

5 (7) MEDICARE-ELIGIBLE INDIVIDUAL.—The  
6 term “medicare-eligible individual” means an indi-  
7 vidual who—

8 (A) is a medicare beneficiary, or

9 (B) is not a medicare beneficiary but is eli-  
10 gible to enroll under part A or part B of title  
11 XVIII of the Social Security Act.

12 (b) ABBREVIATIONS.—In this Act, except as other-  
13 wise provided:

14 (1) AHP; ACCOUNTABLE HEALTH PLAN.—The  
15 terms “accountable health plan” and “AHP” mean  
16 a health plan registered with the Commission under  
17 section 1201(a).

18 (2) COMMISSION.—The term “Commission”  
19 means the Health Care Standards Commission es-  
20 tablished under subtitle D.

21 (3) HPPC; HEALTH PLAN PURCHASING COOP-  
22 ERATIVE.—The terms “health plan purchasing coop-  
23 erative” and “HPPC” mean a health plan purchas-  
24 ing cooperative established under subtitle B.

25 (4) CLOSED AND OPEN PLANS.—

1 (A) CLOSED.—

2 (i) IN GENERAL.—A plan is “closed”  
3 if the plan is limited by structure or law to  
4 one or more large employers.

5 (ii) GRANDFATHER FOR TAFT-HART-  
6 LEY PLANS.—A plan not described in  
7 clause (i) that is maintained pursuant to  
8 one or more collective bargaining agree-  
9 ments between one or more employee orga-  
10 nizations and one or more employers and  
11 that was established as of September 7,  
12 1993, shall be considered to be a closed  
13 plan.

14 (iii) UNIVERSITY PLANS.—Nothing in  
15 this subparagraph shall be construed as  
16 preventing a university from offering en-  
17 rollment, in a closed plan maintained by a  
18 university, to students matriculating at the  
19 university.

20 (iv) SMALL EMPLOYERS.—Subject to  
21 clause (ii), a plan is not a “closed” plan if  
22 the plan was formed by one or more small  
23 employers or for the benefit of employees  
24 of such an employer.

1 (B) OPEN.—A plan is “open” if the plan  
2 is not closed (within the meaning of subpara-  
3 graph (A)).

4 (c) OTHER TERMS.—In this title and titles II and  
5 VI:

6 (1) HEALTH PLAN.—The term “health plan”  
7 means a plan that provides health benefits, whether  
8 through directly, through insurance, or otherwise,  
9 and includes a policy of health insurance, a contract  
10 of a service benefit organization, or a membership  
11 agreement with a health maintenance organization  
12 or other prepaid health plan, and also includes an  
13 employee welfare benefit plan or a multiple employer  
14 welfare plan (as such terms are defined in section 3  
15 of the Employee Retirement Income Security Act of  
16 1974).

17 (2) SMALL EMPLOYER; LARGE EMPLOYER.—

18 (A) IN GENERAL.—Subject to subpara-  
19 graph (B), the term “small employer” means  
20 an employer that normally employed fewer than  
21 101 employees during a typical business day in  
22 the previous year and the term “large em-  
23 ployer” means an employer that is not a small  
24 employer.

1 (B) SPECIAL RULE FOR LARGE EMPLOY-  
2 ERS.—Subject to subparagraph (C), the Com-  
3 mission shall provide a procedure by which, in  
4 the case of an employer that is not a small em-  
5 ployer but normally employs fewer than 101  
6 employees (or, in the case of a State making an  
7 election described in subparagraph (C)(i), the  
8 number of employees specified under the State  
9 law) in a HPPC area (or other locality identi-  
10 fied by the Commission) during a typical busi-  
11 ness day, the employer, upon application, would  
12 be considered to be a small employer with re-  
13 spect to such employees in the HPPC area (or  
14 other locality). Such procedure shall be de-  
15 signed so as to prevent the adverse selection of  
16 employees with respect to which the previous  
17 sentence is applied.

18 (C) STATE ELECTION.—

19 (i) IN GENERAL.—Subject to section  
20 1101(a)(3) and clause (ii), a State may by  
21 law, with respect to employers in the State,  
22 substitute for “101” in subparagraphs (A)  
23 and (B) any greater number, so long as—

24 (I) such number is applied uni-  
25 formly to all employers (other than

1 employers described in clause (ii)) in  
2 a State, and

3 (II) the State demonstrates, to  
4 the satisfaction of the Commission,  
5 that as of the time of enactment of  
6 the State law not more than 50 per-  
7 cent of all employees in the State are  
8 employees of small employers (as de-  
9 termined based upon such substi-  
10 tution).

11 (ii) EXCEPTION FOR CERTAIN LARGE  
12 MULTI-STATE EMPLOYERS.—Clause (i)  
13 shall not apply to an employer that nor-  
14 mally employed at least 500 employees  
15 during a typical business day in the pre-  
16 vious year in each of at least 2 different  
17 States.

18 (3) PREMIUM CLASS.—The term “premium  
19 class” means a class established under section  
20 1205(a)(2).

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

23 (5) STATE.—The term “State” includes the  
24 District of Columbia, Puerto Rico, the Virgin Is-



1 lands, Guam, American Samoa, and the Northern  
2 Mariana Islands.

3 (6) TYPE OF ENROLLMENT.—There are 4  
4 “types of enrollment”:

5 (A) Coverage only of an individual (re-  
6 ferred to in this title as enrollment “on an indi-  
7 vidual basis”).

8 (B) Coverage of an individual and the indi-  
9 vidual’s spouse.

10 (C) Coverage of an individual and one  
11 child.

12 (D) Coverage of an individual and more  
13 than one eligible family member.

14 The types of coverage described in subparagraphs  
15 (B) through (D) are collectively referred to in this  
16 title as enrollment “on a family basis”.

17 (7) UNIFORM SET OF EFFECTIVE BENEFITS.—  
18 The term “uniform set of effective benefits” means,  
19 for a year, such set of benefits as recommended by  
20 the Commission under section 1302(a), if not dis-  
21 approved under such section.

1 **TITLE II—LOW-INCOME ASSIST-**  
2 **ANCE FOR HEALTH COV-**  
3 **ERAGE**

4 **Subtitle A—Low-Income Assistance**

5 **SEC. 2001. ELIGIBILITY.**

6 (a) ENROLLEES UNDER ACCOUNTABLE HEALTH  
7 PLANS.—Each low-income individual (as defined in sec-  
8 tion 2009(a)(1)(A)) who is not a medicare-eligible individ-  
9 ual is eligible—

10 (1) for assistance under section 2002(a) with  
11 respect to premiums,

12 (2) for assistance under section 2003(a) with  
13 respect to cost-sharing otherwise imposed by the  
14 plan, and

15 (3) in the case of a very low-income individual,  
16 for assistance under section 2004 with respect to  
17 certain items and services.

18 (b) MEDICARE-ELIGIBLE INDIVIDUALS.—Each medi-  
19 care-eligible individual who is a low-income individual is  
20 eligible—

21 (1) for assistance under section 2002(b) with  
22 premiums under the medicare program, and

23 (2) in the case of a very low-income individual,  
24 for assistance under section 2003(b) with respect to  
25 other medicare cost-sharing and for assistance under

1 section 2004 with respect to certain items and serv-  
2 ices.

3 **SEC. 2002. PREMIUM ASSISTANCE.**

4 (a) IN GENERAL.—

5 (1) VERY LOW-INCOME INDIVIDUALS.—In the  
6 case of a very low-income individual (as defined in  
7 section 2009(a)(3)) who is enrolled in an AHP, the  
8 premium assistance under this section consists of—

9 (A) an adjustment in premiums charged  
10 the individual under the plan, in accordance  
11 with section 1205(c)(1); and

12 (B) payment to the accountable health  
13 plan (on behalf of the individual and family  
14 members) of the applicable Federal assistance  
15 amount (as defined in section 2009(c)(1)) for  
16 enrollment under the plan.

17 (2) MODERATELY LOW-INCOME INDIVIDUALS.—

18 In the case of a moderately low-income individual  
19 (as defined in section 2009(a)(2)) who is enrolled in  
20 an AHP, the premium assistance under this section  
21 consists of—

22 (A) an adjustment in premiums charged  
23 the individual under the plan, in accordance  
24 with section 1205(c)(2); and

1 (B) payment to the accountable health  
2 plan (on behalf of the individual and family  
3 members) of the applicable Federal assistance  
4 amount (as defined in section 2009(c)(1)) for  
5 enrollment under the plan.

6 (b) MEDICARE-ELIGIBLE INDIVIDUALS.—In the case  
7 of a medicare-eligible individual described in section  
8 2001(b), the premium assistance under this subsection  
9 shall consist of payment for premiums imposed under part  
10 A (if any) or part B of title XVIII of the Social Security  
11 Act. Such assistance shall be provided in a manner so that  
12 no such premium amount is deducted from monthly bene-  
13 fits or transfers under section 1818 or 1840 of such Act.

14 **SEC. 2003. COST-SHARING ASSISTANCE.**

15 (a) NOMINAL COST-SHARING FOR LOW-INCOME IN-  
16 DIVIDUALS.—

17 (1) IN GENERAL.—In the case of a low-income  
18 individual described in section 2001(a) who is en-  
19 rolled in an AHP in an enrollee unit, the cost-shar-  
20 ing assistance under this subsection shall consist  
21 of—

22 (A) an accountable health plan's reduction,  
23 in accordance with section 1202(c), in the cost-  
24 sharing otherwise imposed to amounts that are

1 nominal (as specified by the Commission, con-  
2 sistent with paragraph (2)); and

3 (B) payment to the accountable health  
4 plan (on behalf of the individual and family  
5 members) by the Commission of the adjusted  
6 per enrollee cost-sharing assistance amount de-  
7 termined under paragraph (3).

8 (2) NOMINAL.—In establishing what is “nomi-  
9 nal” for purposes of paragraph (1), the Commission  
10 shall consider regulations established to carry out  
11 section 1916(a)(3) of the Social Security Act (as in  
12 effect before the date of the enactment of this Act).

13 (3) ADJUSTED PER ENROLLEE COST-SHARING  
14 ASSISTANCE AMOUNT.—

15 (A) IN GENERAL.—For purposes of this  
16 section, the term “adjusted per enrollee cost-  
17 sharing assistance amount” means, for a year,  
18 the product of—

19 (i) the amount determined under sub-  
20 paragraph (B)(i), divided by the number  
21 determined under subparagraph (B)(ii);  
22 and

23 (ii) the premium class assistance fac-  
24 tor established under subparagraph (C).

1 (B) DETERMINATION OF AVERAGE PER  
2 ENROLLEE COST-SHARING AMOUNT.—Before  
3 the beginning of each year the Commission  
4 shall estimate—

5 (i) the total amount of cost-sharing  
6 assistance to be provided under this section  
7 to enrollee units in the year, and

8 (ii) the average number of enrollee  
9 units (as defined in section 1701(a)(5)) to  
10 be provided such assistance in the year.

11 (C) PREMIUM CLASS ASSISTANCE FAC-  
12 TOR.—The Commission shall establish a factor,  
13 for each premium class, that reflects the ratio  
14 of the—

15 (i) the average value of the cost-shar-  
16 ing assistance furnished under this section  
17 to individuals within the premium class, to

18 (ii) the average value of the cost-shar-  
19 ing assistance furnished under this sub-  
20 section to individuals within all the pre-  
21 mium classes.

22 (b) CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS.—  
23 In the case of a very low-income individual described in  
24 section 2001(b), the cost-sharing assistance under this

1 subsection shall consist of payment being made under title  
2 XVIII of the Social Security Act—

3 (1) without regard to coinsurance under such  
4 title (including coinsurance described in section 1813  
5 of such title);

6 (2) without regard to deductibles established  
7 under such title (including those described in section  
8 1813 and section 1833(b) of such title); and

9 (3) as though any reference to “80 percent” in  
10 section 1833(a) of such title were a reference to  
11 “100 percent”.

12 (c) APPROPRIATION TO COVER PART A ASSIST-  
13 ANCE.—Section 1817(a) of the Social Security Act (42  
14 U.S.C. 1395i(a)) is amended by adding at the end the fol-  
15 lowing new sentence: “In addition to the amounts appro-  
16 priated under this subsection, there are hereby appro-  
17 priated to the Trust Fund, out of any moneys in the  
18 Treasury not otherwise appropriated, amounts equivalent  
19 to the reductions in the deductibles and coinsurance estab-  
20 lished under section 1813 effected under section 2003(b)  
21 of the Managed Competition Act of 1993.”.

22 **SEC. 2004. ASSISTANCE FOR CERTAIN ITEMS AND SERV-**  
23 **ICES.**

24 (a) IN GENERAL.—In the case of a very low-income  
25 individual, the special assistance under this section con-

1 sists of payment under this section with respect to items  
2 and services described in subsection (b), subject to sub-  
3 section (c).

4 (b) ITEMS AND SERVICES COVERED.—

5 (1) IN GENERAL.—Subject to paragraph (2),  
6 the items and services described in this subsection  
7 are—

8 (A) prescription drugs,

9 (B) eyeglasses and hearing aids, and

10 (C) such other items and services as the  
11 Commission determines were commonly pro-  
12 vided to individuals described in section  
13 1902(a)(10)(A)(i) of the Social Security Act  
14 under State medicaid plans under title XIX of  
15 such Act (as in effect as of the date of the en-  
16 actment of this Act).

17 (2) EXCLUSIONS.—Items and services described  
18 in this subsection shall not include—

19 (A) items and services included in the uni-  
20 form set of effective benefits, and

21 (B) services described in section  
22 2101(c)(1)(A) and similar services.

23 (c) NOMINAL COPAYMENTS.—The Commission shall  
24 provide for cost-sharing under this section in an amount  
25 that is nominal (within the meaning of section 1916(a)(3)



1 of the Social Security Act, as in effect as of the date of  
2 the enactment of this Act).

3 (d) PAYMENT RULES.—The Commission shall pro-  
4 vide for such rules relating to—

5 (1) qualifications of providers of items and serv-  
6 ices, and

7 (2) use of carriers in the administration of this  
8 section,

9 as may be appropriate to carry out this section.

10 **SEC. 2005. COMPUTATION OF BASE FEDERAL PREMIUM**  
11 **AMOUNT.**

12 (a) FORMULA.—

13 (1) IN GENERAL.—For purposes of this Act,  
14 the “base Federal premium amount” for an individ-  
15 ual residing in a HPPC area is equal to the product  
16 of—

17 (A) reference premium rate (as defined in  
18 section 2009(c)(4)) for the individual, and

19 (B) the national subsidy percentage (com-  
20 puted under paragraph (2)).

21 (2) NATIONAL SUBSIDY PERCENTAGE.—In  
22 paragraph (1)(B), the term “national subsidy per-  
23 centage” means, for a year—

24 (A) the amount specified under subsection

25 (b)(1), divided by

1 (B) the total amount of low-income assist-  
2 ance that would be provided if the national sub-  
3 sidy percentage were equal to 100 percent;  
4 expressed as a percentage.

5 (b) COMPUTATION OF TOTAL FEDERAL AMOUNT  
6 AVAILABLE FOR LOW-INCOME ASSISTANCE.—

7 (1) IN GENERAL.—The amount specified in this  
8 paragraph for a year is—

9 (A) the sum determined under paragraph

10 (2) for the year, reduced by

11 (B) the total amount of reductions under  
12 paragraph (3) for the year.

13 (2) AVAILABLE FEDERAL FUNDS.—

14 (A) 1995 THROUGH 1999.—The Health  
15 Care Standards Commission shall compute, in  
16 consultation with the Secretary of Health and  
17 Human Services and the Director of the Office  
18 of Management and Budget, before the begin-  
19 ning of each of years 1995, 1996, 1997, 1998,  
20 and 1999, the sum of—

21 (i) the total dollar amount of Federal  
22 financial participation that would have  
23 been payable to States under section 1903  
24 of the Social Security Act (including such  
25 a plan operating under a waiver under sec-

1           tion 1115 of such Act) for calendar quar-  
2           ters during the year, based on their plans  
3           in effect as of the date of the enactment of  
4           this Act, taking into account changes  
5           scheduled to occur in such a plan as of  
6           such date; and

7                 (ii) subject to paragraph (4)(A), the  
8           total net amount of additional revenues es-  
9           timated by the Secretary of the Treasury  
10          to be received during the year due to the  
11          amendments made by subtitle A of title I  
12          and subtitle C of this title.

13          (B) AFTER 1999.—The Health Care Stand-  
14          ards Commission shall compute, in consultation  
15          with the Secretary of Health and Human Serv-  
16          ices and the Director of the Office of Manage-  
17          ment and Budget, before the beginning of 2000  
18          and each subsequent year the sum of—

19                 (i) the total dollar amount computed  
20           under subparagraph (A)(i) (or this clause)  
21           for the previous year, increased by the per-  
22           centage increase in the gross domestic  
23           product (as determined by the Secretary of  
24           Commerce) for the 4-quarter period ending  
25           in June of the previous year; and

1           (ii) subject to paragraph (4)(A), the  
2           total net amount of additional revenues es-  
3           timated by the Secretary of the Treasury  
4           to be received during the year due to the  
5           amendments made by subtitle A of title I  
6           and subtitle C of this title.

7           (3) REDUCTIONS.—Subject to paragraph  
8           (4)(B), the total amount of reductions described in  
9           this paragraph for a year are the sum of the follow-  
10          ing:

11           (A) LONG-TERM CARE PHASE-DOWN AS-  
12           SISTANCE.—The total amount of long-term care  
13           phase-down assistance to which States are enti-  
14           tled under section 2101 for calendar quarters  
15           during the year.

