

103^D CONGRESS
2^D SESSION

H. R. 3955

To increase the availability and continuity of health coverage for employees and their families, to prevent fraud and abuse in the health care delivery system, to reform medical malpractice liability standards, to reduce paperwork and simplify administration of health care claims, to promote preventive care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 1994

Mr. ROWLAND (for himself, Mr. BILIRAKIS, Mr. SPRATT, Mr. BLILEY, Mr. TAUZIN, Mr. DUNCAN, Mr. PARKER, Mr. HASTERT, Mr. MONTGOMERY, Mr. BARTON of Texas, Mr. PETE GEREN of Texas, Mr. UPTON, Mr. SISISKY, Mr. MOORHEAD, Mr. TANNER, Mrs. VUCANOVICH, Mr. LAUGHLIN, Mr. GOSS, Mr. PICKETT, Mr. CRAPO, Mr. LANCASTER, Mr. GOODLATTE, Mr. HAYES, Mr. ZELIFF, Mrs. LLOYD, Mr. LINDER, Mr. BROWDER, Mr. CASTLE, Mr. ORTON, and Mr. YOUNG of Florida) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Education and Labor, the Judiciary, and Ways and Means

APRIL 5, 1994

Additional sponsors: Mr. BREWSTER, Mr. LEWIS of Florida, Mr. DARDEN, Mr. FIELDS of Texas, Mr. NEAL of North Carolina, Mr. GREENWOOD, Mr. MORAN, Mr. KYL, Mr. CLEMENT, Mr. EWING, Mr. GLICKMAN, Mr. BALLENGER, Mr. STENHOLM, and Mr. CANADY

JULY 20, 1994

Additional sponsors: Mr. BISHOP, Mr. BUNNING, Mr. PENNY, Mr. PAXON, Mr. HEFNER, Mr. LIVINGSTON, Mr. BARLOW, Mr. BOEHNER, Mr. VALENTINE, Mr. COLLINS of Georgia, Mr. CRAMER, Mr. THOMAS of Wyoming, Mr. JOHNSON of Georgia, Mr. SUNDQUIST, Mr. PETERSON of Minnesota, Mr. STEARNS, Mr. DEAL, Mr. HERGER, Mr. MURPHY, Mr. HUTCHINSON, Mr. HUTTO, Mr. GILLMOR, Mr. ORTIZ, Mrs. FOWLER, Mr. JACOBS, Mr. GILCHREST, Mr. BAESLER, and Mr. DICKEY

A BILL

To increase the availability and continuity of health coverage for employees and their families, to prevent fraud and abuse in the health care delivery system, to reform medical malpractice liability standards, to reduce paperwork and simplify administration of health care claims, to promote preventive care, 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 “Health Reform Consensus Act of 1994”.

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

Sec. 1. Short title; table of contents.

TITLE I—INSURANCE REFORM

Subtitle A—Increased Availability and Continuity of Health Coverage for
 Employees and Their Families

PART 1—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES, SPOUSES, AND DEPENDENTS

Sec. 1001. Requiring employers to offer option of coverage for eligible individuals.

PART 2—ASSURING PORTABILITY OF HEALTH COVERAGE

Sec. 1011. Limitation on preexisting condition clauses.

Sec. 1012. Assurance of continuity of coverage through previous satisfaction of preexisting condition requirement.

Sec. 1013. Requirements relating to renewability generally.

PART 3—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

Sec. 1021. Enforcement.

Sec. 1022. Effective dates.

Sec. 1023. Definitions and special rules.

Subtitle B—Reform of Health Insurance Marketplace for Small Business

- Sec. 1101. Requirement for insurers to offer standard and catastrophic plans.
- Sec. 1102. Health plan, standard plan, and catastrophic plan defined.
- Sec. 1103. Establishment of health plan standards.
- Sec. 1104. Limits on premiums and miscellaneous consumer protections.
- Sec. 1105. Limitation on variation in annual premium increases among covered small employers.
- Sec. 1106. Establishment of reinsurance or allocation of risk mechanisms for high risk individuals in marketplace for small business.
- Sec. 1107. Definitions.
- Sec. 1108. Office of Private Health Care Coverage; annual reports on evaluation of health care coverage reform.
- Sec. 1109. Research and demonstration projects; development of a health risk pooling model.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

- Sec. 1201. Prohibition of State benefit mandates for group health plans.
- Sec. 1202. Prohibition of provisions prohibiting employer groups from purchasing health insurance.
- Sec. 1203. Restrictions on managed care.
- Sec. 1204. Definitions.

PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

- Sec. 1211. Limited exemption under preemption rules for multiple employer plans providing health benefits subject to certain Federal standards.

“Part 7—Multiple Employer Health Plans

- “Sec. 701. Definitions.
- “Sec. 702. Exempted multiple employer plans providing benefits in the form of medical care relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
- “Sec. 703. Exemption procedure.
- “Sec. 704. Eligibility requirements.
- “Sec. 705. Additional requirements applicable to exempted arrangements.
- “Sec. 706. Disclosure to participating employers by arrangements providing medical care.
- “Sec. 707. Maintenance of reserves.
- “Sec. 708. Corrective actions.
- “Sec. 709. Expiration, suspension, or revocation of exemption.
- “Sec. 710. Review of actions of the secretary.”
- Sec. 1212. Clarification of scope of preemption rules.
- Sec. 1213. Clarification of treatment of single employer arrangements.
- Sec. 1214. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 1215. Employee leasing health care arrangements.
- Sec. 1216. Enforcement provisions relating to multiple employer welfare arrangements and employee leasing health care arrangements.
- Sec. 1217. Filing requirements for health benefit multiple employer welfare arrangements.
- Sec. 1218. Cooperation between Federal and State authorities.
- Sec. 1219. Effective date; transitional rules.

PART 3—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS
PROVIDING BASIC HEALTH BENEFITS

Sec. 1221. Eliminating commonality of interest or geographic location requirement for tax exempt trust status.

PART 4—SIMPLIFYING FILING OF REPORTS FOR EMPLOYERS COVERED
UNDER INSURED MULTIPLE EMPLOYER HEALTH PLANS

Sec. 1231. Single annual filing for all employers covered under an insured multiple employer health plan.

PART 5—COMPLIANCE WITH COVERAGE OPTION REQUIREMENTS

Sec. 1241. Compliance with coverage requirements through multiple employer health arrangements.

Subtitle D—Health Deduction Fairness

Sec. 1301. Permanent extension and increase in health insurance tax deduction for self-employed individuals.

TITLE II—PREVENTING FRAUD AND ABUSE

Subtitle A—Establishment of All-Payer Health Care Fraud and Abuse
Control Program

- Sec. 2001. All-payer health care fraud and abuse control program.
- Sec. 2002. Authorization of additional appropriations for investigators and other personnel.
- Sec. 2003. Establishment of Anti-fraud and Abuse Trust Fund.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

- Sec. 2101. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 2102. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 2103. Civil monetary penalties.
- Sec. 2104. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 2105. Effective date.

Subtitle C—Administrative and Miscellaneous Provisions

- Sec. 2201. Establishment of the health care fraud and abuse data collection program.
- Sec. 2202. Quarterly publication of final adverse actions taken.

Subtitle D—Amendments to Criminal Law

- Sec. 2301. Penalties for health care fraud.
- Sec. 2302. Rewards for information leading to prosecution and conviction.

TITLE III—MALPRACTICE REFORM

Subtitle A—Findings; Purpose; Definitions

Sec. 3001. Findings; purpose.

Sec. 3002. Definitions.

Subtitle B—Uniform Standards for Malpractice Claims

Sec. 3101. Applicability.

Sec. 3102. Requirement for initial resolution of action through alternative dispute resolution.

Sec. 3103. Procedural requirements for filing of actions.

Sec. 3104. Treatment of noneconomic and punitive damages.

Sec. 3105. Periodic payments for future losses.

Sec. 3106. Treatment of attorney's fees and other costs.

Sec. 3107. Uniform statute of limitations.

Sec. 3108. Special provision for certain obstetric services.

Sec. 3109. Application of medical practice parameters in malpractice liability actions.

Sec. 3110. Jurisdiction of Federal courts.

Sec. 3111. Preemption.

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

Sec. 3201. Basic requirements.