16           (B) MEDICARE LOW-INCOME ASSIST-  
17           ANCE.—The total amount, estimated by the  
18           Commission, of the assistance to be provided  
19           under sections 2002(b) and 2003(b) during the  
20           year.

21           (C) COST-SHARING.—The total amount,  
22           estimated by the Commission, of the cost-shar-  
23           ing assistance to be provided under section  
24           2003(a) during the year.

1 (D) SPECIAL LOW-INCOME ASSISTANCE.—

2 The total amount, estimated by the Commis-  
3 sion, of the special assistance to be provided  
4 under section 2004 during the year.

5 (E) GRANTS AND OTHER EXPENDI-

6 TURES.—In order to provide for grants under  
7 section 2006(g) and additional expenditures  
8 under subtitle E of title I, subtitle B of title  
9 III, subtitle A of title IV, and title V,  
10 \$523,000,000.

11 (4) ADJUSTMENT FOR OVER- AND UNDER-ESTI-  
12 MATES.—

13 (A) FUNDS AVAILABLE.—The amounts de-  
14 termined under subparagraphs (A)(ii) and  
15 (B)(ii) of paragraph (2) for a year shall be in-  
16 creased or decreased by the amount by which  
17 the amount estimated under such respective  
18 subparagraph for the preceding year was below,  
19 or above, the actual amount of revenues for  
20 such year.

21 (B) REDUCTIONS.—The amounts specified  
22 in subparagraphs (A) through (D) of paragraph  
23 (3) for a year shall be increased or decreased  
24 by the amount by which the respective amount  
25 estimated under such subparagraph for the pre-

1           ceding year was below, or above, the actual  
2           amount described in such subparagraph for  
3           such year.

4   **SEC. 2006. APPLICATIONS FOR ASSISTANCE.**

5       (a) IN GENERAL.—Subject to section 2008, any indi-  
6   vidual who seeks assistance under this subtitle (with re-  
7   spect to himself or herself or a family member) shall sub-  
8   mit a written application, by person or mail, to the Com-  
9   mission.

10      (b) BASIS FOR DETERMINATION.—Subject to section  
11   2008 and reconciliation under section 2007(b), eligibility  
12   for assistance under this subtitle shall be based on 4 times  
13   the family adjusted total income (as defined in section  
14   2009(b)(1)) during the 3 months preceding the month in  
15   which the application is filed.

16      (c) FORM AND CONTENTS.—An application for as-  
17   sistance under this subtitle shall be in a form and manner  
18   specified by the Commission and shall require—

19           (1) the provision of information necessary to  
20       make the determinations described in subsection (b),

21           (2) the provision of information respecting the  
22       AHP in which the individual is enrolled (or is in the  
23       process of enrolling), and

24           (3) the individual to assign rights to assistance  
25       under section 2003 to such plan.

1 Such form also shall include notice that the subsidies  
2 under this subtitle will be made as a direct reduction of  
3 premiums and cost-sharing under the AHP involved.

4 (d) FREQUENCY OF APPLICATIONS.—

5 (1) IN GENERAL.—An application for assistance  
6 under this subtitle may be filed at any time during  
7 the year and may be resubmitted (but, except as  
8 provided in paragraph (3), not more frequently than  
9 once every 3 months) based upon a change of in-  
10 come or family composition.

11 (2) NEED TO REAPPLY.—In the case of an indi-  
12 vidual who—

13 (A) is entitled to assistance under this sub-  
14 title in September of a year, and

15 (B) wishes to remain eligible for assistance  
16 for months beginning with January of the fol-  
17 lowing year,

18 the individual (or a family member) must file with  
19 the Commission in October of that preceding year a  
20 new application for assistance. If a new application  
21 under this paragraph is not filed with respect to an  
22 individual, an application for such assistance with  
23 respect to the individual may not be filed during No-  
24 vember or December of that preceding year.

1           (3) CORRECTION OF INCOME.—Nothing in  
2 paragraph (1) shall be construed as preventing an  
3 individual or family from, at any time, submitting an  
4 application to reduce the amount of assistance under  
5 this subtitle based upon an increase in income from  
6 that stated in the previous application.

7           (e) TIMING OF ASSISTANCE.—

8           (1) IN GENERAL.—If an application for assist-  
9 ance under this subtitle is filed—

10                   (A) on or before the 15th day of a month,  
11 assistance under this subtitle shall be available  
12 for premiums for months after such month and,  
13 with respect to the cost-sharing, for expenses  
14 incurred after such month, and, with respect to  
15 special assistance, for items and services fur-  
16 nished after such month; or

17                   (B) after the 15th day of a month, assist-  
18 ance under this subtitle shall be available for  
19 premiums for months after the month following  
20 such month and, with respect to the cost-shar-  
21 ing, for expenses incurred after such following  
22 month, and, with respect to special assistance,  
23 for items and services furnished after such fol-  
24 lowing month.



1           (2) WELFARE RECIPIENTS.—In the case of an  
2       individual or family with respect to whom an appli-  
3       cation for assistance is not required because of sec-  
4       tion 2008, in applying paragraph (1), the date of ap-  
5       proval of aid or benefits described in such section  
6       shall be considered the date of filing of an applica-  
7       tion for assistance under this subtitle.

8       (f) VERIFICATION.—The Commission shall provide  
9       for verification, on a sample basis or other basis, of the  
10      information supplied in applications under this subtitle.  
11      This verification shall be separate from the reconciliation  
12      provided under section 2007.

13      (g) HELP IN COMPLETING APPLICATIONS.—The  
14      Commission shall provide, from funds appropriated to  
15      carry out this subtitle, for grants to public or private non-  
16      profit entities that will make available assistance to indi-  
17      viduals and families in filing applications for assistance  
18      under this subtitle. The Commission shall make grants in  
19      a manner that provides such assistance at a variety of  
20      sites (such as low-income housing projects and shelters for  
21      homeless individuals) that are readily accessible to individ-  
22      uals and families eligible for assistance under this subtitle.  
23      The total amount of the funds provided in any fiscal year  
24      under grants under this subsection may not exceed  
25      \$10,000,000.

1 (h) PENALTIES FOR INACCURATE INFORMATION.—

2 (1) INTEREST FOR UNDERSTATEMENTS.—Each  
3 individual who knowingly understates income re-  
4 ported in an application for assistance under this  
5 subtitle or otherwise makes a material misrepresen-  
6 tation of information in such an application shall be  
7 liable to the Health Care Standards Commission for  
8 excess payments made based on such understate-  
9 ment or misrepresentation, and for interest on such  
10 excess payments at a rate specified by the Commis-  
11 sion.

12 (2) PENALTIES FOR MISREPRESENTATION.—  
13 Each individual who knowingly misrepresents mate-  
14 rial information in an application for assistance  
15 under this subtitle shall be liable to the Health Care  
16 Standards Commission for \$1,000 or, if greater,  
17 three times the excess payments made based on such  
18 misrepresentation.

19 (i) FILING OF APPLICATION DEFINED.—Except as  
20 provided in subsection (e)(2), for purposes of this subtitle,  
21 an application under this subtitle is considered to be  
22 “filed” on the date on which the complete application, in-  
23 cluding all documentation required to act on the applica-  
24 tion, has been filed with the Commission.

1 **SEC. 2007. RECONCILIATION OF PREMIUM ASSISTANCE**  
2 **THROUGH USE OF INCOME STATEMENTS.**

3 (a) REQUIREMENT FOR FILING OF INCOME STATE-  
4 MENT.—

5 (1) IN GENERAL.—Subject to section 2008, in  
6 the case of a family which is receiving low-income  
7 assistance under this subtitle for any month in a  
8 year, a member of the family shall file with the  
9 Commission, by not later than April 15 of the fol-  
10 lowing year, a statement that verifies the family's  
11 total adjusted family income for the taxable year  
12 ending during the previous year. Such a statement  
13 shall provide information necessary to determine the  
14 family adjusted total income during the year and the  
15 number of family members in the family as of the  
16 last day of the year.

17 (2) USE OF INCOME TAX RETURN.—The Com-  
18 mission shall provide a process under which the fil-  
19 ing of a Federal income tax return shall constitute  
20 the filing of a income statement under paragraph  
21 (2).

22 (3) EXTENSION.—The Commission shall permit  
23 the extension of the filing deadline under paragraph  
24 (1) in such cases as the Commission determines to  
25 be appropriate. The Commission shall take into ac-

1 count the extensions permitted for the filing of Fed-  
2 eral income tax returns.

3 (b) RECONCILIATION OF PREMIUM ASSISTANCE  
4 BASED ON ACTUAL INCOME.—Based on and using the in-  
5 come reported in the statement filed under subsection (a)  
6 with respect to a family or individual, subject to section  
7 2008, the Commission shall compute the amount of assist-  
8 ance that should have been provided under section 2002  
9 with respect to premiums for the family in the year in-  
10 volved. If the amount of such assistance computed is—

11 (1) greater than the amount of premium assist-  
12 ance provided, the Commission shall provide for pay-  
13 ment to the family or individual involved of an  
14 amount equal to the amount of the deficit, or

15 (2) less than the amount of assistance provided,  
16 the Commission shall require the family or individ-  
17 ual to pay to the Commission (to the credit of the  
18 program under this subtitle) an amount equal to the  
19 amount of the excess payment.

20 (c) DISQUALIFICATION FOR FAILURE TO FILE.—  
21 Subject to section 2008, in the case of any individual with  
22 respect to whom an information statement under sub-  
23 section (a) is required to be filed in a year and that fails  
24 to file such a statement by the deadline specified in such  
25 subsection, the individual is not eligible for assistance

1 under this subtitle after May 1 of such year. The Commis-  
2 sion shall waive the application of this subsection if there  
3 is established, to the satisfaction of the Commission, good  
4 cause for the failure to file the statement on a timely  
5 basis.

6 (d) PENALTIES FOR FALSE INFORMATION.—Any in-  
7 dividual that provides false information in a statement  
8 under subsection (a) is subject to a criminal penalty to  
9 the same extent as a criminal penalty may be imposed  
10 under section 1128B(a) of the Social Security Act with  
11 respect to a person described in clause (ii) of such section.

12 (e) NOTICE OF REQUIREMENT.—The Commission  
13 shall provide for written notice, in March of each year,  
14 of the requirement of subsection (a) to each family which  
15 received assistance under this subtitle in any month dur-  
16 ing the preceding year and to which such requirement ap-  
17 plies.

18 (f) TRANSMITTAL OF INFORMATION.—The Commis-  
19 sion of the Treasury shall transmit annually to the Com-  
20 mission such information relating to the adjusted total in-  
21 come of individuals for the taxable year ending in the pre-  
22 vious year as may be necessary to verify the reconciliation  
23 of assistance under this section.

24 (g) CONSTRUCTION.—Nothing in this section shall be  
25 construed as authorizing reconciliation of assistance pro-

1 vided with respect to cost-sharing assistance under section  
2 2003 or special assistance under section 2004.

3 **SEC. 2008. TREATMENT OF CERTAIN CASH ASSISTANCE RE-**  
4 **CIPIENTS.**

5 In the case of a family that has been determined to  
6 be eligible for aid under part A or E of title IV of the  
7 Social Security Act or an individual who has been deter-  
8 mined to be eligible for supplemental security income ben-  
9 efits under title XVI of such Act—

10 (1) the family or individual is deemed, without  
11 the need to file an application for assistance under  
12 section 2006, to have adjusted total income below  
13 100 percent of the State-adjusted poverty level for  
14 the State,

15 (2) the family or individual need not file a  
16 statement under section 2007(a), and

17 (3) the assistance received by the family is not  
18 subject to reconciliation under section 2007(b).

19 **SEC. 2009. DEFINITIONS.**

20 (a) DEFINITIONS RELATING TO LOW-INCOME INDIV-  
21 IDUALS.—In this subtitle:

22 (1) LOW-INCOME INDIVIDUAL.—

23 (A) IN GENERAL.—The term “low-income  
24 individual” means, in the case of—

1 (i) a medicare-eligible individual resid-  
2 ing in a State, such an individual whose  
3 family adjusted total income (as defined in  
4 subsection (b)(1)) is less than 120 percent  
5 of the State-adjusted poverty level for the  
6 State; or

7 (ii) an individual who is not a medi-  
8 care-eligible individual and who resides in  
9 a State, an eligible individual (as defined  
10 in section 1701(a)(1)) whose family ad-  
11 justed total income is less than 200 per-  
12 cent of the State-adjusted poverty level for  
13 the State.

14 (2) MODERATELY LOW-INCOME INDIVIDUAL.—  
15 The term “moderately low-income individual” means  
16 a low-income individual (as defined in paragraph  
17 (1)) who is not a very low-income individual (as de-  
18 fined in paragraph (3)).

19 (3) VERY LOW-INCOME INDIVIDUAL.—The term  
20 “very low-income individual” means, with respect to  
21 an individual residing in a State, a low-income indi-  
22 vidual whose family adjusted total income is less  
23 than 100 percent of the State-adjusted poverty level  
24 for the State.

1 (b) DEFINITIONS RELATING TO INCOME AND POV-  
2 ERTY LINE.—In this subtitle:

3 (1) FAMILY ADJUSTED TOTAL INCOME.—The  
4 term “family adjusted total income” means, with re-  
5 spect to an individual, the sum of the modified total  
6 income for the individual and all the other eligible  
7 family members.

8 (2) MODIFIED FAMILY INCOME.—The term  
9 “modified family income” means the sum of—

10 (A) the adjusted gross income (as defined  
11 in section 62(a) of the Internal Revenue Code  
12 of 1986) of the taxpayer and family members  
13 for the taxable year determined without regard  
14 to sections 911, 931, and 933 of such Code, de-  
15 termined without the application of paragraphs  
16 (6) and (7) of section 62(a) of such Code and  
17 without the application of section 162(l) of such  
18 Code, plus

19 (B) the interest received or accrued by the  
20 taxpayer and family members during such tax-  
21 able year which is exempt from income, plus

22 (C) the amount of social security benefits  
23 (described in section 86(d) of such Code) which  
24 is not includable in gross income of the tax-



1 payer and family members under section 86 of  
2 such Code.

3 (3) STATE-ADJUSTED POVERTY LEVEL DE-  
4 FINED.—

5 (A) IN GENERAL.—The term “State-ad-  
6 justed poverty level” means, with respect to an  
7 individual resident in a State, the poverty line  
8 (as defined in paragraph (4)) multiplied by the  
9 State adjustment factor (established under sub-  
10 paragraph (B)) for the State.

11 (B) STATE ADJUSTMENT FACTORS.—The  
12 Health Care Standards Commission shall estab-  
13 lish, for each State, a State adjustment factor  
14 that reflects the relative cost-of-living in the  
15 State compared to the cost-of-living in the con-  
16 tinental United States (including Alaska) and  
17 Hawaii. The weighted average of such factors  
18 shall be 1. Such factors shall be updated annu-  
19 ally.

20 (4) POVERTY LINE.—The term “poverty line”  
21 means the income official poverty line as defined by  
22 the Office of Management and Budget, and revised  
23 annually in accordance with section 673(2) of the  
24 Omnibus Budget Reconciliation Act of 1981.

1           (5) FAMILY SIZE.—The family size to be ap-  
2           plied under this subtitle, with respect to family ad-  
3           justed total income, is the number of eligible family  
4           members (as defined in section 1701(a)(3)).

5           (c) DEFINITIONS RELATING TO ASSISTANCE AND  
6           PREMIUM AMOUNTS.—In this Act:

7           (1) APPLICABLE FEDERAL ASSISTANCE  
8           AMOUNT.—The term “applicable Federal assistance  
9           amount” means, with respect to—

10                   (A) a very low-income individual, the base  
11                   Federal premium amount (as determined under  
12                   section 2005(a)(1)), or

13                   (B) a moderately low-income individual,  
14                   the amount by which (i) the applicable low-in-  
15                   come premium amount (as defined in para-  
16                   graph (2)), exceeds (ii) the base individual pre-  
17                   mium (as defined in paragraph (3)),

18                   reduced by the amount of any contribution made by  
19                   an employer with respect to coverage of the individ-  
20                   ual.

21           (2) APPLICABLE LOW-INCOME PREMIUM  
22           AMOUNT.—The term “applicable low-income pre-  
23           mium amount” means, with respect to a low-income  
24           individual, the base Federal premium amount (deter-

1       mined under section 2005(a)(1)) plus the product  
2       of—

3               (A) the individual responsibility percentage  
4               (as defined in paragraph (5)), and

5               (B) the amount by which (i) the reference  
6               premium rate (as defined in paragraph (4)), ex-  
7               ceeds (ii) the base Federal premium amount.

8       (3) BASE INDIVIDUAL PREMIUM.—The term  
9       “base individual premium” means, with respect to  
10       an individual, the product of—

11              (A) the individual responsibility percentage  
12              (as defined in paragraph (5)), and

13              (B) the reference premium rate (as defined  
14              in paragraph (4)).

15       (4) REFERENCE PREMIUM RATE.—The term  
16       “reference premium rate” means, with respect to an  
17       individual residing in a HPPC area, the lowest pre-  
18       mium—

19              (A) established by an open AHP which en-  
20              rolls at least such proportion of eligible individ-  
21              uals in the HPPC area as the Commission shall  
22              specify, and

23              (B) offered in the area for the premium  
24              class applicable to such individual (including

1 the HPPC overhead amount established under  
2 section 1105(b)(3)).

3 (5) INDIVIDUAL RESPONSIBILITY PERCENT-  
4 AGE.—The term “individual responsibility percent-  
5 age” means—

6 (A) with respect to a very low-income indi-  
7 vidual, 0 percentage points,

8 (B) with respect to a moderately low-in-  
9 come individual, the number of percentage  
10 points by which the family’s family adjusted  
11 total income (expressed as a percent of the ap-  
12 plicable poverty line) exceeds 100 percentage  
13 points, and

14 (C) with respect to any other individual,  
15 100 percentage points.

16 **Subtitle B—Long-Term Care Phase-**  
17 **Down Assistance to States**

18 **SEC. 2101. LONG-TERM CARE PHASE-DOWN ASSISTANCE.**

19 (a) IN GENERAL.—Subject to subsection (b), if the  
20 excess percentage (as defined in subsection (c)(3)) for a  
21 State is greater than 0 percentage points, the State is en-  
22 titled for each calendar quarter in 1995 through 1998 to  
23 payment equal to  $\frac{1}{4}$  of the product of—

24 (1) such excess percentage,

1           (2) the applicable phase-down percentage for  
2           the year, described in subsection (c)(4)), and

3           (3)  $\frac{1}{2}$  of the amount described in subsection  
4           (c)(1)(B).

5           (b) MAINTENANCE OF EFFORT REQUIRED.—A State  
6 is not eligible for assistance under subsection (a) for a  
7 calendar quarter unless the State provides assurances sat-  
8 isfactory to the Commission that the State is incurring  
9 expenses (for services described in subsection (c)(1)(A))  
10 in an amount not less than the sum of—

11           (1) the amount of assistance under subsection  
12           (a), and

13           (2)  $\frac{1}{4}$  of the product of—

14                   (A) the State’s effective State medicaid  
15                   percentage (as defined in subsection (c)(2)),  
16                   and

17                   (B)  $\frac{1}{2}$  of the amount described in sub-  
18                   section (c)(1)(B).

19           (c) DEFINITIONS.—For purposes of this section:

20           (1) LONG-TERM CARE PERCENTAGE.—The  
21           “long-term care percentage” for a State is—

22                   (A) the portion of the amount described in  
23                   subparagraph (B) that is are attributable to  
24                   medical assistance for nursing facility services,  
25                   intermediate care facility services for the men-

1           tally retarded, home health care services, and  
2           home and community-based services, divided by  
3           (B) the total amount of Federal and State  
4           expenditures for medical assistance under the  
5           State plan under title XIX of the Social Secu-  
6           rity Act for calendar quarters during fiscal  
7           years 1992 and 1993;  
8           expressed as a percentage.

9           (2) EFFECTIVE STATE MEDICAID PERCENT-  
10          AGE.—The “effective State medicaid percentage” for  
11          a State is—

12                (A)(i) the amount described in subpara-  
13               graph (B), reduced by (ii) the sum of the  
14               amount of the Federal financial participation  
15               under section 1903(a) of the Social Security  
16               Act paid to the State for calendar quarters dur-  
17               ing fiscal years 1992 and 1993 and the amount  
18               of health-care related taxes (as defined in sec-  
19               tion 1903(w)(3)(A) of such Act) received by the  
20               State during such fiscal years, divided by

21               (B) the total amount of the Federal and  
22               State expenditures under its plan under title  
23               XIX of the Social Security Act during calendar  
24               quarters in fiscal years 1992 and 1993.

1           (3) EXCESS PERCENTAGE.—The term “excess  
2       percentage” means, for a State, percentage by which  
3       (A) the long-term care percentage (as defined in  
4       paragraph (1)) exceeds (B) 2 percentage points plus  
5       the effective State medicaid percentage (as defined  
6       in paragraph (2)).

7           (4) APPLICABLE PHASE-DOWN PERCENTAGE.—  
8       The “applicable phase-down percentage” for—  
9                (A) 1995, is 80 percent,  
10              (B) 1996, is 60 percent,  
11              (C) 1997, is 40 percent, and  
12              (D) 1998, is 20 percent.

## 13                   **Subtitle C—Financing**

### 14                   **PART 1—MEDICARE SAVINGS**

#### 15       **SEC. 2201. REDUCTION IN UPDATE FOR INPATIENT HOS-** 16                   **PITAL SERVICES.**

17       (a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) of  
18       the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)),  
19       as amended by section 13501(a)(1) of the Omnibus Budg-  
20       et Reconciliation Act of 1993 (hereafter in this part re-  
21       ferred to as “OBRA-1993”), is amended—

22           (1) in subclause (XII), by striking “fiscal year  
23       1997, the market basket percentage increase minus  
24       0.5 percentage point” and inserting “each of the fis-  
25       cal years 1997, 1998, and 1999, the market basket

1 percentage increase minus 2.5 percentage points”;  
 2 and

3 (2) in subclause (XIII), by striking “fiscal year  
 4 1998” and inserting “fiscal year 2000”.

5 (b) PPS-EXEMPT HOSPITALS.—Section  
 6 1886(b)(3)(B)(ii)(V) of such Act (42 U.S.C.  
 7 1395ww(b)(3)(B)(ii)(V)), as amended by section  
 8 13502(a)(1) of OBRA–1993, is amended by striking  
 9 “through 1997” and inserting “through 1999”.

10 **SEC. 2202. REDUCTION IN CONVERSION FACTOR FOR PHY-**  
 11 **SICIAN FEE SCHEDULE FOR NON-PRIMARY**  
 12 **CARE SERVICES.**

13 Section 1848(d)(3)(A) of the Social Security Act (42  
 14 U.S.C. 1395w–4(d)(3)(A)), as amended by section  
 15 13511(a)(1) of OBRA–1993, is amended—

16 (1) in clause (i), by striking “through (v)” and  
 17 inserting “through (vi)”;

18 (2) in clause (vi), by striking “(iv) and (v)” and  
 19 inserting “(iv), (v), and (vi)”;

20 (3) by redesignating clause (vi) as clause (vii);  
 21 and

22 (4) by inserting after clause (v) the following  
 23 new clause:

24 “(vi) ADJUSTMENT IN PERCENTAGE  
 25 INCREASE FOR YEARS FROM 1996



1           THROUGH 1999.—In applying clause (i) for  
2           services furnished during the period begin-  
3           ning January 1, 1996, and ending Decem-  
4           ber 31, 1999, the percentage increase in  
5           the appropriate update index shall be re-  
6           duced by such percent as the Secretary de-  
7           termines will result in a reduction in ag-  
8           gregate payments for physicians' services  
9           under this part during such period of at  
10          least \$6,300,000,000 from the amount of  
11          aggregate payments for such services that  
12          would otherwise have been made during  
13          the period.”.

14   **SEC. 2203. REDUCTION IN HOSPITAL OUTPATIENT SERV-**  
15                   **ICES THROUGH ESTABLISHMENT OF PRO-**  
16                   **SPECTIVE PAYMENT SYSTEM.**

17          (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-  
18          cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended  
19          by striking “section 1886)—” and all that follows and in-  
20          serting the following: “section 1886), an amount equal to  
21          a prospectively determined payment rate established by  
22          the Secretary that provides for payments for such items  
23          and services to be based upon a national rate adjusted  
24          to take into account the relative costs of furnishing such  
25          items and services in various geographic areas, except that

1 for items and services furnished during cost reporting pe-  
 2 riods (or portions thereof) in years beginning with 1995,  
 3 such amount shall be equal to 90 percent of the amount  
 4 that would otherwise have been determined;”.

5 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
 6 SYSTEM.—Not later than July 1, 1994, the Secretary of  
 7 Health and Human Services shall establish the prospective  
 8 payment system for hospital outpatient services necessary  
 9 to carry out section 1833(a)(2)(B) of the Social Security  
 10 Act (as amended by subsection (a)).

11 (c) EFFECTIVE DATE.—The amendment made by  
 12 subsection (a) shall apply to items and services furnished  
 13 on or after January 1, 1995.

14 **SEC. 2204. INCREASE IN MEDICARE PART B PREMIUM FOR**  
 15 **INDIVIDUALS WITH HIGH INCOME.**

16 (a) IN GENERAL.—Subchapter A of chapter 1 of the  
 17 Internal Revenue Code of 1986 is amended by adding at  
 18 the end thereof the following new part:

19 **“PART VIII—MEDICARE PART B PREMIUMS FOR**  
 20 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

21 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

22 “(a) IMPOSITION OF TAX.—In the case of an individ-  
 23 ual to whom this section applies for the taxable year, there  
 24 is hereby imposed (in addition to any other tax imposed

1 by this subtitle) a tax for such taxable year equal to the  
2 aggregate of the Medicare part B premium taxes for each  
3 of the months during such year that such individual is  
4 covered by Medicare part B.

5 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—  
6 This section shall apply to any individual for any taxable  
7 year if—

8 “(1) such individual is covered under Medicare  
9 part B for any month during such year, and

10 “(2) the modified adjusted gross income of the  
11 taxpayer for such taxable year exceeds the threshold  
12 amount.

13 “(c) MEDICARE PART B PREMIUM TAX FOR  
14 MONTH.—

15 “(1) IN GENERAL.—The Medicare part B pre-  
16 mium tax for any month is the applicable percentage  
17 (as defined in paragraph (2)) of the amount equal  
18 to the excess of—

19 “(A) 150 percent of the monthly actuarial  
20 rate for enrollees age 65 and over determined  
21 for that calendar year under section 1839(b) of  
22 the Social Security Act, over

23 “(B) the total monthly premium under sec-  
24 tion 1839 of the Social Security Act (deter-

1           mined without regard to subsections (b) and (f)  
2           of section 1839 of such Act).

3           “(2) PHASE-IN OF TAX.—If the modified ad-  
4           justed gross income of the taxpayer for any taxable  
5           years exceeds the threshold amount by—

6                   “(A) less than \$25,000, the applicable per-  
7                   centage under this paragraph is  $33\frac{1}{3}$  percent;

8                   “(B) at least \$25,000, but less than  
9                   \$50,000, the applicable percentage under this  
10                  paragraph is  $66\frac{2}{3}$  percent,

11                  “(C) at least \$50,000, but less than  
12                  \$75,000, the applicable percentage under this  
13                  paragraph is  $65/75$  (expressed as a percent), or

14                  “(D) at least \$75,000, the applicable per-  
15                  centage under this paragraph is 100 percent.

16           “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
17           For purposes of this section—

18                   “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
19                   old amount’ means—

20                           “(A) except as otherwise provided in this  
21                           paragraph, \$75,000,

22                           “(B) \$100,000 in the case of a joint re-  
23                           turn, and

24                           “(C) zero in the case of a taxpayer who—

1           “(i) is married at the close of the tax-  
2           able year but does not file a joint return  
3           for such year, and

4           “(ii) does not live apart from his  
5           spouse at all times during the taxable year.

6           “(2) MODIFIED ADJUSTED GROSS INCOME.—  
7           The term ‘modified adjusted gross income’ means  
8           adjusted gross income—

9           “(A) determined without regard to sections  
10          135, 911, 931, and 933, and

11          “(B) increased by the amount of interest  
12          received or accrued by the taxpayer during the  
13          taxable year which is exempt from tax.

14          “(3) MEDICARE PART B COVERAGE.—An indi-  
15          vidual shall be treated as covered under Medicare  
16          part B for any month if a premium is paid under  
17          part B of title XVIII of the Social Security Act for  
18          the coverage of the individual under such part for  
19          the month.

20          “(4) MARRIED INDIVIDUAL.—The determina-  
21          tion of whether an individual is married shall be  
22          made in accordance with section 7703.”.

23          (b) CLERICAL AMENDMENT.—The table of parts for  
24          subchapter A of chapter 1 of such Code is amended by  
25          adding at the end thereof the following new item:

“Part VIII. Medicare Part B Premiums For High-Income Individuals.”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to months after December 1993  
3 in taxable years ending after December 31, 1993.

4 **SEC. 2205. PHASED-IN ELIMINATION OF MEDICARE HOS-**  
5 **PITAL DISPROPORTIONATE SHARE ADJUST-**  
6 **MENT PAYMENTS.**

7 Section 1886(d)(5)(F) of the Social Security Act (42  
8 U.S.C. 1395ww(d)(5)(F)) is amended—

9 (1) in clause (i), by inserting “and before Sep-  
10 tember 30, 1998,” after “1986,”;

11 (2) in clause (ii), by striking “The amount of  
12 such payment” and inserting “Subject to clause (ix),  
13 the amount of such payment”; and

14 (3) by adding at the end the following new  
15 clause:

16 “(ix) The amount of the additional payment made  
17 under this paragraph for a discharge shall be equal to—

18 “(I) for discharges occurring during fiscal year  
19 1995, 80 percent of the amount otherwise deter-  
20 mined for the discharge under clause (ii);

21 “(II) for discharges occurring during fiscal year  
22 1996, 60 percent of the amount otherwise deter-  
23 mined for the discharge under clause (ii);

1 “(III) for discharges occurring during fiscal  
 2 year 1997, 40 percent of the amount otherwise de-  
 3 termined for the discharge under clause (ii); and

4 “(IV) for discharges occurring during fiscal  
 5 year 1998, 20 percent of the amount otherwise de-  
 6 termined for the discharge under clause (ii).”.

7 **SEC. 2206. REDUCTION IN ROUTINE COST LIMITS FOR**  
 8 **HOME HEALTH SERVICES.**

9 Section 1861(v)(1)(L)(i) of the Social Security Act  
 10 (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

11 (1) in subclause (II), by striking “or” at the  
 12 end;

13 (2) in subclause (III)—

14 (A) by inserting “and before July 1,  
 15 1995,” after “1977,” and

16 (B) by adding “or” at the end; and

17 (3) by inserting after subclause (III) the follow-  
 18 ing new subclause:

19 “(IV) July 1, 1995, 103 percent.”.

20 **SEC. 2207. REDUCTION IN ROUTINE COST LIMITS FOR EX-**  
 21 **TENDED CARE SERVICES.**

22 (a) IN GENERAL.—Section 1888(a) of the Social Se-  
 23 curity Act (42 U.S.C. 1395yy(a)) is amended—

24 (1) by striking “112 percent” and inserting  
 25 “102 percent” each place it appears.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall apply to cost reporting periods begin-  
3 ning on or after October 1, 1994.

4 **SEC. 2208. REDUCTIONS IN PAYMENTS FOR HOSPICE SERV-**  
5 **ICES.**

6 Section 1814(i)(1)(C)(ii) of the Social Security Act  
7 (42 U.S.C. 1395f(i)(1)(C)(ii)), as amended by section  
8 13504 of OBRA–1993, is amended—

9 (1) in subclause (III), by striking “1.5 percent-  
10 age points” and inserting “2.5 percentage points”;

11 (2) in subclause (IV), by striking “1.5 percent-  
12 age points” and inserting “2.5 percentage points”;

13 (3) in subclause (V), by striking “0.5 percent-  
14 age point” and inserting “1.5 percentage points”  
15 and by striking “and” at the end;

16 (4) by redesignating subclause (VI) as  
17 subclause (VIII) ; and

18 (5) by inserting after subclause (V) the follow-  
19 ing new subclauses:

20 “(VI) for fiscal year 1998, the market basket  
21 percentage increase for the fiscal year minus 1.0  
22 percentage point;

23 “(VII) for fiscal year 1999, the market basket  
24 percentage increase for the fiscal year minus 1.0  
25 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

1           (5) the term “Office” means the Office of Per-  
2       sonnel Management.

3       (b) PREFUNDING REQUIREMENT.—

4           (1) IN GENERAL.—Effective as of October 1,  
5       1994, each agency (or February 1, 1995, in the case  
6       of the agency with the greatest number of employ-  
7       ees, as determined by the Office) shall be required  
8       to prepay the Government contributions which are  
9       or will be required in connection with providing  
10      health-benefits coverage for annuitants of such agen-  
11      cy.

12          (2) REGULATIONS.—The Office shall prescribe  
13      such regulations as may be necessary to carry out  
14      this section. The regulations shall be designed to en-  
15      sure at least the following:

16           (A) Amounts paid by each agency shall be  
17           sufficient to cover the amounts which would  
18           otherwise be payable by such agency (on a  
19           “pay-as-you-go” basis), on or after the applica-  
20           ble effective date under paragraph (1), on be-  
21           half of—

22                   (i) individuals who are annuitants of  
23                   the agency as of such effective date; and

24                   (ii) individuals who are employed by  
25                   the agency as of such effective date, or

1           who become employed by the agency after  
2           such effective date, after such individuals  
3           have become annuitants of the agency (in-  
4           cluding their survivors).

5           (B)(i) For purposes of determining any  
6           amounts payable by an agency—

7                   (I) this section shall be treated as if  
8                   it had taken effect at the beginning of the  
9                   20-year period which ends on the effective  
10                  date applicable under paragraph (1) with  
11                  respect to such agency; and

12                  (II) in addition to any amounts pay-  
13                  able under subparagraph (A), each agency  
14                  shall also be responsible for paying any  
15                  amounts for which it would have been re-  
16                  sponsible, with respect to the 20-year pe-  
17                  riod described in subclause (I), in connec-  
18                  tion with any individuals who are annu-  
19                  itants or employees of the agency as of the  
20                  applicable effective date under paragraph  
21                  (1).

22                  (ii) Any amounts payable under this sub-  
23                  paragraph for periods preceding the applicable  
24                  effective date under paragraph (1) shall be pay-

1           able in equal installments over the 20-year pe-  
2           riod beginning on such effective date.

3           (c) FASB STANDARDS.—Regulations under sub-  
4 section (b) shall be in conformance with the provisions of  
5 standard 106 of the Financial Accounting Standards  
6 Board, issued in December 1990.