Sec. 3202. Alternative Dispute Resolution Advisory Board.

Sec. 3203. Certification of State systems; applicability of alternative Federal system.

Sec. 3204. Reports on implementation and effectiveness of alternative dispute resolution systems.

TITLE IV—PAPERWORK REDUCTION AND ADMINISTRATIVE SIMPLIFICATION

Sec. 4001. Preemption of State quill pen laws.

Sec. 4002. Confidentiality of electronic health care information.

Sec. 4003. Standardization for the electronic receipt and transmission of health plan information.

Sec. 4004. Use of uniform health claims forms and identification numbers.

Sec. 4005. Priority among insurers.

Sec. 4006. Furnishing of information among health plans.

Sec. 4007. Definitions.

TITLE V—EXPANDING ACCESS/PREVENTIVE CARE

Subtitle A—Expanding Access Through Community Health Authorities

Sec. 5001. Community health authorities demonstration projects.

Sec. 5002. Health center program amendments.

Subtitle B—Expansion of Public Health Programs on Preventive Health

Sec. 5101. Immunizations against vaccine-preventable diseases.

Sec. 5102. Prevention, control, and elimination of tuberculosis.

Sec. 5103. Lead poisoning prevention.—

Sec. 5104. Preventive health measures with respect to breast and cervical cancers.

Sec. 5105. Office of Disease Prevention and Health Promotion.

Sec. 5106. Preventive health and health services block grant.

TITLE VI—ANTITRUST PROVISIONS

Sec. 6001. Publication of antitrust guidelines on activities of health plans.
 Sec. 6002. Issuance of health care certificates of public advantage.

TITLE VII—PREFUNDING GOVERNMENT HEALTH BENEFITS FOR
 CERTAIN ANNUITANTS

Sec. 7001. Requirement that certain agencies prefund government health benefits contributions for their annuitants.

1 **TITLE I—INSURANCE REFORM**
 2 **Subtitle A—Increased Availability**
 3 **and Continuity of Health Cov-**
 4 **erage for Employees and Their**
 5 **Families**
 6 **PART 1—REQUIRED COVERAGE OPTIONS**
 7 **FOR ELIGIBLE EMPLOYEES, SPOUSES,**
 8 **AND DEPENDENTS**

9 **SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF**
 10 **COVERAGE FOR ELIGIBLE INDIVIDUALS.**

11 (a) IN GENERAL.—Each employer shall make avail-
 12 able with respect to each eligible employee a group health
 13 plan under which—

14 (1) coverage of each eligible individual with re-
 15 spect to such an eligible employee may be elected on
 16 an annual basis for each plan year,

17 (2) subject to subsection (d), coverage is pro-
 18 vided for at least the required coverage specified in
 19 subsection (c), and

20 (3) each eligible employee electing such cov-
 21 erage may elect to have any premiums owed by the
 22 employee collected through payroll deduction.

1 An employer is not required under this subsection to make
2 any contribution to the cost of coverage under such a plan.

3 (b) SPECIAL RULES.—

4 (1) EXCLUSION OF NEW EMPLOYERS AND CER-
5 TAIN SMALL EMPLOYERS.—Subsection (a) shall not
6 apply to any employer for any plan year if, as of the
7 beginning of such plan year—

8 (A) such employer (including any prede-
9 cessor thereof) has been an employer for less
10 than 2 years,

11 (B) such employer has no more than 2 eli-
12 gible employees, or

13 (C) no more than 2 eligible employees are
14 not covered under any group health plan.

15 (2) EXCLUSION OF FAMILY MEMBERS.—Under
16 such procedures as the Secretary may prescribe, any
17 relative of an employer may be, at the election of the
18 employer, excluded from consideration as an eligible
19 employee for purposes of applying the requirements
20 of subsection (a). In the case of an employer that is
21 not an individual, an employee who is a relative of
22 a key employee (as defined in section 416(i)(1) of
23 the Internal Revenue Code of 1986) of the employer
24 may, at the election of the key employee, be consid-
25 ered a relative excludable under this paragraph.

1 (3) OPTIONAL APPLICATION OF WAITING PE-
2 RIOD.—A group health plan shall not be treated as
3 failing to meet the requirements of subsection (a)
4 solely because a period of service by an eligible em-
5 ployee of not more than 60 days is required under
6 the plan for coverage under the plan of eligible indi-
7 viduals with respect to such employee.

8 (c) REQUIRED COVERAGE.—

9 (1) IN GENERAL.—Except as provided in para-
10 graph (2), the required coverage specified in this
11 subsection is standard coverage (consistent with sec-
12 tion 1102(b)).

13 (2) SPECIAL TREATMENT OF SMALL EMPLOY-
14 ERS NOT CONTRIBUTING TO EMPLOYEE COV-
15 ERAGE.—In the case of a small employer (as defined
16 in section 1107(9)) that has not contributed during
17 the previous plan year to the cost of coverage for
18 any eligible employee under any group health plan,
19 the required coverage specified in this subsection for
20 the plan year (with respect to each eligible employee)
21 is—

22 (A) coverage under a standard plan, and

23 (B) coverage under a catastrophic plan,

24 as such terms are defined in section 1102(a)(2).

1 (3) CONSTRUCTION.—Nothing in this section
2 shall be construed as limiting the group health
3 plans, or types of coverage under such a plan, that
4 an employer may offer to an employee.

5 (d) 5-YEAR TRANSITION FOR EXISTING GROUP
6 HEALTH PLANS.—

7 (1) IN GENERAL.—The requirement of sub-
8 section (a)(2), and section 1002(c)(2), shall not
9 apply to a group health plan for a plan year if—

10 (A) the group health plan is in effect in
11 the plan year in which September 1, 1993, oc-
12 curs, and

13 (B) the employer makes (or offers to
14 make), in such plan year and the plan year in-
15 volved, a contribution to the plan on behalf of
16 each employee who is eligible to participate in
17 the plan.

18 (2) SUNSET.—Paragraph (1) shall only apply to
19 a group health plan for each of the 5 plan years be-
20 ginning with the first plan year to which the require-
21 ment of subsection (a) applies.

1 **PART 2—ASSURING PORTABILITY OF**
2 **HEALTH COVERAGE**

3 **SEC. 1011. LIMITATION ON PREEXISTING CONDITION**
4 **CLAUSES.**

5 (a) IN GENERAL.—A group health plan may not im-
6 pose (and an insurer may not require an employer under
7 a group health plan to impose through a waiting period
8 for coverage under a plan or similar requirement) a limita-
9 tion or exclusion of benefits relating to treatment of a con-
10 dition based on the fact that the condition preexisted the
11 effective date of the plan with respect to an individual if—

12 (1) the condition relates to a condition that was
13 not diagnosed or treated within 3 months before the
14 date of coverage under the plan;

15 (2) the limitation or exclusion extends over
16 more than 6 months after the date of coverage
17 under the plan;

18 (3) the limitation or exclusion applies to an in-
19 dividual who, as of the date of birth, was covered
20 under the plan; or

21 (4) the limitation or exclusion relates to preg-
22 nancy.

23 (b) TREATMENT OF WAITING PERIODS.—In the case
24 of an individual who is eligible for coverage under a plan
25 but for a waiting period imposed by the employer, in ap-

1 plying paragraphs (1) and (2) of subsection (a), the indi-
2 vidual shall be treated as having been covered under the
3 plan as of the earliest date of the beginning of the waiting
4 period.

5 **SEC. 1012. ASSURANCE OF CONTINUITY OF COVERAGE**
6 **THROUGH PREVIOUS SATISFACTION OF PRE-**
7 **EXISTING CONDITION REQUIREMENT.**

8 (a) IN GENERAL.—Each group health plan shall
9 waive any period applicable to a preexisting condition for
10 similar benefits with respect to an individual to the extent
11 that the individual, prior to the date of such individual's
12 enrollment in such plan, was covered for the condition
13 under any other health plan that was in effect before such
14 date.

15 (b) CONTINUOUS COVERAGE REQUIRED.—

16 (1) IN GENERAL.—Subsection (a) shall no
17 longer apply if there is a continuous period of more
18 than 60 days (or, in the case of an individual de-
19 scribed in paragraph (3), 6 months) on which the in-
20 dividual was not covered under a group health plan.

21 (2) TREATMENT OF WAITING PERIODS.—In ap-
22 plying paragraph (1), any waiting period imposed by
23 an employer before an employee is eligible to be cov-
24 ered under a plan shall be treated as a period in

1 which the employee was covered under a group
2 health plan.

3 (3) JOB TERMINATION.—An individual is de-
4 scribed in this paragraph if the individual loses cov-
5 erage under a group health plan due to termination
6 of employment.

7 (4) EXCLUSION OF CASH-ONLY AND DREAD
8 DISEASE PLANS.—In this subsection, the term
9 “group health plan” does not include any group
10 health plan which is offered primarily to provide—

11 (A) coverage for a specified disease or ill-
12 ness, or

13 (B) a hospital or fixed indemnity policy,
14 unless the Secretary determines that such a
15 plan provides sufficiently comprehensive cov-
16 erage of a benefit so that it should be treated
17 as a group health plan under this subsection.

18 **SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY**

19 **GENERALLY.**

20 (a) MULTIEMPLOYER PLANS AND EXEMPTED MUL-
21 TIPLE EMPLOYER HEALTH PLANS.—A multiemployer
22 plan and an exempted multiple employer health plan may
23 not cancel coverage or deny renewal of coverage under
24 such a plan with respect to an employer other than—

25 (1) for nonpayment of contributions,

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

3 (3) for noncompliance with plan provisions,

4 (4) for misuse of a provider network provision,

5 or

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

8 (b) INSURERS.—

9 (1) IN GENERAL.—An insurer may not cancel a
10 health insurance plan or deny renewal of coverage
11 under such a plan other than—

12 (A) for nonpayment of premiums,

13 (B) for fraud or other misrepresentation
14 by the insured,

15 (C) for noncompliance with plan provi-
16 sions,

17 (D) in the case of a plan issued to a small
18 employer, for failure to maintain minimum par-
19 ticipation rates (consistent with paragraph (3)),

20 (E) for misuse of a provider network provi-
21 sion, or

22 (F) because the insurer is ceasing to pro-
23 vide any health insurance plan in a State, or,
24 in the case of a health maintenance organiza-
25 tion, in a geographic area.

1 (2) LIMITATION ON MARKET REENTRY.—If an
2 insurer terminates the offering of health insurance
3 plans in an area, the insurer may not offer such a
4 health insurance plan to any employer in the area
5 until 5 years after the date of the termination.

6 (3) MINIMUM PARTICIPATION RATES.—An in-
7 surer may require, with respect to a health insur-
8 ance plan issued to a small employer, that a mini-
9 mum percentage of eligible employees who do not
10 otherwise have health insurance are enrolled in such
11 plan if such percentage is applied uniformly to all
12 plans offered to employers of comparable size.

13 **PART 3—ENFORCEMENT; EFFECTIVE**
14 **DATES; DEFINITIONS**

15 **SEC. 1021. ENFORCEMENT.**

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

18 (1) IN GENERAL.—For purposes of part 5 of
19 subtitle B of title I of the Employee Retirement In-
20 come Security Act of 1974, the provisions of parts
21 1 and 2 of this subtitle shall be deemed to be provi-
22 sions of title I of such Act irrespective of exclusions
23 under section 4(b) of such Act.

24 (2) REGULATORY AUTHORITY.—With respect to
25 the regulatory authority of the Secretary of Labor

1 under this subtitle pursuant to subsection (a), sec-
2 tion 505 of the Employee Retirement Income Secu-
3 rity Act of 1974 (29 U.S.C. 1135) shall apply.

4 (b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
5 ALTIES FOR INSURERS.—

6 (1) IN GENERAL.—Subject to paragraph (2), an
7 insurer that fails to comply with the requirements
8 applicable to the insurer under part 2 of this subtitle
9 is subject to a civil money penalty under this sub-
10 section.

11 (2) EXCEPTION.—Paragraph (1) shall not
12 apply to a failure by an insurer in a State if the Sec-
13 retary determines that the State has in effect a reg-
14 ulatory enforcement mechanism that provides ade-
15 quate sanctions with respect to such a failure by
16 such an insurer.

17 (3) AMOUNT OF PENALTY.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the amount of the civil money pen-
20 alty imposed under this subsection shall be
21 \$100 for each day during which such failure
22 persists for each individual to which such fail-
23 ure relates.

24 (B) LIMITATION.—The amount of the pen-
25 alty imposed by this subsection for an insurer

1 with respect to a health insurance plan shall
2 not exceed 25 percent of the amounts received
3 under the plan for coverage during the period
4 such failure persists.

5 (4) EXCEPTIONS.—

6 (A) CORRECTIONS WITHIN 30 DAYS.—No
7 civil money penalty be imposed under this sub-
8 section by reason of any failure if—

9 (i) such failure was due to reasonable
10 cause and not to willful neglect, and

11 (ii) such failure is corrected within the
12 30-day period beginning on the earliest
13 date the insurer knew, or exercising rea-
14 sonable diligence would have known, that
15 such failure existed.

16 (B) WAIVER BY SECRETARY.—In the case
17 of a failure which is due to reasonable cause
18 and not to willful neglect, the Secretary may
19 waive part or all of the penalty imposed by this
20 subsection to the extent that payment of such
21 penalty would be excessive relative to the failure
22 involved.

23 (5) PROCEDURES.—The Secretary by regulation
24 shall provide for procedures for the imposition of
25 civil money penalties under this subsection. Such

1 procedures shall assure written notice and oppor-
2 tunity for a determination to be made on the record
3 after a hearing at which the insurer is entitled to be
4 represented by counsel, to present witnesses, and to
5 cross-examine witnesses against the insurer. The pro-
6 visions of subsections (e), (f), (j), and (k) of section
7 1128A of the Social Security Act shall apply to de-
8 terminations and civil money penalties under this
9 section in the same manner as they apply to deter-
10 minations and civil money penalties under such
11 section.

12 **SEC. 1022. EFFECTIVE DATES.**

13 (a) PART 1.—The requirements of part 1 shall apply
14 to plans years beginning after December 31, 1996.

15 (b) PART 2.—The requirements of part 2 with re-
16 spect to—

17 (1) group health plans and employers shall
18 apply to plans years beginning after December 31,
19 1996, and

20 (2) insurers shall take effect on January 1,
21 1997.

22 **SEC. 1023. DEFINITIONS AND SPECIAL RULES.**

23 (a) IN GENERAL.—For purposes of this subtitle:

1 (1) DEPENDENT.—The term “dependent”
2 means, with respect to any individual, any person
3 who is—

4 (A) the spouse or surviving spouse of the
5 individual, or

6 (B) under regulations of the Secretary, a
7 child (including an adopted child) of such indi-
8 vidual and—

9 (i) under 19 years of age, or

10 (ii) under 25 years of age and a full-
11 time student.

12 (2) ELIGIBLE EMPLOYEE.—The term “eligible
13 employee” means, with respect to an employer, an
14 employee who normally performs on a monthly basis
15 at least 30 hours of service per week for that
16 employer.

17 (3) ELIGIBLE INDIVIDUAL.—The term “eligible
18 individual” means, with respect to an eligible em-
19 ployee, such employee, and any dependent of such
20 employee.

21 (4) EMPLOYER.—The term “employer” shall
22 have the meaning applicable under section 3(5) of
23 the Employee Retirement Income Security Act of
24 1974.

1 (5) EXEMPTED MULTIPLE EMPLOYER HEALTH
2 PLAN.—The term “exempted multiple employer
3 health plan” means a multiple employer welfare ar-
4 rangement treated as an employee welfare benefit
5 plan by reason of an exemption under part 7 of sub-
6 title B of title I of the Employee Retirement Income
7 Security Act of 1974 (as added by part 2 of subtitle
8 C of this title).

9 (6) GROUP HEALTH PLAN; PLAN.—(A) The
10 term “group health plan” means an employee wel-
11 fare benefit plan providing medical care (as defined
12 in section 213(d) of the Internal Revenue Code of
13 1986) to participants or beneficiaries directly or
14 through insurance, reimbursement, or otherwise, but
15 does not include any type of coverage excluded from
16 the definition of a health insurance plan under sec-
17 tion 1107(4)(B).