7           (d) CLARIFICATION.—Nothing in this section shall be  
8 considered to permit or require duplicative payments on  
9 behalf of any individuals.

10          (e) DRAFT LEGISLATION.—The Office shall prepare  
11 and submit to Congress any draft legislation which may  
12 be necessary in order to carry out this section.

## 13           **Subtitle D—Repeal of Medicaid** 14                                   **Program**

### 15   **SEC. 2301. REPEAL OF MEDICAID PROGRAM.**

16          (a) IN GENERAL.—Title XIX of the Social Security  
17 Act is repealed.

18          (b) REPORT ON CONFORMING CHANGES.—By not  
19 later than May 1, 1994, the Health Care Standards Com-  
20 mission shall submit to Congress a report on—

21               (1) changes in laws that should be made in  
22 order to conform those laws to the repeal in the  
23 medicaid program effected under subsection (a), and

24               (2) the need for any special or transitional pro-  
25 visions that should be made in order to ensure con-

1       tinuous assistance for the medical needs of the med-  
2       icaid population.

3       (c) EFFECTIVE DATE.—The repeal made by sub-  
4       section (a) shall apply to items and service furnished on  
5       or after January 1, 1995.

6       **TITLE III—TRAINING AND EDU-**  
7       **CATION OF HEALTH CARE**  
8       **PROFESSIONALS**

9       **Subtitle A—Reform of Federal**  
10       **Funding for Medical Residency**  
11       **Training**

12       **SEC. 3001. DEFINITIONS.**

13       In this subtitle, the following definitions shall apply:

14               (1) The term “entry position” means, with re-  
15       spect to a medical residency training program, a po-  
16       sition as a resident in the initial year of study in the  
17       program.

18               (2) The term “Fund” means the National Med-  
19       ical Education Fund established under section 3005.

20               (3) The term “medical residency training pro-  
21       gram” means a residency or other postgraduate  
22       medical training program participation in which may  
23       be counted toward certification in a specialty or sub-  
24       specialty and includes formal postgraduate training

1 programs in geriatric medicine approved by the  
2 Health Care Standards Commission.

3 (4) The term “primary care resident” means a  
4 resident enrolled in a medical residency training pro-  
5 gram in family medicine, general internal medicine,  
6 general pediatrics, preventive medicine, geriatric  
7 medicine, or osteopathic general practice.

8 (5) The term “resident” includes any partici-  
9 pant in a medical residency training program (or,  
10 for purposes of section 3003, a physician retraining  
11 program).

12 (6) The term “United States medical graduate”  
13 means a resident who is a graduate of —

14 (A) a school of medicine accredited by the  
15 Liaison Committee on Medical Education of the  
16 American Medical Association (or approved by  
17 such Committee as meeting the standards nec-  
18 essary for such accreditation); or

19 (B) a school of osteopathy accredited by  
20 the American Osteopathic Association (or ap-  
21 proved by such Association as meeting the  
22 standards necessary for such accreditation).

1 **SEC. 3002. APPROVAL OF MEDICAL RESIDENCY TRAINING**  
2 **POSITIONS.**

3 (a) IN GENERAL.—The Health Care Standards Com-  
4 mission shall approve a resident training position in a  
5 medical residency training program for purposes of fund-  
6 ing under section 3003(a) if—

7 (1) the program submits an application for ap-  
8 proval of the position to the Commission (at such  
9 time and in such manner as the Commission may re-  
10 quire); and

11 (2) the Commission determines that the entry  
12 position relating to such resident training position in  
13 the program has been allocated to the program  
14 under subsection (b).

15 (b) ALLOCATION OF ENTRY POSITIONS AMONG PRO-  
16 GRAMS.—

17 (1) IN GENERAL.—For purposes of subsection  
18 (a)(2), the Commission shall establish a process for  
19 the allocation of entry positions among medical resi-  
20 dency training programs consistent with this sub-  
21 section.

22 (2) TOTAL NUMBER OF FUNDED POSITIONS.—

23 (A) IN GENERAL.—In consultation with ac-  
24 countable health plans, medical societies, and  
25 medical specialty societies, the Commission  
26 shall determine the appropriate total number of

1 entry positions that will be allocated to medical  
2 residency training programs under this sub-  
3 section in the United States for each residency  
4 year. In this subsection, the term “residency  
5 year” means a 12-month period beginning with  
6 July of the year in which the program begins.

7 (B) BASIS FOR TOTAL NUMBER OF ENTRY  
8 POSITIONS.—Subject to subparagraph (C), such  
9 total number of entry positions shall be based  
10 on the need for health care professionals to pro-  
11 vide cost effective health care services in the  
12 United States. In determining such number the  
13 Commission shall take into account the popu-  
14 lation-to-physician ratio, consistent with de-  
15 mand for health care services.

16 (C) LIMIT ON TOTAL NUMBER OF ENTRY  
17 POSITIONS.—The total number of entry posi-  
18 tions determined under this paragraph for any  
19 residency year shall not exceed 110 percent of  
20 the number of United States medical graduates  
21 who complete undergraduate medical education  
22 in the previous year.

23 (D) NO APPLICATION TO RESIDENTS WHO  
24 HAVE COMPLETED ANOTHER TRAINING PRO-  
25 GRAM.—The total number determined under



1           this paragraph shall only apply to residents who  
2           may enroll in a program without having pre-  
3           viously completed another medical residency  
4           training program.

5           (3) GENERAL DISTRIBUTION OF POSITIONS  
6           AMONG SPECIALITIES.—

7                   (A) IN GENERAL.—In consultation with ac-  
8           countable health plans, medical societies, and  
9           medical specialty societies, the Commission  
10          shall determine the appropriate distribution of  
11          the total number of entry positions determined  
12          under paragraph (2) among the various medical  
13          specialties.

14                  (B) BASIS FOR DISTRIBUTION.—Such dis-  
15          tribution shall be based on the need for health  
16          care professionals in different medical speciali-  
17          ties to provide cost effective health care services  
18          in the United States. In determining such dis-  
19          tribution the Commission shall take into ac-  
20          count the population-to-physician ratio with re-  
21          spect to each medical specialty, consistent with  
22          demand for health care services, and the spe-  
23          cific needs of accountable health plans.

24          (4) ALLOCATION AMONG PROGRAMS.—

1 (A) IN GENERAL.—The Commission shall  
2 allocate entry positions, distributed among med-  
3 ical specialties under paragraph (3), among spe-  
4 cific medical residency training programs.

5 (B) BASIS FOR ALLOCATION.—Such alloca-  
6 tion shall be based on the recommendations (if  
7 any) submitted by the Accreditation Council for  
8 Graduate Medical Education and the Residency  
9 Review Committees of such Council and the fol-  
10 lowing objectives:

11 (i) Allocating positions among pro-  
12 grams on the basis of quality.

13 (ii) Allocating positions among pro-  
14 grams to avoid an inappropriate geo-  
15 graphic distribution of physicians.

16 (iii) Allocating positions among pro-  
17 grams to assure a sufficient number of  
18 residents in outpatient settings.

19 **SEC. 3003. FUNDING FOR APPROVED MEDICAL RESIDENCY**  
20 **TRAINING PROGRAMS AND PHYSICIAN RE-**  
21 **TRAINING PROGRAMS.**

22 (a) IN GENERAL.—In the case of an entry position  
23 in a medical residency training program that is approved  
24 by the Commission under section 3002(a) and in the case  
25 of an entry position in a physician retraining program de-

1 scribed in subsection (d)(1) for a residency year, the Com-  
2 mission shall provide a payment to the program on the  
3 first day of each month of the year from the National  
4 Medical Education Fund established under section 3005  
5 in the amount determined under subsection (b). This sub-  
6 section constitutes budget authority in advance of appro-  
7 priations Acts, and represents the obligation of the Fed-  
8 eral Government to make payments to such programs in  
9 accordance with this subtitle. No payment shall be made  
10 under this subsection for a month before July 1995.

11 (b) PAYMENT AMOUNT.—

12 (1) IN GENERAL.—Subject to subsection (e),  
13 the amount of payment made to an approved medi-  
14 cal residency training program or a physician re-  
15 training program for each approved entry position  
16 for a full-time equivalent resident, shall be equal to  
17 the applicable percentage (as defined in paragraph  
18 (3)) of the base per resident amount established by  
19 the Commission for the year under paragraph (2)  
20 for that resident.

21 (2) BASE PER RESIDENT AMOUNT.—The Com-  
22 mission shall establish a base per resident amount  
23 for each year (beginning with 1995) that reflects an  
24 appropriate measure of the salary and benefits paid  
25 to residents in medical residency training programs

1 during the year. The Commission may vary such  
2 amount for residents to take into account—

3 (A) increases provided in the salaries and  
4 benefits of residents on the basis of the length  
5 of service in the program; and

6 (B) the relative wages and other costs of  
7 goods and services among the various geo-  
8 graphic areas in which such programs are oper-  
9 ated.

10 (3) APPLICABLE PERCENTAGE DEFINED.—In  
11 paragraph (1), the “applicable percentage” with re-  
12 spect to a resident is equal to—

13 (A) 175 percent, in the case of a primary  
14 care resident; and

15 (B) 150 percent, in the case of a resident  
16 who is not a primary care resident.

17 (c) LIMIT ON LENGTH OF SERVICE OF RESIDENT.—

18 (1) IN GENERAL.—No payment shall be made  
19 under subsection (a) for any resident who has com-  
20 pleted 4 years of medical residency training in any  
21 program.

22 (2) EXCEPTION.—Paragraph (1) shall not  
23 apply to a resident enrolled in a physician retraining  
24 program described in subsection (d)(1).

1 (d) FUNDING OF PHYSICIAN RETRAINING PRO-  
2 GRAMS.—

3 (1) PROGRAM DESCRIBED.—A physician re-  
4 training program described in this paragraph is a  
5 program that—

6 (A) provides training over a period of not  
7 to exceed 2 years for primary care residents for  
8 physicians who have completed training in a  
9 medical residency training program (other than  
10 as a primary care resident); and

11 (B) meets such other requirements as the  
12 Commission (in consultation with the Accredita-  
13 tion Council for Graduate Medical Education)  
14 may impose.

15 (2) FUNDING FOR PILOT PROGRAMS.—The  
16 Health Care Standards Commission shall make pay-  
17 ments from the Fund to assist the development of  
18 physician retraining programs described in para-  
19 graph (1).

20 (e) LIMIT ON EXPENDITURES FOR PROGRAMS.—The  
21 amounts otherwise payable under this section shall be re-  
22 duced, in a pro rata manner, to the extent necessary to  
23 assure that the total amount expended by the Health Care  
24 Standards Commission during a year for payments under  
25 this section do not exceed the Commission's estimate of

1 the amount of funds available for expenditure from the  
2 Fund in the year.

3 **SEC. 3004. FINANCING.**

4 (a) ASSESSMENT AGAINST PREMIUMS OF ACCOUNT-  
5 ABLE HEALTH PLANS.—For requirement of payment by  
6 accountable health plans to the National Medical Edu-  
7 cation Fund of 1 percent of gross premium receipts, see  
8 section 1211.

9 (b) PAYMENTS FROM MEDICARE.—Title XVIII of  
10 the Social Security Act (42 U.S.C. 1395 et seq.) is amend-  
11 ed by inserting after section 1889 the following new  
12 section:

13 “PAYMENTS TO NATIONAL MEDICAL EDUCATION FUND  
14 “SEC. 1890. (a) ANNUAL PAYMENT REQUIRED.—  
15 For each month (beginning with July 1995), the Secretary  
16 shall make a payment to the National Medical Education  
17 Fund established under section 3005 of the Managed  
18 Competition Act of 1993 in an amount that is equal, for  
19 a month in a fiscal year, to  $\frac{1}{12}$  of 1 percent of the Sec-  
20 retary’s estimate of the total expenditures made by the  
21 Secretary under this title during the preceding fiscal year,  
22 adjusted to the extent of any overpayment or  
23 underpayment which the Secretary determines was made  
24 under this section for any prior fiscal year and with re-  
25 spect to which adjustment has not already been made  
26 under this subsection.

1       “(b) ALLOCATION AMONG TRUST FUNDS.—The Sec-  
2       retary shall provide for an allocation of the payment made  
3       under subsection (a) between the Federal Hospital Insur-  
4       ance Trust Fund and the Federal Supplementary Medical  
5       Insurance Trust Fund in a proportion that reasonably re-  
6       flects the proportion of medical education costs of hos-  
7       pitals for which payment was made under this title for  
8       cost reporting periods during fiscal year 1993 that are as-  
9       sociated with the provision of services under part A and  
10      part B.”.

11      **SEC. 3005. NATIONAL MEDICAL EDUCATION FUND.**

12       (a) ESTABLISHMENT.—There is hereby established in  
13      the Treasury of the United States a fund to be known  
14      as the “National Medical Education Fund”, which shall  
15      consist of—

16              (1) amounts paid into the Fund by (or on be-  
17              half of) accountable health plans pursuant to section  
18              1211;

19              (2) amounts paid into the Fund by the Sec-  
20              retary of Health and Human Services under section  
21              1890 of the Social Security Act (as added by section  
22              3004(b)); and

23              (3) such other amounts that may otherwise be  
24              deposited in or appropriated to the Fund.

1 (b) USE OF AMOUNTS IN FUND.—Amounts in the  
2 Fund shall be used by the Health Care Standards Com-  
3 mission to make payments to medical residency training  
4 programs and physician retraining programs under sec-  
5 tion 3003(b).

6 (c) MANAGEMENT OF FUND.—

7 (1) IN GENERAL; REPORTS ON OPERATION.—

8 The Secretary of the Treasury shall, in consultation  
9 with the Health Care Standards Commission, man-  
10 age the Fund, and shall report to Congress each  
11 year on the financial condition and the results of the  
12 operation of the Fund during the preceding year and  
13 on the expected condition and operations of the  
14 Fund during the next 5 years.

15 (2) INVESTMENT.—The Secretary of the Treas-  
16 ury shall invest the portion of the Fund that is not,  
17 in the judgment of the Secretary and of the Health  
18 Care Standards Commission, required to meet cur-  
19 rent withdrawals. Any investments of monies in the  
20 Fund may be made only in interest-bearing obliga-  
21 tions of the United States.

22 **SEC. 3006. REPEAL OF SEPARATE MEDICAL EDUCATION**  
23 **PAYMENTS UNDER MEDICARE.**

24 (a) PROHIBITING RECOGNITION OF MEDICAL EDU-  
25 CATION COSTS UNDER PART B.—Section 1861(v)(1) of



1 the Social Security Act (42 U.S.C. 1395x(v)(1)) is amend-  
2 ed by adding at the end the following new subparagraph:

3 “(T) In determining such reasonable costs, the Sec-  
4 retary may not include any costs incurred by a provider  
5 for graduate medical education.”.

6 (b) REPEAL OF ADJUSTMENT FOR INDIRECT MEDI-  
7 CAL EDUCATION COSTS.—Section 1886(d)(5) of such Act  
8 (42 U.S.C. 1395ww(d)(5)) is amended by striking sub-  
9 paragraph (B).

10 (c) REPEAL OF PAYMENTS FOR DIRECT GRADUATE  
11 MEDICAL EDUCATION COSTS.—Section 1886 of such Act  
12 (42 U.S.C. 1395ww) is amended by striking subsection (h)  
13 and redesignating subsection (i) as subsection (h).

14 (d) CONFORMING AMENDMENTS.—Section 1886(d)  
15 of such Act (42 U.S.C. 1395ww(d)) is amended—

16 (1) in paragraph (3)(C)(ii)—

17 (A) by inserting “and before October 1,  
18 1994,” after “September 30, 1986,”; and

19 (B) by inserting “and on or before Sep-  
20 tember 30, 1994,” after “October 1, 1986,”;  
21 and

22 (2) in paragraph (9)(D), by striking clause (ii)  
23 and redesignating clauses (iii) and (iv) as clauses (ii)  
24 and (iii).

25 (e) EFFECTIVE DATES.—

1           (1) REASONABLE COSTS.—The amendment  
2           made by subsection (a) shall apply to costs incurred  
3           on or after July 1, 1995.

4           (2) INDIRECT MEDICAL EDUCATION ADJUST-  
5           MENT.—The amendments made by subsections (b)  
6           and (d) shall apply to discharges occurring on or  
7           after July 1, 1995.

8           (3) DIRECT MEDICAL EDUCATION.—The  
9           amendment made by subsection (c) shall apply to  
10          portions of cost reporting periods beginning on or  
11          after July 1, 1995.

12                   **Subtitle B—Other Medical**  
13           **Education Grants and Programs**

14   **SEC. 3101. SCHOLARSHIP AND LOAN REPAYMENT PRO-**  
15                   **GRAMS OF NATIONAL HEALTH SERVICE**  
16                   **CORPS.**

17          Section 338H(b)(1) of the Public Health Service Act  
18   (42 U.S.C. 254q(b)(1)) is amended—

19           (1) by striking “and” after “1991,”; and

20           (2) by striking “through 2000.” and inserting  
21          “through 1994, \$150,000,000 for fiscal year 1995,  
22          \$175,000,000 for fiscal year 1996, \$200,000,000 for  
23          fiscal year 1997, \$225,000,000 for fiscal year 1998,  
24          and \$250,000,000 for fiscal year 1999.”.

1 **SEC. 3102. AREA HEALTH EDUCATION CENTERS.**

2 Section 746(i)(1)(A) of the Public Health Service Act  
3 (42 U.S.C. 293j(i)(1)(A)) is amended by striking  
4 “through 1995” and inserting “through 1994 and  
5 \$30,000,000 for each of the fiscal years 1995 through  
6 1999”.