18 (B) The term “plan” means, unless used with
19 a modifying term or the context specifically indicates
20 otherwise, a group health plan (including any such
21 plan which is a multiemployer plan), an exempted
22 multiple employer health plan, or an insured mul-
23 tiple employer health plan.

1 (7) HEALTH INSURANCE PLAN.—The term
2 “health insurance plan” has the meaning given such
3 term in section 1107(4).

4 (8) INSURED MULTIPLE EMPLOYER HEALTH
5 PLAN.—The term “insured multiple employer health
6 plan” has the meaning given such term in section
7 701(11) of Employee Retirement Income Security
8 Act of 1974 (as added by section 1211 of this title).

9 (9) INSURER.—The term “insurer” has the
10 meaning given such term in section 1107(6).

11 (b) SPECIAL RULES.—

12 (1) GENERAL RULE.—Except as otherwise pro-
13 vided in this subtitle, for definitions of terms used
14 in this subtitle, see section 3 of the Employee Re-
15 tirement Income Security Act of 1974 (29 U.S.C.
16 1002).

17 (2) SECRETARY.—Except with respect to ref-
18 erences specifically to the Secretary of Labor, the
19 term “Secretary” means the Secretary of Health
20 and Human Services.

1 **Subtitle B—Reform of Health In-**
2 **surance Marketplace for Small**
3 **Business**

4 **SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER**
5 **STANDARD AND CATASTROPHIC PLANS.**

6 (a) REQUIREMENT.—

7 (1) IN GENERAL.—Each insurer (as defined in
8 section 1107(6)) that makes available any health in-
9 surance plan (as defined in section 1107(4)) to a
10 small employer (as defined in section 1107(9)) in a
11 State shall make available to each small employer in
12 the State—

13 (A) a standard plan (as defined in section
14 1102(a)(2)), and

15 (B) a catastrophic plan (as defined in such
16 section).

17 (2) SPECIAL RULE FOR HEALTH MAINTENANCE
18 ORGANIZATIONS.—The requirements of paragraph
19 (1)(B) shall not apply with respect to a health insur-
20 ance plan that—

21 (A) is a federally qualified health mainte-
22 nance organization (as defined in section
23 1301(a) of the Public Health Service Act), or

24 (B) is not such an organization but is rec-
25 ognized under State law as a health mainte-

1 nance organization or managed care organiza-
2 tion or a similar organization regulated under
3 State law for solvency.

4 (3) EXCEPTION IF STATE PROVIDES FOR GUAR-
5 ANTEED AVAILABILITY (RATHER THAN GUARANTEED
6 ISSUE).—Paragraph (1) shall not apply to an insurer
7 in a State if the State is providing—

8 (A) access to each small employer in the
9 State to a standard plan and to a catastrophic
10 plan, and

11 (B) a risk allocation mechanism described
12 in subsection (c).

13 (b) GUARANTEED ISSUE OF STANDARD AND CATA-
14 STROPHIC PLANS.—Subject to subsection (c)—

15 (1) IN GENERAL.—Subject to paragraph (2),
16 each insurer that offers a standard or catastrophic
17 plan to a small employer in a State—

18 (A) must accept every small employer in
19 the State that applies for coverage under the
20 plan; and

21 (B) must accept for enrollment under the
22 plan every eligible individual (as defined in
23 paragraph (4)) who applies for enrollment on a
24 timely basis (consistent with paragraph (3))
25 and may not place any restriction on the eligi-

1 bility of an individual to enroll so long as such
2 individual is an eligible individual.

3 (2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a plan offered by a health maintenance organization, the plan
4 may—
5 may—

6 may—
7 (A) limit the employers that may apply for
8 coverage to those with eligible individuals residing in the service area of the plan;
9

10 (B) limit the individuals who may be enrolled under the plan to those who reside in the
11 service area of the plan; and
12

13 (C) within the service area of the plan, deny coverage to such employers if the plan
14 demonstrates that—
15

16 (i) it will not have the capacity to deliver services adequately to enrollees of any
17 additional groups because of its obligations to existing group contract holders and enrollees, and
18

19 (ii) it is applying this subparagraph uniformly to all employers without regard
20 to the health status, claims experience, or duration of coverage of those employers
21 and their employees.
22
23
24
25

1 In this paragraph, the term “health maintenance or-
2 ganization” includes an organization recognized
3 under State law as a health maintenance organiza-
4 tion or managed care organization or a similar orga-
5 nization regulated under State law for solvency.

6 (3) CLARIFICATION OF TIMELY ENROLL-
7 MENT.—

8 (A) GENERAL INITIAL ENROLLMENT RE-
9 QUIREMENT.—Except as provided in this para-
10 graph, a standard or catastrophic plan may
11 consider enrollment of an eligible individual not
12 to be timely if the eligible employee or depend-
13 ent fails to enroll in the plan during an initial
14 enrollment period, if such period is at least 30
15 days long.

16 (B) ENROLLMENT DUE TO LOSS OF PRE-
17 VIOUS EMPLOYER COVERAGE.—Enrollment in a
18 standard or catastrophic plan is considered to
19 be timely in the case of an eligible individual
20 who—

21 (i) was covered under another health
22 insurance plan or group health plan at the
23 time of the individual’s initial enrollment
24 period,

1 (ii) stated at the time of the initial en-
2 rollment period that coverage under a
3 health insurance plan or a group health
4 plan was the reason for declining enroll-
5 ment,

6 (iii) lost coverage under another
7 health insurance plan or group health plan
8 (as a result of the termination of the other
9 plan's coverage, termination or reduction
10 of employment, or other reason), and

11 (iv) requests enrollment within 30
12 days after termination of such coverage.

13 (C) REQUIREMENT APPLIES DURING OPEN
14 ENROLLMENT PERIODS.—Each standard or cat-
15 astrophic plan shall provide for at least one pe-
16 riod (of not less than 30 days) each year during
17 which enrollment under the plan shall be con-
18 sidered to be timely.

19 (D) EXCEPTION FOR COURT ORDERS.—
20 Enrollment of a spouse or minor child of an
21 employee shall be considered to be timely if—

22 (i) a court has ordered that coverage
23 be provided for the spouse or child under
24 a covered employee's group health plan,
25 and

1 (ii) a request for enrollment is made
2 within 30 days after the date the court is-
3 sues the order.

4 (E) ENROLLMENT OF SPOUSES AND DE-
5 PENDENTS.—

6 (i) IN GENERAL.—Enrollment of the
7 spouse (including a child of the spouse)
8 and any dependent child of an eligible em-
9 ployee shall be considered to be timely if a
10 request for enrollment is made either—

11 (I) within 30 days of the date of
12 the marriage or of the date of the
13 birth or adoption of a child, if family
14 coverage is available as of such date,
15 or

16 (II) within 30 days of the date
17 family coverage is first made avail-
18 able.

19 (ii) COVERAGE.—If a plan makes
20 family coverage available and enrollment is
21 made under the plan on a timely basis
22 under clause (i)(I), the coverage shall be-
23 come effective not later than the first day
24 of the first month beginning after the date

1 of the marriage or the date of birth or
2 adoption of the child (as the case may be).

3 (4) DEFINITIONS.—In this subsection, the
4 terms “eligible individual” and “group health plan”
5 have the meanings given such terms in section
6 1023(a).

7 (c) STATE OPTION OF GUARANTEED AVAILABILITY
8 THROUGH ALLOCATION OF RISK (RATHER THAN
9 THROUGH GUARANTEED ISSUE).—The requirements of
10 subsection (b) shall not apply in a State if the State has
11 provided (in accordance with standards established under
12 this subtitle) a mechanism under which—

13 (1) each insurer offering a health insurance
14 plan to a small employer in the State must partici-
15 pate in a program for assigning high-risk small em-
16 ployer groups (or individuals within such a group)
17 among some or all such insurers, and

18 (2) the insurers to which such high-risk small
19 employer groups or individuals are so assigned com-
20 ply with the requirements of subsection (b).

21 **SEC. 1102. HEALTH PLAN, STANDARD PLAN, AND CATA-**
22 **STROPHIC PLAN DEFINED.**

23 (a) HEALTH PLAN DEFINED.—In this subtitle:

24 (1) IN GENERAL.—The term “health plan”
25 means a health insurance plan (whether a managed-

1 care plan, indemnity plan, or other plan) that meets
2 the following requirements:

3 (A) The plan—

4 (i) is designed to provide standard
5 coverage (consistent with subsection (b) or
6 (d)) with substantial cost-sharing, or

7 (ii) is designed to provide only cata-
8 strophic coverage (consistent with sub-
9 section (c) or (d)).

10 (B) The plan meets the applicable require-
11 ments of section 1101(b) (relating to guaran-
12 teed issue).

13 (C) The plan meets the consumer protec-
14 tion standards established under section
15 1103(a)(1)(B).

16 (D) The plan meets any participation re-
17 quirements with respect to an applicable rein-
18 surance or allocation of risk mechanism estab-
19 lished by a State or the Secretary under section
20 1106.

21 (2) STANDARD AND CATASTROPHIC PLANS.—

22 The terms “standard plan” and “catastrophic plan”
23 mean a health plan that provides for at least stand-
24 ard coverage (referred to in paragraph (1)(A)(i) or

1 for only catastrophic coverage (referred to in para-
2 graph (1)(A)(ii)), respectively.

3 (b) STANDARD BENEFIT PACKAGE.—

4 (1) IN GENERAL.—Subject to the succeeding
5 provisions of this subsection, subsection (d) (permit-
6 ting variation of benefits among actuarially equiva-
7 lent plans), and subsection (e) (permitting plans not
8 to cover specific treatments, procedures, or classes),
9 a health insurance plan is considered to provide
10 standard coverage consistent with this subsection if
11 the benefits are limited to payment for—

12 (A) inpatient and outpatient hospital care,
13 except that treatment for a mental disorder is
14 subject to the special limitations described in
15 subparagraph (E)(i);

16 (B) inpatient and outpatient physicians'
17 services, except that psychotherapy or counsel-
18 ing for a mental disorder is subject to the spe-
19 cial limitations described in subparagraph
20 (E)(ii);

21 (C) diagnostic tests;

22 (D) preventive services limited to—

23 (i) prenatal care and well-baby care
24 provided to children who are 1 year of age
25 or younger;

1 (ii) well child care;

2 (iii) Pap smears;

3 (iv) mammograms; and

4 (v) colorectal screening services; and

5 (E)(i) inpatient hospital care for a mental
6 disorder for not less than 45 days per year, ex-
7 cept that days of partial hospitalization or resi-
8 dential care may be substituted for days of in-
9 patient care; and

10 (ii) outpatient psychotherapy and counsel-
11 ing for a mental disorder for not less than 20
12 visits per year provided by a provider who is
13 acting within the scope of State law and who—

14 (I) is a physician; or

15 (II) is a duly licensed or certified clin-
16 ical psychologist or a duly licensed or cer-
17 tified clinical social worker, a duly licensed
18 or certified equivalent mental health pro-
19 fessional, or a clinic or center providing
20 duly licensed or certified mental health
21 services.

22 (2) AMOUNT, SCOPE, AND DURATION OF CER-
23 TAIN BENEFITS.—

24 (A) IN GENERAL.—Except as provided in
25 subparagraph (B) and in paragraph (3), a

1 health insurance plan providing for standard
2 coverage shall place no limits on the amount,
3 scope, or duration of benefits described in sub-
4 paragraphs (A) through (C) of paragraph (1).

5 (B) PREVENTIVE SERVICES.—A health in-
6 surance plan providing for standard coverage
7 may limit the amount, scope, and duration of
8 preventive services described in subparagraph
9 (D) of paragraph (1) provided that the amount,
10 scope, and duration of such services are reason-
11 ably consistent with recommendations and peri-
12 odicity schedules developed by appropriate med-
13 ical experts.

14 (3) EXCEPTIONS.—Paragraph (1) shall not be
15 construed as requiring a plan to include payment
16 for—

17 (A) items and services that are not essen-
18 tial and medically necessary;

19 (B) routine physical examinations or pre-
20 ventive care (other than care and services de-
21 scribed in subparagraph (D) of paragraph (1));

22 or

23 (C) experimental services and procedures.

24 (4) LIMITATION ON DEDUCTIBLES.—

1 (A) IN GENERAL.—Except as permitted
2 under subparagraph (B), a health insurance
3 plan providing standard coverage shall not pro-
4 vide a deductible amount for benefits provided
5 in any plan year that exceeds—

6 (i) with respect to benefits payable for
7 items and services furnished to any em-
8 ployee with no family member enrolled
9 under the plan, for a plan year beginning
10 in—

11 (I) a calendar year prior to 1996,

12 \$450; or

13 (II) for a subsequent calendar
14 year, the limitation specified in this
15 clause for the previous calendar year
16 increased by the percentage increase
17 in the consumer price index for all
18 urban consumers (United States city
19 average, as published by the Bureau
20 of Labor Statistics) for the 12-month
21 period ending on September 30 of the
22 preceding calendar year; and

23 (ii) with respect to benefits payable
24 for items and services furnished to any em-
25 ployee with a family member enrolled

1 under the standard benefit package plan,
2 for a plan year beginning in—

3 (I) a calendar year prior to 1996,
4 \$450 per family member and \$780
5 per family; or

6 (II) for a subsequent calendar
7 year, the limitation specified in this
8 clause for the previous calendar year
9 increased by the percentage increase
10 in the consumer price index for all
11 urban consumers (United States city
12 average, as published by the Bureau
13 of Labor Statistics) for the 12-month
14 period ending on September 30 of the
15 preceding calendar year.

16 If the limitation computed under clause (i)(II)
17 or (ii)(II) is not a multiple of \$10, it shall be
18 rounded to the next highest multiple of \$10.

19 (B) WAGE-RELATED DEDUCTIBLE.—A
20 health insurance plan may provide for any other
21 deductible amount instead of the limitations
22 under—

23 (i) subparagraph (A)(i), if such
24 amount does not exceed (on an annualized

1 basis) 1 percent of the total wages paid to
2 the employee in the plan year; or

3 (ii) subparagraph (A)(ii), if such
4 amount does not exceed (on an annualized
5 basis) 1 percent per family member or 2
6 percent per family of the total wages paid
7 to the employee in the plan year.

8 (5) LIMITATION ON COPAYMENTS AND COIN-
9 SURANCE.—

10 (A) IN GENERAL.—Subject to subpara-
11 graphs (B) through (D), a health insurance
12 plan providing standard coverage may not re-
13 quire the payment of any copayment or coinsur-
14 ance for an item or service for which coverage
15 is required under this section—

16 (i) in an amount that exceeds 20 per-
17 cent of the amount payable for the item or
18 service under the plan; or

19 (ii) after an employee and family cov-
20 ered under the plan have incurred out-of-
21 pocket expenses under the plan that are
22 equal to the out-of-pocket limit (as defined
23 in subparagraph (E)(ii)) for a plan year.

24 (B) EXCEPTION FOR MANAGED CARE
25 PLANS.—A health insurance plan that is a man-

1 aged care plan may require payments in excess
2 of the amount permitted under subparagraph
3 (A) in the case of items and services furnished
4 by nonparticipating providers.

5 (C) EXCEPTION FOR IMPROPER UTILIZA-
6 TION.—A health insurance plan may provide for
7 copayment or coinsurance in excess of the
8 amount permitted under subparagraph (A) for
9 any item or service that an individual obtains
10 without complying with procedures established
11 by a managed care plan or under a utilization
12 program to ensure the efficient and appropriate
13 utilization of covered services.

14 (D) EXCEPTIONS FOR MENTAL HEALTH
15 CARE.—In the case of care described in para-
16 graph (1)(E)(ii), a health insurance plan shall
17 not require payment of any copayment or coin-
18 surance for an item or service for which cov-
19 erage is required by this subtitle in an amount
20 that exceeds 50 percent of the amount payable
21 for the item or service.

22 (6) LIMIT ON OUT-OF-POCKET EXPENSES.—

23 (A) OUT-OF-POCKET EXPENSES DE-
24 FINED.—As used in this section, the term “out-
25 of-pocket expenses” means, with respect to an

1 employee in a plan year, amounts payable under
2 the plan as deductibles and coinsurance with re-
3 spect to items and services provided under the
4 plan and furnished in the plan year on behalf
5 of the employee and family covered under the
6 plan.