7 **SEC. 3103. PUBLIC HEALTH AND PREVENTIVE MEDICINE.**

8 Section 765(a) of the Public Health Service Act (42  
9 U.S.C. 294c(a)) is amended by striking “through 1995”  
10 and inserting “through 1999”.

11 **SEC. 3104. FAMILY MEDICINE.**

12 Section 747(d)(1) of the Public Health Service Act  
13 (42 U.S.C. 293k(d)(1)) is amended by striking “through  
14 1995” and inserting “through 1999”.

15 **SEC. 3105. GENERAL INTERNAL MEDICINE AND PEDIAT-**  
16 **RICS.**

17 Section 748(c) of the Public Health Service Act (42  
18 U.S.C. 293l(c)) is amended by striking “through 1995”  
19 and inserting “through 1999”.

20 **SEC. 3106. PHYSICIAN ASSISTANTS.**

21 Section 750(d)(1) of the Public Health Service Act  
22 (42 U.S.C. 293n(d)(1)) is amended by striking “through  
23 1995” and inserting “through 1999”.

1 **SEC. 3107. ALLIED HEALTH PROJECT GRANTS AND CON-**  
2 **TRACTS.**

3 Section 767(d) of the Public Health Service Act (42  
4 U.S.C. 294e(d)) is amended by striking “through 1995”  
5 and inserting “through 1999”.

6 **SEC. 3108. NURSE ALLIED HEALTH PROJECT GRANTS AND**  
7 **CONTRACTS.**

8 Section 767(d) of the Public Health Service Act (42  
9 U.S.C. 294e(d)) is amended by striking “through 1995”  
10 and inserting “through 1999”.

11 **SEC. 3109. NURSE PRACTITIONER AND NURSE MIDWIFE**  
12 **PROGRAMS.**

13 Section 822(d) of the Public Health Service Act (42  
14 U.S.C. 296m(d)) is amended by striking “and 1994” and  
15 inserting “through 1999”.

16 **SEC. 3110. USE OF HEALTH CARE POLICY AND RESEARCH**  
17 **FUNDS FOR PRIMARY CARE.**

18 Section 926 of the Public Health Service Act (42  
19 U.S.C. 299c-5), as amended by section 10 of Public Law  
20 102-410 (106 Stat. 2101), is amended by adding at the  
21 end the following subsection:

22 “(f) ALLOCATION REGARDING PRIMARY CARE.—Of  
23 the amounts made available for a fiscal year for carrying  
24 out this title, the Secretary shall obligate not less than  
25 15 percent for carrying out section 902 with respect to  
26 primary care.”.

1 **TITLE IV—PREVENTIVE HEALTH**  
2 **AND INDIVIDUAL RESPON-**  
3 **SIBILITY**

4 **Subtitle A—Expansion of Public**  
5 **Health Programs**

6 **SEC. 4001. IMMUNIZATIONS AGAINST VACCINE-PREVENT-**  
7 **ABLE DISEASES.**

8 Section 317(j)(1)(A) of the Public Health Service Act  
9 (42 U.S.C. 247b(j)(1)(A)) is amended by striking  
10 “through 1995” and inserting “through 1999”.

11 **SEC. 4002. PREVENTION, CONTROL, AND ELIMINATION OF**  
12 **TUBERCULOSIS.**

13 Section 317(j)(2) of the Public Health Service Act  
14 (42 U.S.C. 247b(j)(2)) is amended by striking “through  
15 1995” and inserting “through 1999”.

16 **SEC. 4003. LEAD POISONING PREVENTION.—**

17 Section 317A(l)(1) of the Public Health Service Act  
18 (42 U.S.C. 247b–1(l)(1)) is amended by striking “through  
19 1997” and inserting “through 1999”.

20 **SEC. 4004. PREVENTIVE HEALTH MEASURES WITH RE-**  
21 **SPECT TO BREAST AND CERVICAL CANCERS.**

22 Section 1509(a) of the Public Health Service Act (42  
23 U.S.C. 300n–5(a)) is amended—

24 (1) by striking “and” after “1991,” and

1           (2) by striking “1993.” and inserting “1993,  
2       \$100,000,000 for each of the fiscal years 1994  
3       through 1996, and such sums as may be necessary  
4       for each of the fiscal years 1997 through 1999.”.

5   **SEC. 4005. OFFICE OF DISEASE PREVENTION AND HEALTH**  
6                           **PROMOTION.**

7       (a) IN GENERAL.—Section 1701(b) of the Public  
8   Health Service Act (42 U.S.C. 300u(b)) is amended by  
9   striking “through 1996” and inserting “through 1999”.

10      (b) PROMOTION OF INDIVIDUAL RESPONSIBILITY.—  
11   Section 1701(a)(11) of such Act (42 U.S.C. 300u(a)(11))  
12   is amended—

13           (1) by striking “and” at the end of subpara-  
14   graph (C),

15           (2) by redesignating subparagraph (D) as sub-  
16   paragraph (E), and

17           (3) by inserting after subparagraph (C) the fol-  
18   lowing new subparagraph:

19                   “(D) promote individual responsibility in  
20           personal health care and in the use of valuable  
21           health care resources; and”.

22      (c) MINORITY HEALTH.—Section 1707(f) of such Act  
23   (42 U.S.C. 300u–6(f)) is amended by striking “1993.”  
24   and inserting “1993, \$35,000,000 for each of the fiscal

1 years 1994 through 1996, and such sums as may be nec-  
2 essary for each of the fiscal years 1997 through 1999.”.

3 **SEC. 4006. PREVENTIVE HEALTH AND HEALTH SERVICES**  
4 **BLOCK GRANT.**

5 Section 1901(a) of the Public Health Service Act (42  
6 U.S.C. 300w(a)) is amended by striking “through 1997”  
7 and inserting “through 1999”.

8 **SEC. 4007. CATEGORICAL GRANTS FOR EARLY INTERVEN-**  
9 **TION REGARDING ACQUIRED IMMUNE DEFICIENCY SYNDROME.**  
10

11 Section 2655 of the Public Health Service Act (42  
12 U.S.C. 300ff-55) is amended by striking “through 1995”  
13 and inserting “through 1999”.

14 **SEC. 4008. PROGRAMS OF OFFICE OF SMOKING AND**  
15 **HEALTH.**

16 In addition to any other authorization of appropria-  
17 tions that is available for programs of the Centers for Dis-  
18 ease Control regarding the smoking of tobacco products,  
19 there is authorized to be appropriated for such programs  
20 \$10,000,000 for each of the fiscal years 1995 through  
21 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.



1           “(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B),  
2           no payment may be made under this part for  
3           a screening fecal-occult blood test provided to  
4           an individual for the purpose of early detection  
5           of colon cancer—

7                   “(i) if the individual is under 50 years  
8                   of age; or

9                   “(ii) if the test is performed within  
10                  the 11 months after a previous screening  
11                  fecal-occult blood test.

12           “(2) SCREENING FLEXIBLE SIGMOIDOS-  
13           COPIES.—

14           “(A) PAYMENT AMOUNT.—The Secretary  
15           shall establish a payment amount under section  
16           1848 with respect to screening flexible  
17           sigmoidoscopies provided for the purpose of  
18           early detection of colon cancer that is consistent  
19           with payment amounts under such section for  
20           similar or related services, except that such  
21           payment amount shall be established without  
22           regard to subsection (a)(2)(A) of such section.

23           “(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B),  
24           no payment may be made under this part for  
25

1 a screening flexible sigmoidoscopy provided to  
2 an individual for the purpose of early detection  
3 of colon cancer—

4 “(i) if the individual is under 50 years  
5 of age; or

6 “(ii) if the procedure is performed  
7 within the 59 months after a previous  
8 screening flexible sigmoidoscopy.

9 “(3) REDUCTIONS IN PAYMENT LIMIT AND RE-  
10 VISION OF FREQUENCY.—

11 “(A) REDUCTIONS IN PAYMENT LIMIT.—

12 The Secretary shall review from time to time  
13 the appropriateness of the amount of the pay-  
14 ment limit established for screening fecal-occult  
15 blood tests under paragraph (1)(A). The Sec-  
16 retary may, with respect to tests performed in  
17 a year after 1997, reduce the amount of such  
18 limit as it applies nationally or in any area to  
19 the amount that the Secretary estimates is re-  
20 quired to assure that such tests of an appro-  
21 priate quality are readily and conveniently  
22 available during the year.

23 “(B) REVISION OF FREQUENCY.—

24 “(i) REVIEW.—The Secretary, in con-  
25 sultation with the Director of the National

1 Cancer Institute, shall review periodically  
2 the appropriate frequency for performing  
3 screening fecal-occult blood tests and  
4 screening flexible sigmoidoscopies based on  
5 age and such other factors as the Sec-  
6 retary believes to be pertinent.

7 “(ii) REVISION OF FREQUENCY.—The  
8 Secretary, taking into consideration the re-  
9 view made under clause (i), may revise  
10 from time to time the frequency with  
11 which such tests and procedures may be  
12 paid for under this subsection, but no such  
13 revision shall apply to tests or procedures  
14 performed before January 1, 1998.

15 “(4) LIMITING CHARGES OF NONPARTICIPATING  
16 PHYSICIANS.—

17 “(A) IN GENERAL.—In the case of a  
18 screening flexible sigmoidoscopy provided to an  
19 individual for the purpose of early detection of  
20 colon cancer for which payment may be made  
21 under this part, if a nonparticipating physician  
22 provides the procedure to an individual enrolled  
23 under this part, the physician may not charge  
24 the individual more than the limiting charge (as

1 defined in subparagraph (B), or, if less, as de-  
2 fined in section 1848(g)(2)).

3 “(B) LIMITING CHARGE DEFINED.—In  
4 subparagraph (A), the term ‘limiting charge’  
5 means 115 percent of the payment limit estab-  
6 lished under paragraph (2)(A).

7 “(C) ENFORCEMENT.—If a physician or  
8 supplier knowing and willfully imposes a charge  
9 in violation of subparagraph (A), the Secretary  
10 may apply sanctions against such physician or  
11 supplier in accordance with section  
12 1842(j)(2).”.

13 (b) CONFORMING AMENDMENTS.—(1) Paragraphs  
14 (1)(D) and (2)(D) of section 1833(a) of such Act (42  
15 U.S.C. 1395l(a)) are each amended by striking “sub-  
16 section (h)(1),” and inserting “subsection (h)(1) or section  
17 1834(d)(1),”.

18 (2) Section 1833(h)(1)(A) of such Act (42 U.S.C.  
19 1395l(h)(1)(A)) is amended by striking “The Secretary”  
20 and inserting “Subject to paragraphs (1) and (3)(A) of  
21 section 1834(d), the Secretary”.

22 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) of  
23 such Act (42 U.S.C. 1395w-4(a)(2)(A)) are each amended  
24 by striking “a service” and inserting “a service (other  
25 than a screening flexible sigmoidoscopy provided to an in-

1 dividual for the purpose of early detection of colon can-  
2 cer)’’.

3 (4) Section 1862(a) of such Act (42 U.S.C. 1395y(a))  
4 is amended—

5 (A) in paragraph (1)—

6 (i) in subparagraph (E), by striking “and”  
7 at the end,

8 (ii) in subparagraph (F), by striking the  
9 semicolon at the end and inserting “, and”, and

10 (iii) by adding at the end the following new  
11 subparagraph:

12 “(G) in the case of screening fecal-occult blood  
13 tests and screening flexible sigmoidoscopies provided  
14 for the purpose of early detection of colon cancer,  
15 which are performed more frequently than is covered  
16 under section 1834(d);”; and

17 (B) in paragraph (7), by striking “paragraph  
18 (1)(B) or under paragraph (1)(F)” and inserting  
19 “subparagraphs (B), (F), or (G) of paragraph (1)”.

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to screening fecal-occult blood tests  
22 and screening flexible sigmoidoscopies performed on or  
23 after January 1, 1995.

1 **SEC. 4102. COVERAGE OF CERTAIN IMMUNIZATIONS.**

2 (a) IN GENERAL.—Section 1861(s)(10) of the Social  
3 Security Act (42 U.S.C. 1395x(s)(10)) is amended—

4 (1) in subparagraph (A)—

5 (A) by striking “, subject to section  
6 4071(b) of the Omnibus Budget Reconciliation  
7 Act of 1987,” and

8 (B) by striking “; and” and inserting a  
9 comma;

10 (2) in subparagraph (B), by striking the semi-  
11 colon at the end and inserting “, and”; and

12 (3) by adding at the end the following new sub-  
13 paragraph:

14 “(C) tetanus-diphtheria booster and its admin-  
15 istration;”.

16 (b) LIMITATION ON FREQUENCY.—Section  
17 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as  
18 amended by section 4101(b)(4)(A) of this Act, is amend-  
19 ed—

20 (1) in subparagraph (F), by striking “and” at  
21 the end;

22 (2) in subparagraph (G), by striking the semi-  
23 colon at the end and inserting “, and”; and

24 (3) by adding at the end the following new sub-  
25 paragraph:

1           “(H) in the case of an influenza vaccine, which  
2           is administered within the 11 months after a pre-  
3           vious influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within  
4           the 119 months after a previous tetanus-diphtheria  
5           booster;”.

6           (c) CONFORMING AMENDMENT.—Section 1862(a)(7)  
7           of such Act (42 U.S.C. 1395y(a)(7)), as amended by sec-  
8           tion 4101(b)(4)(B) of this Act, is amended by striking “or  
9           (G)” and inserting “(G), or (H)”.

10          (d) EFFECTIVE DATE.—The amendments made by  
11          this section shall apply to influenza vaccines and tetanus-  
12          diphtheria boosters administered on or after January 1,  
13          1995.

14          **SEC. 4103. COVERAGE OF WELL-CHILD CARE.**

15          (a) IN GENERAL.—Section 1861(s)(2) of the Social  
16          Security Act (42 U.S.C. 1395x(s)(2)), as amended by sec-  
17          tion 13553(a) of the Omnibus Budget Reconciliation Act  
18          of 1993, is amended—

19                (1) by striking “and” at the end of subpara-  
20                graph (P);

21                (2) by striking the semicolon at the end of sub-  
22                paragraph (Q) and inserting “; and”; and

23                (3) by adding at the end the following new sub-  
24                paragraph:  
25

1           “(R) well-child services (as defined in sub-  
2       section (ll)(1)) provided to an individual entitled to  
3       benefits under this title who is under 7 years of  
4       age;”.

5       (b) SERVICES DEFINED.—Section 1861 of such Act  
6       (42 U.S.C. 1395x) is amended—

7           (1) by redesignating the subsection (jj) added  
8       by section 4156(a)(2) of the Omnibus Budget Rec-  
9       onciliation Act of 1990 as subsection (kk); and

10          (2) by inserting after subsection (kk) (as so re-  
11       designated) the following new subsection:

12                       “Well-Child Services

13       “(ll)(1) The term ‘well-child services’ means well-  
14       child care, including routine office visits, routine immuni-  
15       zations (including the vaccine itself), routine laboratory  
16       tests, and preventive dental care, provided in accordance  
17       with the periodicity schedule established with respect to  
18       the services under paragraph (2).

19       “(2) The Secretary, in consultation with the Amer-  
20       ican Academy of Pediatrics, the Advisory Committee on  
21       Immunization Practices, and other entities considered ap-  
22       propriate by the Secretary, shall establish a schedule of  
23       periodicity which reflects the appropriate frequency with  
24       which the services referred to in paragraph (1) should be  
25       provided to healthy children.”.



1 (c) CONFORMING AMENDMENTS.—(1) Section  
2 1861(s)(2)(O) of such Act (42 U.S.C. 1395x(s)(2)(O)) is  
3 amended by striking “subsection (jj)” and inserting “sub-  
4 section (kk)”.

5 (2) Section 1862(a)(1) of such Act (42 U.S.C.  
6 1395y(a)(1)), as amended by sections 4101(b)(4)(A) and  
7 4102(b) of this Act, is amended—

8 (A) in subparagraph (G), by striking “and” at  
9 the end;

10 (B) in subparagraph (H), by striking the semi-  
11 colon at the end and inserting “, and”; and

12 (C) by adding at the end the following new sub-  
13 paragraph:

14 “(I) in the case of well-child services, which are  
15 provided more frequently than is provided under the  
16 schedule of periodicity established by the Secretary  
17 under section 1861(ll)(2) for such services;”.

18 (3) Section 1862(a)(7) of such Act (42 U.S.C.  
19 1395y(a)(7)), as amended by sections 4101(b)(4)(B) and  
20 4102(c) of this Act, is amended by striking “or (H)” and  
21 inserting “(H), or (I)”.

22 (d) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to well-child services provided on  
24 or after January 1, 1995.

1 **SEC. 4104. ANNUAL SCREENING MAMMOGRAPHY.**

2 (a) ANNUAL SCREENING MAMMOGRAPHY FOR  
3 WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the So-  
4 cial Security Act (42 U.S.C. 1395m(b)(2)(A)) is amend-  
5 ed—

6 (1) in clause (iv), by striking “but under 65  
7 years of age,”, and

8 (2) by striking clause (v).

9 (b) EFFECTIVE DATE.—The amendments made by  
10 subsection (a) shall apply to screening mammography per-  
11 formed on or after January 1, 1995.

12 **SEC. 4105. FINANCING OF ADDITIONAL BENEFITS.**

13 (a) PREMIUM FOR 1995.—Section 1839(e)(1)(B)(v)  
14 of the Social Security Act (42 U.S.C. 1395r(e)(1)(B)(v))  
15 is amended by striking “\$46.10” and inserting “\$47.50”.