7 (B) OUT-OF-POCKET LIMIT DEFINED.—As
8 used in this section and except as provided in
9 subparagraph (C), the term “out-of-pocket
10 limit” means for a plan year beginning in—

11 (i) a calendar year prior to 1996,
12 \$3,400; or

13 (ii) for a subsequent calendar year,
14 the limit specified in this subparagraph for
15 the previous calendar year increased by the
16 percentage increase in the consumer price
17 index for all urban consumers (United
18 States city average, as published by the
19 Bureau of Labor Statistics) for the 12-
20 month period ending on September 30 of
21 the preceding calendar year.

22 If the limit computed under clause (ii) is not a
23 multiple of \$10, it shall be rounded to the next
24 highest multiple of \$10.

1 (C) ALTERNATIVE OUT-OF-POCKET
2 LIMIT.—A health insurance plan may provide
3 for an out-of-pocket limit other than that de-
4 fined in subparagraph (B) if, for a plan year
5 with respect to an employee and the family of
6 the employee, the limit does not exceed (on an
7 annualized basis) 10 percent of the total wages
8 paid to the employee in the plan year.

9 (7) LIMITED PREEMPTION OF STATE MAN-
10 DATED BENEFITS.—No State law or regulation in
11 effect in a State that requires health insurance plans
12 offered to small employers in the State to include
13 specified items and services other than those speci-
14 fied by this subsection shall apply with respect to a
15 health insurance plan providing standard coverage
16 offered by an insurer to a small employer.

17 (c) CATASTROPHIC BENEFITS PACKAGE.—

18 (1) IN GENERAL.—Subject to the succeeding
19 provisions of this subsection, subsection (d) (permit-
20 ting variation of benefits among actuarially equiva-
21 lent plans), and subsection (e) (permitting plans not
22 to cover specific treatments, procedures, or classes),
23 a health insurance plan is considered to provide cat-
24 astrophic coverage consistent with this subsection if
25 benefits are limited to payment for—

1 (A) inpatient and outpatient hospital care,
2 including emergency services;

3 (B) inpatient and outpatient physicians'
4 services;

5 (C) diagnostic tests; and

6 (D) preventive services (which may include
7 one or more of the following services)—

8 (i) prenatal care and well-baby care
9 provided to children who are 1 year of age
10 or younger;

11 (ii) well-child care;

12 (iii) Pap smears;

13 (iv) mammograms; and

14 (v) colorectal screening services.

15 (2) COST-SHARING.—Each health insurance
16 plan providing catastrophic coverage issued to a
17 small employer by an insurer may impose premiums,
18 deductibles, copayments, or other cost-sharing on en-
19 rollees of such plan.

20 (3) OUT-OF-POCKET LIMIT.—Each health insur-
21 ance plan providing catastrophic coverage shall pro-
22 vide for a limit on out-of-pocket expenses.

23 (4) LIMITED PREEMPTION OF STATE MAN-
24 DATED BENEFITS.—No State law or regulation in
25 effect in a State that requires health insurance plans

1 offered to small employers in the State to include
2 specified items and services other than those de-
3 scribed in this subsection shall apply with respect to
4 a health insurance plan providing catastrophic cov-
5 erage offered by an insurer to a small employer.

6 (d) ACTUARIAL EQUIVALENCE IN BENEFITS PER-
7 MITTED.—

8 (1) STANDARD BENEFIT PACKAGE.—A health
9 insurance plan also is considered to provide standard
10 coverage consistent with subsection (b) if the bene-
11 fits are determined, in accordance with the set of ac-
12 tuarial equivalence rules certified under paragraph
13 (3), to have a value that is within 5 percentage
14 points of the target actuarial value for standard cov-
15 erage established under paragraph (4).

16 (2) CATASTROPHIC BENEFIT PACKAGE.—A
17 health insurance plan also is considered to provide
18 catastrophic coverage consistent with subsection (c)
19 if the benefits are determined, in accordance with
20 the set of actuarial equivalence rules certified under
21 paragraph (3), to have a value that is within 5 per-
22 centage points of the target actuarial value for cata-
23 strophic coverage established under paragraph (5).

24 (3) RULES OF ACTUARIAL EQUIVALENCE.—

1 (A) INITIAL DETERMINATION.—The NAIC
2 is requested to submit to the Secretary, within
3 6 months after the date of the enactment of
4 this Act, a set of rules which the NAIC deter-
5 mines is sufficient for determining, in the case
6 of any health insurance plan and for purposes
7 of this subsection, the actuarial value of the
8 coverage offered by the plan.

9 (B) CERTIFICATION.—If the Secretary de-
10 termines that the NAIC has submitted a set of
11 rules that comply with the requirements of sub-
12 paragraph (A), the Secretary shall certify such
13 set of rules for use under this subsection. If the
14 Secretary determines that such a set of rules
15 has not been submitted or does not comply with
16 such requirements, the Secretary shall promptly
17 establish a set of rules that meets such require-
18 ments.

19 (4) DETERMINATION OF TARGET ACTUARIAL
20 VALUE FOR STANDARD COVERAGE.—

21 (A) INITIAL DETERMINATION.—The NAIC
22 is requested to submit to the Secretary, within
23 6 months after the date of the enactment of
24 this Act, a target actuarial value for standard
25 coverage equal to the average actuarial value of

1 the standard coverage described in subsection
2 (b). No specific procedure or treatment, or
3 classes thereof, is required to be considered in
4 such determination by this Act or through regu-
5 lations. The determination of such value shall
6 be based on a representative distribution of the
7 population of eligible employees to be offered
8 standard coverage and a single set of standard-
9 ized utilization and cost factors.

10 (B) CERTIFICATION.—If the Secretary de-
11 termines that the NAIC has submitted a target
12 actuarial value for standard coverage that com-
13 plies with the requirements of subparagraph
14 (A), the Secretary shall certify such value for
15 use under this subsection. If the Secretary de-
16 termines that such a value has not been submit-
17 ted or does not comply with such requirements,
18 the Secretary shall promptly determine such a
19 target actuarial value that meets such require-
20 ments.

21 (5) DETERMINATION OF TARGET ACTUARIAL
22 VALUE FOR CATASTROPHIC COVERAGE.—

23 (A) INITIAL DETERMINATION.—The NAIC
24 is requested to submit to the Secretary, within
25 6 months after the date of the enactment of

1 this Act, a target actuarial value for cata-
2 strophic coverage equal to the average actuarial
3 value of the catastrophic coverage described in
4 subsection (c). No specific procedure or treat-
5 ment, or classes thereof, is required to be con-
6 sidered in such determination by this Act or
7 through regulations. The determination of such
8 value shall be based on a representative dis-
9 tribution of the population of eligible employees
10 to be offered catastrophic coverage and a single
11 set of standardized utilization and cost factors.

12 (B) CERTIFICATION.—If the Secretary de-
13 termines that the NAIC has submitted a target
14 actuarial value for catastrophic coverage that
15 complies with the requirements of subparagraph
16 (A), the Secretary shall certify such value for
17 use under this subsection. If the Secretary de-
18 termines that such a value has not been submit-
19 ted or does not comply with such requirements,
20 the Secretary shall promptly determine such a
21 target actuarial value that meets such require-
22 ments.

23 (6) SUBSEQUENT REVISIONS OF RULES AND
24 TARGET VALUES.—

1 (A) NAIC.—The NAIC may submit from
2 time to time to the Secretary revisions of the
3 set of rules of actuarial equivalence and target
4 actuarial values previously established or deter-
5 mined under this subsection if the NAIC deter-
6 mines such revision necessary to take into ac-
7 count changes in the relevant types of health
8 benefits provisions, in deductible levels for cata-
9 strophic coverage, or in demographic conditions
10 which form the basis for such set of rules or
11 values. The provisions of paragraph (3)(B) shall
12 apply to such a revision in the same manner as
13 they apply to the initial determination of the set
14 of rules.

15 (B) SECRETARY.—The Secretary may by
16 regulation revise such set or rules and values
17 from time to time if the Secretary determines
18 such revision necessary to take into account
19 changes described in subparagraph (A).

20 (e) NO COVERAGE OF SPECIFIC TREATMENT, PRO-
21 CEDURES, OR CLASSES REQUIRED.—Nothing in this sec-
22 tion may be construed to require the coverage of any spe-
23 cific procedure, treatment, or class of service in a health
24 plan under this Act or through regulations.

1 **SEC. 1103. ESTABLISHMENT OF HEALTH PLAN STANDARDS.**

2 (a) ESTABLISHMENT OF GENERAL STANDARDS.—

3 (1) ROLE OF NAIC.—The Secretary shall re-
4 quest the NAIC to develop, within 9 months after
5 the date of the enactment of this Act, model regula-
6 tions that specify standards with respect to each of
7 the following:

8 (A)(i) The requirement, under section
9 1101(a), that insurers make available health
10 plans.

11 (ii) The requirements of guaranteed avail-
12 ability of health plans to small employers under
13 section 1101(b).

14 (iii) The requirements for standard and
15 catastrophic coverage under subsections (b) and
16 (c) of section 1102.

17 (B)(i) The requirements of section 1104
18 (relating to limits on premiums and miscellane-
19 ous consumer protections).

20 (ii) The requirement of section 1105 (re-
21 lating to limitation on annual premium in-
22 creases).

23 If the NAIC develops recommended regulations
24 specifying such standards within such period, the
25 Secretary shall review the standards. Such review
26 shall be completed within 60 days after the date the

1 regulations are developed. Unless the Secretary de-
2 termines within such period that the standards do
3 not meet the requirements, such standards shall
4 serve as the standards under this section, with such
5 amendments as the Secretary deems necessary.

6 (2) CONTINGENCY.—If the NAIC does not de-
7 velop such model regulations within such period or
8 the Secretary determines that such regulations do
9 not specify standards that meet the requirements de-
10 scribed in paragraph (1), the Secretary shall specify,
11 within 15 months after the date of the enactment of
12 this Act, standards to carry out those requirements.

13 (3) EFFECTIVE DATE.—The health plan stand-
14 ards and consumer protection standards (as defined
15 in paragraph (5)) shall apply to health plans and
16 health insurance plans in a State on or after the re-
17 spective date the standards are implemented in the
18 State under subsections (b) and (c).

19 (4) DEFINITIONS.—In this section:

20 (A) CONSUMER PROTECTION STAND-
21 ARDS.—The term “consumer protection stand-
22 ards” means the standards established under
23 paragraph (1)(B).

24 (B) HEALTH PLAN STANDARDS.—The
25 term “health plan standards” means the stand-

1 ards established under paragraph (1)(A) (relat-
2 ing to the requirements of sections 1101 and
3 1102), and includes the consumer protection
4 standards insofar as they relate to health plans.

5 (b) APPLICATION OF STANDARDS THROUGH
6 STATES.—

7 (1) APPLICATION OF HEALTH PLAN STAND-
8 ARDS.—

9 (A) IN GENERAL.—Each State shall sub-
10 mit to the Secretary, by the deadline specified
11 in subparagraph (B), a report on steps the
12 State is taking to implement and enforce the
13 consumer protection standards with respect to
14 insurers, and health plans offered, not later
15 than such deadline.

16 (B) DEADLINE FOR REPORT.—

17 (i) 1 YEAR AFTER STANDARDS ESTAB-
18 LISHED.—Subject to clause (ii), the dead-
19 line under this subparagraph is 1 year
20 after the date the health plan standards
21 are established under subsection (a).

22 (ii) EXCEPTION FOR LEGISLATION.—
23 In the case of a State which the Secretary
24 identifies, in consultation with the NAIC,
25 as—

1 (I) requiring State legislation
2 (other than legislation appropriating
3 funds) in order for insurers and
4 health plans offered to meet the
5 health plan standards established
6 under subsection (a), but

7 (II) having a legislature which is
8 not scheduled to meet in 1995 in a
9 legislative session in which such legis-
10 lation may be considered,

11 the date specified in this subparagraph is
12 the first day of the first calendar quarter
13 beginning after the close of the first legis-
14 lative session of the State legislature that
15 begins on or after January 1, 1997. For
16 purposes of the previous sentence, in the
17 case of a State that has a 2-year legislative
18 session, each year of such session shall be
19 deemed to be a separate regular session of
20 the State legislature.

21 (2) FEDERAL ROLE.—If the Secretary deter-
22 mines that a State has failed to submit a report by
23 the deadline specified under paragraph (1) or finds
24 that the State has not implemented and provided
25 adequate enforcement of the health plan standards

1 under such paragraph, the Secretary shall notify the
2 State and provide the State a period of 60 days in
3 which to submit such report or to implement and en-
4 force such standards under such paragraph. If, after
5 such 60-day period, the Secretary finds that such a
6 failure has not been corrected, the Secretary shall
7 provide for such mechanism for the implementation
8 and enforcement of such standards in the State as
9 the Secretary determines to be appropriate. Such
10 implementation and enforcement shall take effect
11 with respect to insurers, and health plans offered or
12 renewed, on or after 3 months after the date of the
13 Secretary's finding under the previous sentence, and
14 until the date the Secretary finds that such a failure
15 has been corrected. In exercising authority under
16 this subparagraph, the Secretary shall determine
17 whether the use of a risk-allocation mechanism, de-
18 scribed in section 1101(c), would be more consistent
19 with the small employer group health coverage mar-
20 ket in the State than the guaranteed availability pro-
21 visions of section 1101(b).

22 (3) APPLICATION OF CONSUMER PROTECTION
23 STANDARDS.—

24 (A) IN GENERAL.—Each State shall sub-
25 mit to the Secretary, by the deadline specified

1 in subparagraph (B), a report on steps the
2 State is taking to implement and enforce the
3 health plan standards with respect to insurers,
4 and health insurance plans (other than health
5 plans) offered, not later than such deadline.

6 (B) DEADLINE FOR REPORT.—

7 (i) 1 YEAR AFTER STANDARDS ESTAB-
8 LISHED.—Subject to clause (ii), the dead-
9 line under this subparagraph is 1 year
10 after the date the consumer protection
11 standards are established under subsection
12 (a).

13 (ii) EXCEPTION FOR LEGISLATION.—

14 In the case of a State which the Secretary
15 identifies, in consultation with the NAIC,
16 as—

17 (I) requiring State legislation
18 (other than legislation appropriating
19 funds) in order for insurers and
20 health insurance plans offered to meet
21 the consumer protection standards es-
22 tablished under subsection (a), but

23 (II) having a legislature which is
24 not scheduled to meet in 1994 in a

1 legislative session in which such legis-
2 lation may be considered,
3 the date specified in this subparagraph is
4 the first day of the first calendar quarter
5 beginning after the close of the first legis-
6 lative session of the State legislature that
7 begins on or after January 1, 1996. For
8 purposes of the previous sentence, in the
9 case of a State that has a 2-year legislative
10 session, each year of such session shall be
11 deemed to be a separate regular session of
12 the State legislature.

13 (4) FEDERAL ROLE.—If the Secretary deter-
14 mines that a State has failed to submit a report by
15 the deadline specified under paragraph (1) or finds
16 that the State has not implemented and provided
17 adequate enforcement of the consumer protection
18 standards under such paragraph, the Secretary shall
19 notify the State and provide the State a period of
20 60 days in which to submit such report or to imple-
21 ment and enforce such standards under such para-
22 graph. If, after such 60-day period, the Secretary
23 finds that such a failure has not been corrected, the
24 Secretary shall provide for such mechanism for the
25 implementation and enforcement of such standards

1 in the State as the Secretary determines to be ap-
2 propriate. Such implementation and enforcement
3 shall take effect with respect to insurers, and health
4 insurance plans (other than health plans) offered or
5 renewed, on or after 3 months after the date of the
6 Secretary's finding under the previous sentence, and
7 until the date the Secretary finds that such a failure
8 has been corrected.

9 **SEC. 1104. LIMITS ON PREMIUMS AND MISCELLANEOUS**
10 **CONSUMER PROTECTIONS.**

11 (a) LIMITS ON PREMIUMS.—

12 (1) LIMIT ON VARIATION OF INDEX RATES BE-
13 TWEEN CLASSES OF BUSINESS.—

14 (A) IN GENERAL.—As a standard under
15 section 1103(a)(1)(B)(i), the index rate for a
16 rating period for any class of business of an in-
17 surer may not exceed by more than 20 percent
18 the index rate for any other class of business.