16 (b) PREMIUMS FOR 1996–1998.—(1) Section 1839 of  
17 such Act (42 U.S.C. 1395r) is amended by adding at the  
18 end the following new subsection:

19 “(g) Except as provided in subsections (b) and (f),  
20 the monthly premium otherwise determined, without re-  
21 gard to this subsection, for each individual enrolled under  
22 this part shall be increased by \$1.40 for each month in  
23 1996, 1997, and 1998.”.

24 (2) Section 1839 of such Act (42 U.S.C. 1395r) is  
25 amended—

1 (A) in subsection (a)(2), by striking “(b) and  
2 (e)” and inserting “(b), (e), and (g)”,

3 (B) in subsection (a)(3), by striking “subsection  
4 (e)” and inserting “subsections (e) and (g)”, and

5 (C) in subsection (b), by striking “determined  
6 under subsection (a) or (e)” and inserting “other-  
7 wise determined under this section (without regard  
8 to subsection (f))”.

9 **PART 2—NOTICE OF ADVANCE DIRECTIVE**

10 **RIGHTS**

11 **SEC. 4111. PROVIDING NOTICE OF RIGHTS REGARDING**  
12 **MEDICAL CARE TO INDIVIDUALS ENTERING**  
13 **MEDICARE.**

14 (a) IN GENERAL.—Section 1804 of the Social Secu-  
15 rity Act (42 U.S.C. 1395b–2) is amended—

16 (1) in paragraph (2), by striking “and” at the  
17 end;

18 (2) in paragraph (3), by striking the period at  
19 the end and inserting “, and”; and

20 (3) by inserting after paragraph (3) the follow-  
21 ing new paragraph:

22 “(4) a description of an individual’s rights  
23 under State law to make decisions concerning medi-  
24 cal care, including the right to accept or refuse med-  
25 ical or surgical treatment and the right to formulate

1 advance directives (as defined in section  
2 1866(f)(3)).”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall apply to notices provided under section  
5 1804 of the Social Security Act on or after January 1  
6 of the first year beginning after the date of the enactment  
7 of this Act.

## 8 **TITLE V—MALPRACTICE** 9 **REFORM**

### 10 **Subtitle A—Findings; Purpose;** 11 **Definitions**

#### 12 **SEC. 5001. FINDINGS; PURPOSE.**

13 (a) FINDINGS.—Congress finds that—

14 (1) the health care and insurance industries are  
15 industries affecting interstate commerce and the  
16 medical malpractice litigation systems existing  
17 throughout the United States affect interstate com-  
18 merce by contributing to the high cost of health care  
19 and premiums for malpractice insurance purchased  
20 by health care providers; and

21 (2) the Federal Government has a major inter-  
22 est in health care as a direct provider of health care  
23 and as a source of payment for health care, and has  
24 a demonstrated interest in assessing the quality of

1 care, access to care, and the costs of care through  
2 the evaluative activities of several Federal agencies.

3 (b) PURPOSE.—It is the purpose of this title to—

4 (1) provide grants to States to develop alter-  
5 native dispute resolution procedures to attain a more  
6 efficient, expeditious, and equitable resolution of  
7 health care malpractice disputes;

8 (2) enhance general knowledge concerning the  
9 benefits of different forms of alternative dispute res-  
10 olution mechanisms; and

11 (3) establish uniformity and curb excesses in  
12 the State-based medical liability systems through  
13 Federally-mandated reforms.

14 **SEC. 5002. DEFINITIONS.**

15 As used in this title:

16 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
17 TEM.—The term “alternative dispute resolution sys-  
18 tem” means a system that is enacted or adopted by  
19 a State to resolve medical malpractice claims other  
20 than through a medical malpractice liability action.

21 (2) CLAIMANT.—The term “claimant” means  
22 any person who brings a health care liability action  
23 and, in the case of an individual who is deceased, in-  
24 competent, or a minor, the person on whose behalf  
25 such an action is brought.

1           (3) CLEAR AND CONVINCING EVIDENCE.—The  
2       term “clear and convincing evidence” is that meas-  
3       ure or degree of proof that will produce in the mind  
4       of the trier of fact a firm belief or conviction as to  
5       the truth of the allegations sought to be established,  
6       except that such measure or degree of proof is more  
7       than that required under preponderance of the evi-  
8       dence, but less than that required for proof beyond  
9       a reasonable doubt.

10          (4) ECONOMIC DAMAGES.—The term “economic  
11       damages” means damages paid to compensate an in-  
12       dividual for losses for hospital and other medical ex-  
13       penses, lost wages, lost employment, and other pecu-  
14       niary losses.

15          (5) HEALTH CARE PROFESSIONAL.—The term  
16       “health care professional” means any individual who  
17       provides health care services in a State and who is  
18       required by State law or regulation to be licensed or  
19       certified by the State to provide such services in the  
20       State.

21          (6) HEALTH CARE PROVIDER.—The term  
22       “health care provider” means any organization or  
23       institution that is engaged in the delivery of health  
24       care services in a State that is required by State law  
25       or regulation to be licensed or certified by the State

1 to engage in the delivery of such services in the  
2 State.

3 (7) INJURY.—The term “injury” means any ill-  
4 ness, disease, or other harm that is the subject of  
5 a medical malpractice claim.

6 (8) MEDICAL MALPRACTICE LIABILITY AC-  
7 TION.—The term “medical malpractice liability ac-  
8 tion” means any civil action brought pursuant to  
9 State law in which a plaintiff alleges a medical mal-  
10 practice claim against a health care provider or  
11 health care professional, but does not include any  
12 action in which the plaintiff’s sole allegation is an al-  
13 legation of an intentional tort.

14 (9) MEDICAL MALPRACTICE CLAIM.—The term  
15 “medical malpractice claim” means any claim relat-  
16 ing to the provision of (or the failure to provide)  
17 health care services or the use of a medical product,  
18 without regard to the theory of liability asserted,  
19 and includes any third-party claim, cross-claim,  
20 counterclaim, or contribution claim in a medical  
21 malpractice liability action.

22 (10) MEDICAL PRODUCT.—

23 (A) IN GENERAL.—The term “medical  
24 product” means, with respect to the allegation  
25 of a claimant, a drug (as defined in section

1           201(g)(1) of the Federal Food, Drug, and Cos-  
2           metic Act (21 U.S.C. 321(g)(1)) or a medical  
3           device (as defined in section 201(h) of the Fed-  
4           eral Food, Drug, and Cosmetic Act (21 U.S.C.  
5           321(h)) if—

6                   (i) such drug or device was subject to  
7                   premarket approval under section 505,  
8                   507, or 515 of the Federal Food, Drug,  
9                   and Cosmetic Act (21 U.S.C. 355, 357, or  
10                  360e) or section 351 of the Public Health  
11                  Service Act (42 U.S.C. 262) with respect  
12                  to the safety of the formulation or per-  
13                  formance of the aspect of such drug or de-  
14                  vice which is the subject of the claimant's  
15                  allegation or the adequacy of the packag-  
16                  ing or labeling of such drug or device, and  
17                  such drug or device is approved by the  
18                  Food and Drug Administration; or

19                  (ii) the drug or device is generally rec-  
20                  ognized as safe and effective under regula-  
21                  tions issued by the Secretary of Health  
22                  and Human Services under section 201(p)  
23                  of the Federal Food, Drug, and Cosmetic  
24                  Act (21 U.S.C. 321(p)).



1 (B) EXCEPTION IN CASE OF MISREPRE-  
2 SENTATION OR FRAUD.—Notwithstanding sub-  
3 paragraph (A), the term “medical product”  
4 shall not include any product described in such  
5 subparagraph if the claimant shows that the  
6 product is approved by the Food and Drug Ad-  
7 ministration for marketing as a result of with-  
8 held information, misrepresentation, or an ille-  
9 gal payment by manufacturer of the product.

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

18 (12) PUNITIVE DAMAGES.—The term “punitive  
19 damages” means compensation, in addition to com-  
20 pensation for actual harm suffered, that is awarded  
21 for the purpose of punishing a person for conduct  
22 deemed to be malicious, wanton, willful, or exces-  
23 sively reckless.

24 (13) SECRETARY.—The term “Secretary”  
25 means the Secretary of Health and Human Services.

1           (14) STATE.—The term “State” means each of  
2       the several States, the District of Columbia, the  
3       Commonwealth of Puerto Rico, the Virgin Islands,  
4       and Guam.

5       **Subtitle B—Uniform Standards for**  
6           **Malpractice Claims**

7       **SEC. 5101. APPLICABILITY.**

8       Except as provided in section 5111, this subtitle shall  
9       apply to any medical malpractice liability action brought  
10      in a Federal or State court, and to any medical mal-  
11      practice claim subject to an alternative dispute resolution  
12      system, that is initiated on or after January 1, 1995.

13      **SEC. 5102. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**  
14                   **TION THROUGH ALTERNATIVE DISPUTE RES-**  
15                   **OLUTION.**

16      (a) IN GENERAL.—

17           (1) STATE CASES.—A medical malpractice li-  
18      ability action may not be brought in any State court  
19      during a calendar year unless the medical mal-  
20      practice liability claim that is the subject of the ac-  
21      tion has been initially resolved under an alternative  
22      dispute resolution system certified for the year by  
23      the Secretary under section 5202(a), or, in the case  
24      of a State in which such a system is not in effect

1 for the year, under the alternative Federal system  
2 established under section 5202(b).

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

12 (3) CLAIMS AGAINST UNITED STATES.—

13 (A) ESTABLISHMENT OF PROCESS FOR  
14 CLAIMS.—The Attorney General shall establish  
15 an alternative dispute resolution process for the  
16 resolution of tort claims consisting of medical  
17 malpractice liability claims brought against the  
18 United States under chapter 171 of title 28,  
19 United States Code. Under such process, the  
20 resolution of a claim shall occur after the com-  
21 pletion of the administrative claim process ap-  
22 plicable to the claim under section 2675 of such  
23 title.

24 (B) REQUIREMENT FOR INITIAL RESOLU-  
25 TION UNDER PROCESS.—A medical malpractice

1 liability action based on a medical malpractice  
2 liability claim described in subparagraph (A)  
3 may not be brought in any Federal court unless  
4 the claim has been initially resolved under the  
5 alternative dispute resolution process estab-  
6 lished by the Attorney General under such sub-  
7 paragraph.

8 (b) INITIAL RESOLUTION OF CLAIMS UNDER  
9 ADR.—For purposes of subsection (a), an action is “ini-  
10 tially resolved” under an alternative dispute resolution  
11 system if—

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

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

17 (c) PROCEDURES FOR FILING ACTIONS.—

18 (1) NOTICE OF INTENT TO CONTEST DECI-  
19 SION.—Not later than 60 days after a decision is is-  
20 sued with respect to a medical malpractice liability  
21 claim under an alternative dispute resolution system,  
22 each party affected by the decision shall submit a  
23 sealed statement to a court of competent jurisdiction  
24 indicating whether or not the party intends to con-  
25 test the decision.

1           (2) DEADLINE FOR FILING ACTION.—A medical  
2       malpractice liability action may not be brought by a  
3       party unless—

4           (A) the party has filed the notice of intent  
5       required by paragraph (1); and

6           (B) the party files the action in a court of  
7       competent jurisdiction not later than 90 days  
8       after the decision resolving the medical mal-  
9       practice liability claim that is the subject of the  
10      action is issued under the applicable alternative  
11      dispute resolution system.

12          (3) COURT OF COMPETENT JURISDICTION.—  
13      For purposes of this subsection, the term “court of  
14      competent jurisdiction” means—

15           (A) with respect to actions filed in a State  
16      court, the appropriate State trial court; and

17           (B) with respect to actions filed in a Fed-  
18      eral court, the appropriate United States dis-  
19      trict court.

20          (d) LEGAL EFFECT OF UNCONTESTED ADR DECI-  
21      SION.—The decision reached under an alternative dispute  
22      resolution system shall, for purposes of enforcement by a  
23      court of competent jurisdiction, have the same status in  
24      the court as the verdict of a medical malpractice liability  
25      action adjudicated in a State or Federal trial court. The

1 previous sentence shall not apply to a decision that is con-  
2 tested by a party affected by the decision pursuant to sub-  
3 section (c)(1).

4 **SEC. 5103. PROCEDURAL REQUIREMENTS FOR FILING OF**  
5 **ACTIONS.**

6 (a) CERTIFICATE OF MERIT.—

7 (1) IN GENERAL.—Each individual who files a  
8 medical malpractice liability action shall, not later  
9 than 90 days after filing the action—

10 (A) submit a certificate of merit described  
11 in subsection (b); or

12 (B) post a surety (or equivalent security)  
13 bond of \$4,000 (or, during the 45-day period  
14 that begins on the date the action is filed, a  
15 cost bond of \$2,000) with the court.

16 (2) EXTENSION OF DEADLINE.—On the motion  
17 of any party to the action or upon a written agree-  
18 ment of the parties filed with the court, the court  
19 may extend the deadline specified in paragraph (1)  
20 for a period not to exceed 30 days.

21 (3) DISMISSAL FOR FAILURE TO MEET RE-  
22 QUIREMENT.—If an individual filing a medical mal-  
23 practice liability action fails to meet the require-  
24 ments of paragraph (1)—

1 (A) the court shall dismiss the action with-  
2 out prejudice to the refiling of the action by the  
3 individual; and

4 (B) require the individual to pay any court  
5 costs incurred by the defendants as a result of  
6 the filing of the action.

7 (4) WAIVER FOR GOOD CAUSE.—The court may  
8 waive the application of paragraph (1) to a plaintiff  
9 if the plaintiff shows good cause that such para-  
10 graph should not apply.

11 (5) CERTIFICATE OF MERIT DESCRIBED.—In  
12 paragraph (1), a “certificate of merit” is, with re-  
13 spect to an individual filing a medical malpractice li-  
14 ability action, an affidavit declaring that the individ-  
15 ual (or the individual’s attorney) has obtained a  
16 written opinion from a medical expert who is knowl-  
17 edgeable of the relevant medical issues involved in  
18 the action that the defendant was negligent and the  
19 defendant’s conduct was a proximate cause of the al-  
20 leged injury that is the subject of the action.

21 (b) RESPONSE TO STANDARD INTERROGATORIES  
22 AND REQUESTS FOR DOCUMENTS.—

1           (1) DEADLINE.—Each party to a medical mal-  
2       practice liability action shall respond to the standard  
3       set of interrogatories and requests for production of  
4       documents developed pursuant to paragraph (4) as  
5       follows:

6           (A) In the case of a plaintiff, the party  
7       shall provide the defendant (or the defendant's  
8       attorney) with full and complete responses not  
9       later than 45 days after filing the action.

10          (B) In the case of a defendant, the party  
11       shall provide the plaintiff (or the plaintiff's at-  
12       torney) with full and complete responses not  
13       later than 45 days after receiving the plaintiff's  
14       responses under subparagraph (A).

15          (C) In the case of a party who is added to  
16       the action after the action is filed, the party  
17       shall provide all other parties (or such parties'  
18       attorneys) with full and complete responses not  
19       later than 45 days after the date of the filing  
20       of the pleading by which the party is added to  
21       the action.

22          (2) EXTENSION OF DEADLINE.—On the motion  
23       of any party to the action that is supported by good  
24       cause, or upon a written agreement of the parties  
25       filed with the court, the court shall extend the dead-



1 line specified in paragraph (1) for a period not to  
2 exceed 30 days.

3 (3) IMPOSITION OF SANCTIONS FOR FAILURE  
4 TO RESPOND.—If a party to a medical malpractice  
5 liability action fails to respond to the standard set  
6 of interrogatories and requests for production of  
7 documents as required under paragraph (1), the  
8 party shall be subject to sanctions by the court  
9 under any applicable laws, rules, and regulations  
10 governing the imposition of sanctions by the court.

11 (4) DEVELOPMENT OF STANDARD INTERROG-  
12 ATORIES AND REQUESTS.—

13 (A) APPOINTMENT OF EXPERT PANELS.—

14 The Governor of each State shall appoint a  
15 panel to develop the standard set of interro-  
16 gatories and requests for production of docu-  
17 ments that will be used for purposes of this  
18 subsection in the courts of the State. The set  
19 shall be comprehensive and designed to expedite  
20 the discovery process in the courts. The Attor-  
21 ney General shall appoint a panel to develop  
22 such set that will be used for purposes of this  
23 subsection in the Federal courts.

24 (B) COMPOSITION.—Each panel appointed  
25 pursuant to subparagraph (A) shall consist of

1 not less than 6 and not more than 12 members,  
2 of whom an equal number shall be attorneys  
3 who customarily represent plaintiffs in medical  
4 malpractice liability actions and attorneys who  
5 customarily represent defendants in such ac-  
6 tions.

7 (C) DEADLINES.—Not later than October  
8 1, 1994, each panel appointed pursuant to sub-  
9 paragraph (A) shall complete and publish the  
10 standard set of interrogatories and requests for  
11 production of documents.

12 **SEC. 5104. TREATMENT OF NONECONOMIC AND PUNITIVE**  
13 **DAMAGES.**

14 (a) LIMITATION ON NONECONOMIC DAMAGES.—The  
15 total amount of noneconomic damages that may be award-  
16 ed to a claimant and the members of the claimant's family  
17 for losses resulting from the injury which is the subject  
18 of a medical malpractice liability action may not exceed  
19 \$250,000, regardless of the number of parties against  
20 whom the action is brought or the number of actions  
21 brought with respect to the injury.

22 (b) NO AWARD OF PUNITIVE DAMAGES AGAINST  
23 MANUFACTURER OF MEDICAL PRODUCT.—In the case of  
24 a medical malpractice liability action in which the plaintiff  
25 alleges a claim against the manufacturer of a medical

1 product, no punitive or exemplary damages may be award-  
2 ed against such manufacturer.

3 (c) SEVERAL LIABILITY FOR NONECONOMIC DAM-  
4 AGES.—The liability of each defendant for noneconomic  
5 damages shall be several only and shall not be joint, and  
6 each defendant shall be liable only for the amount of non-  
7 economic damages allocated to the defendant in direct pro-  
8 portion to the defendant's percentage of responsibility (as  
9 determined by the trier of fact).

10 (d) ALLOCATION OF PUNITIVE DAMAGE AWARDS  
11 FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVI-  
12 TIES.—

13 (1) IN GENERAL.—The total amount of any pu-  
14 nitive damages awarded in a medical malpractice li-  
15 ability action shall be paid to the State in which the  
16 action is brought (or, in a case brought in Federal  
17 court, in the State in which the health care services  
18 that caused the injury that is the subject of the ac-  
19 tion were provided) for the purposes of carrying out  
20 the activities described in paragraph (2).

21 (2) ACTIVITIES DESCRIBED.—A State shall use  
22 amounts paid pursuant to paragraph (1) to carry  
23 out activities to assure the safety and quality of  
24 health care services provided in the State, including  
25 (but not limited to)—

1 (A) licensing or certifying health care pro-  
2 fessionals and health care providers in the  
3 State;

4 (B) implementing health care quality as-  
5 surance programs;

6 (C) carrying out public education programs  
7 to increase awareness of the availability of com-  
8 parative quality information on accountable  
9 health plans;

10 (D) carrying out programs to reduce mal-  
11 practice-related costs for providers volunteering  
12 to provide services in medically underserved  
13 areas; and

14 (E) implementing and operating a State  
15 alternative dispute resolution system certified  
16 by the Secretary under section 5202.

17 (3) MAINTENANCE OF EFFORT.—A State shall  
18 use any amounts paid pursuant to paragraph (1) to  
19 supplement and not to replace amounts spent by the  
20 State for the activities described in paragraph (2).

21 (e) DEVELOPMENT OF ALTERNATIVE LIMITS ON  
22 NONECONOMIC DAMAGES.—

23 (1) IN GENERAL.—Not later than 1 year after  
24 the date of the enactment of this Act, the Health  
25 Care Standards Commission shall develop and trans-

1 mit to Congress alternative limits on the amount of  
2 noneconomic damages that may be awarded with re-  
3 spect to medical malpractice liability claims, together  
4 with legislative specifications necessary to replace  
5 the limit imposed under subsection (a) on the  
6 amount of such damages with such alternative lim-  
7 its. The purpose of the development of the limits is  
8 to provide certainty and fairness in malpractice  
9 awards and to avoid unwarranted disparities among  
10 health care providers and health care professionals  
11 who have engaged in similar conduct.

12 (2) ESTABLISHMENT OF SEPARATE LIMITS FOR  
13 CATEGORIES OF INJURIES.—In developing limits  
14 under paragraph (1), the Commission shall establish  
15 separate limits for noneconomic damages resulting  
16 from each of the following categories of injuries:

- 17 (A) Non-physical injuries.
- 18 (B) Insignificant physical injuries.
- 19 (C) Temporary minor physical injuries.
- 20 (D) Temporary major physical injuries.
- 21 (E) Permanent minor physical injuries.
- 22 (F) Permanent substantial physical inju-  
23 ries.
- 24 (G) Permanent major physical injuries.
- 25 (H) Permanent grave physical injuries.

1 (I) Death.

2 (3) FACTORS CONSIDERED.—In developing lim-  
3 its under paragraph (1) for each of the categories  
4 described in paragraph (2), the Commission shall—

5 (A) examine the most recent available data  
6 on the amount of damages awarded with re-  
7 spect to such claims; and

8 (B) set specific limits that reasonably com-  
9 pensate most injured parties at the level of  
10 compensation currently provided, excluding  
11 those levels of compensation that the Commis-  
12 sion finds unreasonably large.

13 (4) CONSULTATION.—In developing limits  
14 under this subsection, the Commission shall consult  
15 with representatives of each of the following:

16 (A) Attorneys who represent plaintiffs in  
17 medical malpractice liability actions.

18 (B) Attorneys who represent health care  
19 professionals and health care providers in medi-  
20 cal malpractice liability actions.

21 (C) Physicians and other health care pro-  
22 fessionals and providers.

23 (D) Individuals who have suffered injury  
24 as a result of medical malpractice.

1 (E) Judges who preside over medical mal-  
2 practice liability actions.

3 (F) Medical ethicists.

4 (G) Health care economists.

5 (H) Liability insurers.

6 (5) GUIDANCE TO ENTITIES RESOLVING  
7 CLAIMS.—If Congress enacts legislation that imposes  
8 the limits developed by the Commission under this  
9 subsection on the amount of noneconomic damages  
10 that may be awarded with respect to medical mal-  
11 practice liability claims, the Commission shall pre-  
12 pare and disseminate guidelines to assist courts and  
13 other entities resolving such claims in the determina-  
14 tion of the particular category of injury specified in  
15 paragraph (2) to which a claimant's injury shall be  
16 assigned for purposes of applying the appropriate  
17 limit on such damages.

18 **SEC. 5105. PERIODIC PAYMENTS FOR FUTURE LOSSES.**

19 (a) IN GENERAL.—In any medical malpractice liabil-  
20 ity action in which the damages awarded for future eco-  
21 nomic loss exceeds \$100,000, a defendant may not be re-  
22 quired to pay such damages in a single, lump-sum pay-  
23 ment, but may be permitted to make such payments on  
24 a periodic basis. The periods for such payments shall be

1 determined by the court, based upon projections of when  
2 such expenses are likely to be incurred.

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

7 **SEC. 5106. TREATMENT OF ATTORNEY'S FEES AND OTHER**  
8 **COSTS.**

9 (a) LIMITATION ON AMOUNT OF CONTINGENCY  
10 FEES.—

11 (1) IN GENERAL.—An attorney who represents,  
12 on a contingency fee basis, a claimant in a medical  
13 malpractice liability claim may not charge, demand,  
14 receive, or collect for services rendered in connection  
15 with such claim in excess of the following amount re-  
16 covered by judgment or settlement under such claim:

17 (A) 25 percent of the first \$150,000 (or  
18 portion thereof) recovered, plus

19 (B) 10 percent of any amount in excess of  
20 \$150,000 recovered.

21 (2) CALCULATION OF PERIODIC PAYMENTS.—In  
22 the event that a judgment or settlement includes  
23 periodic or future payments of damages, the amount  
24 recovered for purposes of computing the limitation  
25 on the contingency fee under paragraph (1) shall be



1       based on the cost of the annuity or trust established  
2       to make the payments. In any case in which an an-  
3       nuity or trust is not established to make such pay-  
4       ments, such amount shall be based on the present  
5       value of the payments.

6       (b) REQUIRING PARTY CONTESTING ADR RULING  
7       TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

8               (1) IN GENERAL.—The court in a medical mal-  
9       practice liability action shall require the party that  
10      (pursuant to section 5102(c)(1)) contested the ruling  
11      of the alternative dispute resolution system with re-  
12      spect to the medical malpractice liability claim that  
13      is the subject of the action to pay to the opposing  
14      party the costs incurred by the opposing party under  
15      the action, including attorney's fees, fees paid to ex-  
16      pert witnesses, and other litigation expenses (but not  
17      including court costs, filing fees, or other expenses  
18      paid directly by the party to the court, or any fees  
19      or costs associated with the resolution of the claim  
20      under the alternative dispute resolution system), but  
21      only if—

22               (A) in the case of an action in which the  
23              party that contested the ruling is the claimant,  
24              the amount of damages awarded to the party  
25              under the action is not greater than the amount

1 of damages awarded to the party under the  
2 ADR system; and

3 (B) in the case of an action in which the  
4 party that contested the ruling is the defendant,  
5 the amount of damages assessed against the  
6 party under the action is not less than the  
7 amount of damages assessed under the ADR  
8 system.

9 (2) EXCEPTIONS.—Paragraph (1) shall not  
10 apply if—

11 (A) the party contesting the ruling made  
12 under the previous alternative dispute resolu-  
13 tion system shows that—

14 (i) the ruling was procured by corrup-  
15 tion, fraud, or undue means,

16 (ii) there was partiality or corruption  
17 under the system,

18 (iii) there was other misconduct under  
19 the system that materially prejudiced the  
20 party's rights, or

21 (iv) the ruling was based on an error  
22 of law;

23 (B) the party contesting the ruling made  
24 under the alternative dispute resolution system  
25 presents new evidence before the trier of fact

1           that was not available for presentation under  
2           the ADR system;

3           (C) the medical malpractice liability action  
4           raised a novel issue of law; or

5           (D) the court finds that the application of  
6           such paragraph to a party would constitute an  
7           undue hardship, and issues an order waiving or  
8           modifying the application of such paragraph  
9           that specifies the grounds for the court's deci-  
10          sion.

11          (3) LIMIT ON ATTORNEY'S FEES PAID.—Attor-  
12          neys' fees that are required to be paid under para-  
13          graph (1) by the contesting party shall not exceed  
14          the amount of the attorneys' fees incurred by the  
15          contesting party in the action. If the attorneys' fees  
16          of the contesting party are based on a contingency  
17          fee agreement, the amount of attorneys' fees for  
18          purposes of the preceding sentence shall not exceed  
19          the reasonable value of those services.

20          (4) RECORDS.—In order to receive attorneys'  
21          fees under paragraph (1), counsel of record in the  
22          medical malpractice liability action involved shall  
23          maintain accurate, complete records of hours worked  
24          on the action, regardless of the fee arrangement  
25          with the client involved.

1 (c) CONTINGENCY FEE DEFINED.—As used in this  
2 section, the term “contingency fee” means any fee for pro-  
3 fessional legal services which is, in whole or in part, con-  
4 tingent upon the recovery of any amount of damages,  
5 whether through judgment or settlement.

6 **SEC. 5107. UNIFORM STATUTE OF LIMITATIONS.**

7 (a) IN GENERAL.—No medical malpractice claim  
8 may be initiated after the expiration of the 2-year period  
9 that begins on the date on which the alleged injury that  
10 is the subject of such claim was discovered or the date  
11 on which such injury should reasonably have been discov-  
12 ered, whichever is earlier.

13 (b) EXCEPTION FOR MINORS.—In the case of an al-  
14 leged injury suffered by a minor who has not attained 6  
15 years of age, a medical malpractice claim may be initiated  
16 after the expiration of the period described in subsection  
17 (a) if the claim is initiated before the minor attains 8  
18 years of age.

19 **SEC. 5108. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
20 **SERVICES.**

21 (a) IN GENERAL.—In the case of a medical mal-  
22 practice claim relating to services provided during labor  
23 or the delivery of a baby, if the health care professional  
24 or health care provider against whom the claim is brought  
25 did not previously treat the claimant for the pregnancy,

1 the trier of fact may not find that such professional or  
2 provider committed malpractice and may not assess dam-  
3 ages against such professional or provider unless the mal-  
4 practice is proven by clear and convincing evidence.

5 (b) APPLICABILITY TO GROUP PRACTICES OR  
6 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-  
7 section (a), a health care professional shall be considered  
8 to have previously treated an individual for a pregnancy  
9 if the professional is a member of a group practice whose  
10 members previously treated the individual for the preg-  
11 nancy or is providing services to the individual during  
12 labor or the delivery of a baby pursuant to an agreement  
13 with another professional.

14 **SEC. 5109. UNIFORM STANDARD FOR DETERMINING LIABIL-**  
15 **ITY IN ACTIONS BASED ON NEGLIGENCE.**

16 (a) STANDARD OF REASONABLENESS.—Except as  
17 provided in subsection (b), a defendant in a medical mal-  
18 practice liability action may not be found to have commit-  
19 ted malpractice unless the defendant's conduct at the time  
20 of providing the health care services that are the subject  
21 of the action was not reasonable.

22 (b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—  
23 Subsection (a) shall not apply with respect to a medical  
24 malpractice action if (in accordance with applicable State

1 law) the theory of liability upon which the action is based  
2 is a theory of strict liability.

3 **SEC. 5110. JURISDICTION OF FEDERAL COURTS.**

4 Nothing in this subtitle shall be construed to estab-  
5 lish jurisdiction over any medical malpractice liability ac-  
6 tion in the district courts of the United States on the basis  
7 of sections 1331 or 1337 of title 28, United States Code.

8 **SEC. 5111. PREEMPTION.**

9 (a) IN GENERAL.—This subtitle supersedes any State  
10 law only to the extent that the State law permits the recov-  
11 ery by a claimant or the assessment against a defendant  
12 of a greater amount of damages or establishes a less strict  
13 standard of proof for determining whether a defendant has  
14 committed malpractice, than the provisions of this sub-  
15 title.

16 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
17 OF LAW OR VENUE.—Nothing in this subtitle shall be con-  
18 strued to—

19 (1) waive or affect any defense of sovereign im-  
20 munity asserted by any State under any provision of  
21 law;

22 (2) waive or affect any defense of sovereign im-  
23 munity asserted by the United States;

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

1           (4) preempt State choice-of-law rules with re-  
2           spect to claims brought by a foreign nation or a citi-  
3           zen of a foreign nation; or

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

9   **Subtitle C—Requirements for State**  
10   **Alternative Dispute Resolution**  
11   **Systems (ADR)**

12   **SEC. 5201. BASIC REQUIREMENTS.**

13           (a) IN GENERAL.—A State’s alternative dispute reso-  
14           lution system meets the requirements of this section if the  
15           system—

16           (1) applies to all medical malpractice liability  
17           claims under the jurisdiction of the courts of that  
18           State;

19           (2) requires that a written opinion resolving the  
20           dispute be issued not later than 6 months after the  
21           date by which each party against whom the claim is  
22           filed has received notice of the claim (other than in  
23           exceptional cases for which a longer period is re-  
24           quired for the issuance of such an opinion), and that  
25           the opinion contain—

1 (A) findings of fact relating to the dispute,  
2 and

3 (B) a description of the costs incurred in  
4 resolving the dispute under the system (includ-  
5 ing any fees paid to the individuals hearing and  
6 resolving the claim), together with an appro-  
7 priate assessment of the costs against any of  
8 the parties;

9 (3) requires individuals who hear and resolve  
10 claims under the system to meet such qualifications  
11 as the State may require (in accordance with regula-  
12 tions of the Secretary);

13 (4) is approved by the State or by local govern-  
14 ments in the State;

15 (5) with respect to a State system that consists  
16 of multiple dispute resolution procedures—

17 (A) permits the parties to a dispute to se-  
18 lect the procedure to be used for the resolution  
19 of the dispute under the system, and

20 (B) if the parties do not agree on the pro-  
21 cedure to be used for the resolution of the dis-  
22 pute, assigns a particular procedure to the par-  
23 ties;

24 (6) provides for the transmittal to the State  
25 agency responsible for monitoring or disciplining



1 health care professionals and health care providers  
2 of any findings made under the system that such a  
3 professional or provider committed malpractice, un-  
4 less, during the 90-day period beginning on the date  
5 the system resolves the claim against the profes-  
6 sional or provider, the professional or provider  
7 brings an action contesting the decision made under  
8 the system; and

9 (7) provides for the regular transmittal to the  
10 Administrator for Health Care Policy and Research  
11 of information on disputes resolved under the sys-  
12 tem, in a manner that assures that the identity of  
13 the parties to a dispute shall not be revealed.

14 (b) APPLICATION OF MALPRACTICE LIABILITY  
15 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—  
16 The provisions of subtitle B (other than sections 5102 and  
17 5103) shall apply with respect to claims brought under  
18 a State alternative dispute resolution system or the alter-  
19 native Federal system in the same manner as such provi-  
20 sions apply with respect to medical malpractice liability  
21 actions brought in the State.

22 **SEC. 5202. CERTIFICATION OF STATE SYSTEMS; APPLICA-**  
23 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

24 (a) CERTIFICATION.—

1           (1) IN GENERAL.—Not later than October 1 of  
2       each year (beginning with 1994), the Secretary, in  
3       consultation with the Attorney General, shall deter-  
4       mine whether a State’s alternative dispute resolution  
5       system meets the requirements of this part for the  
6       following calendar year.

7           (2) BASIS FOR CERTIFICATION.—The Secretary  
8       shall certify a State’s alternative dispute resolution  
9       system under this subsection for a calendar year if  
10      the Secretary determines under paragraph (1) that  
11      the system meets the requirements of section 5201.

12      (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-  
13      TEM.—

14           (1) ESTABLISHMENT AND APPLICABILITY.—  
15      Not later than October 1, 1994, the Secretary, in  
16      consultation with the Attorney General, shall estab-  
17      lish by rule an alternative Federal ADR system for  
18      the resolution of medical malpractice liability claims  
19      during a calendar year in States that do not have  
20      in effect an alternative dispute resolution system  
21      certified under subsection (a) for the year.

22           (2) REQUIREMENTS FOR SYSTEM.—Under the  
23      alternative Federal ADR system established under  
24      paragraph (1)—

1 (A) paragraphs (1), (2), (6), and (7) of  
2 section 5201(a) shall apply to claims brought  
3 under the system;

4 (B) if the system provides for the resolu-  
5 tion of claims through arbitration, the claims  
6 brought under the system shall be heard and  
7 resolved by arbitrators appointed by the Sec-  
8 retary in consultation with the Attorney Gen-  
9 eral; and

10 (C) with respect to a State in which the  
11 system is in effect, the Secretary may (at the  
12 State's request) modify the system to take into  
13 account the existence of dispute resolution pro-  
14 cedures in the State that affect the resolution  
15 of medical malpractice liability claims.

16 (3) TREATMENT OF STATES WITH ALTER-  
17 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-  
18 eral ADR system established under this subsection is  
19 applied with respect to a State for a calendar year,  
20 the State shall make a payment to the United States  
21 (at such time and in such manner as the Secretary  
22 may require) in an amount equal to 110 percent of  
23 the costs incurred by the United States during the  
24 year as a result of the application of the system with  
25 respect to the State.

1 **SEC. 5203. GRANTS TO STATES.**

2 (a) IN GENERAL.—The Secretary shall make grants  
3 to States for a 2-year period to assist States in implement-  
4 ing and operating alternative dispute resolution systems  
5 that meet the requirements of section 5201.

6 (b) ELIGIBILITY.—A State is eligible to receive a  
7 grant under this section if the Secretary has certified the  
8 State’s alternative dispute resolution system under section  
9 5202(b).

10 (c) LIMITATION ON AMOUNT OF GRANT.—The  
11 amount of funds provided to a State under a grant under  
12 this section may not exceed \$5,000,000 during the 2-year  
13 period of the grant.

14 **SEC. 5204. REPORTS ON IMPLEMENTATION AND EFFEC-**  
15 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**  
16 **LUTION SYSTEMS.**

17 (a) IN GENERAL.—Not later than 5 years after the  
18 date of the enactment of this Act, the Secretary shall pre-  
19 pare and submit to the Congress a report describing and  
20 evaluating State alternative dispute resolution systems op-  
21 erated pursuant to this subtitle and the alternative Fed-  
22 eral system established under section 5202(b).

23 (b) CONTENTS OF REPORT.—The Secretary shall in-  
24 clude in the report prepared and submitted under sub-  
25 section (a)—

26 (1) information on—

1 (A) the effect of the alternative dispute  
2 resolution systems on the cost of health care  
3 within each State,

4 (B) the impact of such systems on the ac-  
5 cess of individuals to health care within the  
6 State, and

7 (C) the effect of such systems on the qual-  
8 ity of health care provided within the State; and

9 (2) to the extent that such report does not pro-  
10 vide information on no-fault systems operated by  
11 States as alternative dispute resolution systems pur-  
12 suant to this part, an analysis of the feasibility and  
13 desirability of establishing a system under which  
14 medical malpractice liability claims shall be resolved  
15 on a no-fault basis.

16 **Subtitle D—Grants to States for**  
17 **Development of Practice Guide-**  
18 **lines**

19 **SEC. 5301. GRANTS TO STATES.**

20 (a) IN GENERAL.—The Secretary shall make grants  
21 to States for a 2-year period for the development of medi-  
22 cal practice guidelines for health care professionals (in-  
23 cluding mid-level practitioners) that may be applied to re-  
24 solve medical malpractice liability claims and actions in  
25 the State.

1       (b) ELIGIBILITY.—A State is eligible to receive a  
2 grant under this section if the State submits to the Sec-  
3 retary an application at such time, in such form, and con-  
4 taining such information and assurances as the Secretary  
5 may require, including assurances that the State will sub-  
6 mit such periodic reports on the development and applica-  
7 tion of the State’s medical practice guidelines as the Sec-  
8 retary may require.

9       (c) NUMBER OF GRANTS.—

10           (1) IN GENERAL.—Except as provided in para-  
11 graph (2), the Secretary shall award not less than  
12 10 grants under this section.

13           (2) EXCEPTION.—Notwithstanding paragraph  
14 (1), the Secretary may award less than 10 grants  
15 under this section if the Secretary determines that  
16 there are an inadequate number of applications sub-  
17 mitted that meet the eligibility and approval require-  
18 ments of this section.

19       (d) LIMITATION ON AMOUNT OF GRANT.—The  
20 amount of funds provided to a State under a grant under  
21 this section may not exceed \$5,000,000 during the 2-year  
22 period of the grant.

1 **TITLE VI—PAPERWORK REDUC-**  
2 **TION AND ADMINISTRATIVE**  
3 **SIMPLIFICATION**

4 **SEC. 6001. PREEMPTION OF STATE QUILL PEN LAWS.**

5 After 1994, no effect shall be given to any provision  
6 of State law that requires medical or health insurance  
7 records (including billing information) to be maintained  
8 in written, rather than electronic, form.

9 **SEC. 6002. CONFIDENTIALITY OF ELECTRONIC HEALTH**  
10 **CARE INFORMATION.**

11 (a) PROMULGATION OF REQUIREMENTS.—

12 (1) IN GENERAL.—The Health Care Standards  
13 Commission shall promulgate, and may modify from  
14 time to time, requirements to facilitate and ensure  
15 the uniform, confidential treatment of individually  
16 identifiable health care information in electronic en-  
17 vironments.

18 (2) ITEMS TO BE INCLUDED.—The require-  
19 ments under this subsection shall—

20 (A) provide for the preservation of con-  
21 fidentiality and privacy rights in electronic  
22 health care claims processing and payment;

23 (B) apply to the collection, storage, han-  
24 dling, and transmission of individually identifi-  
25 able health care data (including initial and sub-

1           sequent disclosures) in electronic form by all ac-  
2           countable health plans, public and private third-  
3           party payers, providers of health care, and all  
4           other entities involved in the transactions;

5           (C) not apply to public health reporting re-  
6           quired under State or Federal law;

7           (D) delineate protocols for securing elec-  
8           tronic storage, processing, and transmission of  
9           health care data;

10          (E) specify fair information practices that  
11          assure a proper balance between required dis-  
12          closures and use of data, including—

13               (i) creating a proper balance between  
14               what an individual is expected to divulge to  
15               a record-keeping organization and what the  
16               individual seeks in return,

17               (ii) minimizing the extent to which in-  
18               formation concerning an individual is itself  
19               a source of unfairness in any decision  
20               made on the basis of such information, and

21               (iii) creating and defining obligations  
22               respecting the uses and disclosures that  
23               will be made of recorded information about  
24               an individual;



1 (F) require publication of the existence of  
2 health care data banks;

3 (G) establish appropriate protections for  
4 highly sensitive data (such as data concerning  
5 mental health, substance abuse, and commu-  
6 nicable and genetic diseases);

7 (H) encourage the use of alternative dis-  
8 pute resolution mechanisms (where appro-  
9 priate); and

10 (I) provide for the deletion of information  
11 that is no longer needed to carry out the pur-  
12 pose for which it was collected.

13 (3) CONSULTATION WITH WORKING GROUP.—In  
14 promulgating and modifying requirements under this  
15 subsection, the Commission shall consult with a  
16 working group of knowledgeable individuals rep-  
17 resenting all interested parties (including third-party  
18 payers, providers, consumers, employers, information  
19 managers, and technical experts).

20 (4) DEADLINE.—The Commission shall first  
21 promulgate requirements under this subsection by  
22 not later than six months after the date of the en-  
23 actment of this Act.

24 (b) APPLICATION OF REQUIREMENTS.—

1           (1) STATE ENFORCEMENT OF SIMILAR RE-  
2           QUIREMENTS.—The requirements promulgated  
3           under subsection (a) shall not apply to health care  
4           information in a State if—

5                   (A) the State has applied to the Health  
6           Care Standards Commission for a determina-  
7           tion that the State has in effect a law that pro-  
8           vides for the application of requirements with  
9           respect to such information (and enforcement  
10          provisions with respect to such requirements)  
11          consistent with such requirements (and with the  
12          enforcement provisions of subsection (c)), and

13                   (B) the Commission determines that the  
14          State has such a law in effect.

15          (2) APPLICATION TO CURRENT INFORMA-  
16          TION.—The Health Care Standards Commission  
17          shall specify the extent to which (and manner in  
18          which) the requirements promulgated under sub-  
19          section (a) apply to information collected before the  
20          effective date of the requirements.

21          (c) DEFENSE FOR PROPER DISCLOSURES.—An en-  
22          tity that establishes that it has disclosed health care infor-  
23          mation in accordance with the requirements promulgated  
24          under subsection (a) has established a defense in an action  
25          brought for improper disclosure of such information.

1 (d) PENALTIES FOR VIOLATIONS.—An entity that  
2 collects, stores, handles, transmits, or discloses health care  
3 information in violation of the requirements promulgated  
4 under subsection (a) is liable for civil damages, equitable  
5 remedies, and attorneys' fees (if appropriate), in accord-  
6 ance with regulations of the Health Care Standards Com-  
7 mission.

8 **SEC. 6003. STANDARDIZATION FOR THE ELECTRONIC RE-**  
9 **CEIPT AND TRANSMISSION OF HEALTH PLAN**  
10 **INFORMATION.**

11 (a) GOALS.—The Health Care Standards Commis-  
12 sion shall establish national goals, and time frameworks,  
13 respecting the progress to be made by the health care in-  
14 dustry in eliminating unnecessary paperwork and achiev-  
15 ing appropriate standardization in the areas of electronic  
16 receipt and transmission of health care claims and health  
17 plan information and eligibility verification (consistent  
18 with the requirements promulgated under section  
19 6002(a)).

20 (b) CONTINGENT REQUIREMENTS.—If the Commis-  
21 sion determines that the health care industry has failed  
22 to meet the goals established under subsection (a) by the  
23 deadlines established by the Commission under such sub-  
24 section, the Commission shall promulgate (and may, from  
25 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           (1) the format and content of basic claims  
2       forms under health plans, and

3           (2) the common identification numbers to be  
4       used by health plans to identify health plan bene-  
5       ficiaries and health care providers.

6       (c) CONSULTATION.—The Commission shall conduct  
7       activities under this section in consultation with the  
8       Workgroup for Electronic Data Interchange and with in-  
9       surers, providers, and others.

10   **SEC. 6005. PRIORITY AMONG INSURERS.**

11       (a) GOALS.—The Health Care Standards Commis-  
12       sion shall establish national goals, and time frameworks,  
13       respecting the progress to be made by the health care in-  
14       dustry in achieving uniformity in the rules for determining  
15       the liability of insurers when benefits are payable under  
16       two or more health plans.

17       (b) CONTINGENT REQUIREMENTS.—If the Commis-  
18       sion determines that the health care industry has failed  
19       to meet the goals established under subsection (a) by the  
20       deadlines established by the Commission under such sub-  
21       section, the Commission shall promulgate (and may, from  
22       time to time, modify) rules for determining the liability  
23       of health plans when benefits are payable under two or  
24       more health plans.

1 (c) CONSULTATION.—The Commission shall conduct  
2 activities under this section in consultation with health  
3 plans.

4 **SEC. 6006. FURNISHING OF INFORMATION AMONG HEALTH**  
5 **PLANS.**

6 (a) GOALS.—The Health Care Standards Commis-  
7 sion shall establish national goals, and time frameworks,  
8 respecting the progress to be made by the health care in-  
9 dustry in achieving uniformity in the availability of infor-  
10 mation among health plans when benefits are payable  
11 under two or more health plans.

12 (b) CONTINGENT REQUIREMENTS.—If the Commis-  
13 sion determines that the health care industry has failed  
14 to meet the goals established under subsection (a) by the  
15 deadlines established by the Commission under such sub-  
16 section, the Commission shall promulgate (and may, from  
17 time to time, modify) requirements concerning the trans-  
18 fer among health plans (and annual updating) of appro-  
19 priate information (which may include requirements for  
20 the use of unique identifiers, and for the listing of all indi-  
21 viduals covered under a health plan).

22 (c) CONSULTATION.—The Commission shall conduct  
23 activities under this section in consultation with health  
24 plans.

1 **SEC. 6007. FAILURE TO SATISFY CERTAIN HEALTH PLAN**  
2 **REQUIREMENTS.**

3 (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
4 nue Code of 1986 (relating to taxes on group health plans)  
5 is amended by adding at the end the following new section:

6 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN HEALTH PLAN**  
7 **REQUIREMENTS.**

8 “(a) GENERAL RULE.—There is hereby imposed, on  
9 any administrator of a health plan, a tax on any failure  
10 to comply with an applicable requirement of sections 6003  
11 through 6006 of the Managed Competition Act of 1993.  
12 The Health Care Standards Commission shall determine  
13 whether any such administrator meets the requirements  
14 of those sections.

15 “(b) AMOUNT OF TAX.—The amount of tax imposed  
16 by subsection (a) for a taxable year in which an adminis-  
17 trator fails to comply with a requirement described in that  
18 subsection shall be equal to \$100 for each such failure.

19 “(c) CONTROLLED GROUPS.—

20 “(1) EMPLOYERS.—In the case of an adminis-  
21 trator that is an employer, for purposes of this sec-  
22 tion all persons that are treated as part of the same  
23 employer (within the meaning of section 414) as the  
24 administrator shall be treated as the same person.

1           “(2) OTHER ADMINISTRATORS.—In the case of  
2           an administrator that is not an employer, for pur-  
3           poses of this section—

4                   “(A) CONTROLLED GROUP OF CORPORA-  
5                   TIONS.—All corporations which are members of  
6                   the same controlled group of corporations shall  
7                   be treated as 1 person. For purposes of the pre-  
8                   ceding sentence, the term ‘controlled group of  
9                   corporations’ has the meaning given to such  
10                  term by section 1563(a), except that—

11                           “(i) ‘more than 50 percent’ shall be  
12                           substituted for ‘at least 80 percent’ each  
13                           place it appears in section 1563(a)(1), and

14                           “(ii) the determination shall be made  
15                           without regard to subsections (a)(4) and  
16                           (e)(3)(C) of section 1563.

17                   “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
18                   ETC., WHICH ARE UNDER COMMON CONTROL.—  
19                   Under regulations prescribed by the Secretary,  
20                   all trades or businesses (whether or not incor-  
21                   porated) which are under common control shall  
22                   be treated as 1 person. The regulations pre-  
23                   scribed under this subparagraph shall be based  
24                   on principles similar to the principles which  
25                   apply in the case of subparagraph (A).



1 “(d) LIMITATIONS ON TAX.—

2 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
3 DISCOVERED EXERCISING REASONABLE DILI-  
4 GENCE.—No tax shall be imposed by subsection (a)  
5 with respect to any failure for which it is established  
6 to the satisfaction of the Secretary that the person  
7 liable for tax did not know, and by exercising rea-  
8 sonable diligence would not have known, that the  
9 failure existed.

10 “(2) TAX NOT TO APPLY TO FAILURES COR-  
11 RECTED WITHIN 30 DAYS.—No tax shall be imposed  
12 by subsection (a) on any failure if—

13 “(A) the failure was due to reasonable  
14 cause and not to willful neglect, and

15 “(B) the failure is corrected during the 30-  
16 day period beginning on the 1st date the person  
17 liable for the tax knew, or by exercising reason-  
18 able diligence would have known, that the fail-  
19 ure existed.

20 “(3) WAIVER BY SECRETARY.—In the case of a  
21 failure which is due to reasonable cause and not to  
22 willful neglect, the Secretary may waive part or all  
23 of the tax imposed by subsection (a) to the extent  
24 that the payment of that tax would be excessive rel-  
25 ative to the failure involved.”

1 (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of  
2 section 275(a) of that Code (relating to nondeductibility  
3 of certain taxes) is amended by inserting “47,” after  
4 “46,”.

5 (c) CLERICAL AMENDMENTS.—The table of sections  
6 for chapter 47 of that Code is amended by adding at the  
7 end the following new item:

“5000A. Failure to satisfy certain health plan requirements.”.

8 **SEC. 6008. DEFINITIONS.**

9 For purposes of this title—

10 (1) The term “health plan” means any contract  
11 or arrangement under which an entity bears all or  
12 part of the cost of providing health care items and  
13 services, including a hospital or medical expense in-  
14 curred policy or certificate, hospital or medical serv-  
15 ice plan contract, or health maintenance subscriber  
16 contract (including any closed accountable health  
17 plan), but does not include (except for purposes of  
18 sections 6005 and 6006)—

19 (A) coverage only for accident, dental, vi-  
20 sion, disability, or long term care, medicare  
21 supplemental health insurance, or any combina-  
22 tion thereof,

23 (B) coverage issued as a supplement to li-  
24 ability insurance,

1 (C) workers' compensation or similar in-  
2 surance, or

3 (D) automobile medical-payment insur-  
4 ance.

5 (2) The term "provider" means a physician,  
6 hospital, pharmacy, laboratory, or other person li-  
7 censed or otherwise authorized under applicable  
8 State laws to furnish health care items or services.

9 **TITLE VII—ADDITIONAL BENE-**  
10 **FITS ON A PAY-AS-YOU-GO**  
11 **BASIS**

12 **SEC. 7001. SENSE OF CONGRESS.**

13 It is the sense of Congress that additional benefits  
14 should be provided by the Federal Government to the ex-  
15 tent that additional financing is made available for such  
16 benefits on a pay-as-you-go basis, including the following  
17 benefits:

18 (1) Providing tax preferences for expenses for  
19 long-term care, including tax deductibility of em-  
20 ployer contributions for long-term care insurance.

21 (2) Providing direct Federal subsidies for ex-  
22 penses for long-term care.

23 (3) Expanding coverage under the medicare  
24 program, including coverage of outpatient prescrip-  
25 tion drugs and coverage of long-term care services.

- 1           (4) Increasing the income threshold for eligi-  
2           bility for premium assistance (under section 2002).

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