19 (B) EXCEPTION.—The limitation of sub-
20 paragraph (A) shall not apply to a class of busi-
21 ness if—

22 (i) the class is one for which the in-
23 surer does not reject, and never has re-
24 jected, small employers included within the
25 definition of employers eligible for the class

1 of business or otherwise eligible employees
2 and dependents who enroll on a timely
3 basis, based upon their claim experience or
4 health status,

5 (ii) the insurer does not involuntarily
6 transfer, and never has involuntarily trans-
7 ferred, a health insurance plan into or out
8 of the class of business, and

9 (iii) the class of business is currently
10 available for purchase.

11 (2) LIMIT ON VARIATION OF PREMIUM RATES
12 WITHIN A CLASS OF BUSINESS.—For a class of busi-
13 ness of an insurer, as a standard under section
14 1103(a)(1)(B)(i), the highest premium rates charged
15 during a rating period to small employers with simi-
16 lar demographic and other similar objective charac-
17 teristics (and not relating to claims experience,
18 health status, industry, occupation, or duration of
19 coverage since issue) for the same or similar cov-
20 erage, or the highest rates which could be charged
21 to such employers under the rating system for that
22 class of business, shall not exceed an amount that is
23 1.5 times the base premium rate for the class of
24 business for a rating period (or portion thereof) that
25 occurs in the first 3 years in which this section is

1 in effect, and 1.35 times the base premium rate
2 thereafter.

3 (3) OBJECTIVE BASIS FOR DIFFERENCES IN
4 PREMIUMS FOR STANDARD AND CATASTROPHIC
5 PLANS.—The difference between the index rates for
6 catastrophic plans and the index rates for standard
7 plans shall be reasonable and shall reflect the dif-
8 ference in plan design and shall not take into ac-
9 count differences due to the nature of the groups as-
10 sumed to select particular health plans.

11 (4) LIMIT ON TRANSFER OF EMPLOYERS
12 AMONG CLASSES OF BUSINESS.—As a standard
13 under section 1103(a)(1)(B)(i), an insurer may not
14 involuntarily transfer a small employer into or out of
15 a class of business. An insurer may not offer to
16 transfer a small employer into or out of a class of
17 business unless such offer is made to transfer all
18 small employers in the class of business without re-
19 gard to demographic characteristics, claim experi-
20 ence, health status, industry, occupation, or duration
21 since issue.

22 (5) DEFINITIONS.—In this subsection:

23 (A) BASE PREMIUM RATE.—The term
24 “base premium rate” means, for each class of
25 business for each rating period, the lowest pre-

1 mium rate charged or which could have been
2 charged under a rating system for that class of
3 business by the insurer to small employers with
4 similar demographic characteristics and other
5 similar objective characteristics (not relating to
6 claims experience, health status, industry, occu-
7 pation, or duration of coverage since issue) for
8 health insurance plans with the same or similar
9 coverage.

10 (B) CLASS OF BUSINESS.—The term
11 “class of business” means, with respect to an
12 insurer, all (or a distinct group of) small em-
13 ployers as shown on the records of the insurer.

14 (C) RULES FOR ESTABLISHING CLASSES
15 OF BUSINESS.—For purposes of subparagraph
16 (B)—

17 (i) an insurer may establish, subject
18 to clause (ii), a distinct group of small em-
19 ployers on the basis that the applicable
20 health insurance plans either—

21 (I) are marketed and sold
22 through individuals and organizations
23 which are not participating in the
24 marketing or sale of other distinct

1 groups of small employers for the in-
2 surer,

3 (II) have been acquired from an-
4 other insurer as a distinct group, or

5 (III) are provided through an as-
6 sociation that has a membership of
7 not less than 100 small employers and
8 that has been formed for purposes
9 other than obtaining health coverage;

10 (ii) an insurer may not establish more
11 than 2 groupings under each class of busi-
12 ness based on the insurer's use of man-
13 aged-care techniques if the techniques are
14 expected to produce substantial variation
15 in health care costs; and

16 (iii) notwithstanding clauses (i) and
17 (ii), a State commissioner of insurance,
18 upon application and if authorized under
19 State law, may approve additional distinct
20 groups upon a finding that such approval
21 would enhance the efficiency and fairness
22 of the small employer marketplace.

23 (D) INDEX RATE.—The term “index rate”
24 means, with respect to a class of business, the
25 arithmetic average of the applicable base pre-

1 premium rate and the corresponding highest pre-
2 premium rate for the class.

3 (E) DEMOGRAPHIC CHARACTERISTICS.—

4 Except as otherwise permitted under the stand-
5 ard under section 1103(b)(1)(B)(i), the term
6 “demographic characteristics” means age, gen-
7 der, geographic area, family composition, and
8 group size.

9 (b) FULL DISCLOSURE OF RATING PRACTICES.—At
10 the time an insurer offers a health insurance plan to a
11 small employer, the insurer shall fully disclose to the em-
12 ployer rating practices for health insurance plans, includ-
13 ing rating practices for different populations and benefit
14 designs.

15 (c) ACTUARIAL CERTIFICATION.—Each insurer that
16 offers a health insurance plan to a small employer in a
17 State shall file annually with the State commissioner of
18 insurance a written statement by a member of the Amer-
19 ican Academy of Actuaries (or other individual acceptable
20 to the commissioner) that, based upon an examination by
21 the individual which includes a review of the appropriate
22 records and of the actuarial assumptions of the insurer
23 and methods used by the insurer in establishing premium
24 rates for applicable health insurance plans—

1 (1) the insurer is in compliance with the appli-
2 cable provisions of this section, and

3 (2) the rating methods are actuarially sound.

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

6 (d) REGISTRATION AND REPORTING.—Each insurer
7 that issues any health insurance plan to a small employer
8 in a State shall be registered or licensed with the State
9 commissioner of insurance and shall comply with any re-
10 porting requirements of the commissioner relating to such
11 a plan.

12 **SEC. 1105. LIMITATION ON VARIATION IN ANNUAL PRE-**
13 **MIUM INCREASES AMONG COVERED SMALL**
14 **EMPLOYERS.**

15 An insurer may not provide for an increase in the
16 premium charged a small employer for a health insurance
17 plan in a percentage that exceeds the percentage change
18 in the premium charged under the plan for a newly cov-
19 ered small employer within the same class of business rate
20 plus 10 percentage points.

21 **SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCA-**
22 **TION OF RISK MECHANISMS FOR HIGH RISK**
23 **INDIVIDUALS IN MARKETPLACE FOR SMALL**
24 **BUSINESS.**

25 (a) ESTABLISHMENT OF STANDARDS.—

1 (1) ROLE OF NAIC.—The Secretary shall re-
2 quest the NAIC to develop, within 9 months after
3 the date of the enactment of this Act, models for re-
4 insurance or allocation of risk mechanisms (each in
5 this section referred to as a “reinsurance or alloca-
6 tion of risk mechanism”) for health insurance plans
7 made available to small employers and for whom an
8 insurer is at risk of incurring high costs under the
9 plan. If the NAIC develops such models within such
10 period, the Secretary shall review such models to de-
11 termine if they provide for an effective reinsurance
12 or allocation of risk mechanism. Such review shall be
13 completed within 30 days after the date the models
14 are developed. Unless the Secretary determines with-
15 in such period that such a model is not an effective
16 reinsurance or allocation of risk mechanism, such re-
17 maining models shall serve as the models under this
18 section, with such amendments as the Secretary
19 deems necessary.

20 (2) CONTINGENCY.—If the NAIC does not de-
21 velop such models within such period or the Sec-
22 retary determines that all such models do not pro-
23 vide for an effective reinsurance or allocation of risk
24 mechanism, the Secretary shall specify, within 15

1 months after the date of the enactment of this Act,
2 models to carry out this section.

3 (b) IMPLEMENTATION OF REINSURANCE OR ALLOCA-
4 TION OF RISK MECHANISMS.—

5 (1) BY STATES.—Each State shall establish
6 and maintain one or more reinsurance or allocation
7 of risk mechanisms that are consistent with a model
8 established under subsection (a) by not later than
9 the deadline specified in section 1103(b)(1)(B). A
10 State may establish and maintain such a mechanism
11 jointly with one or more other States.

12 (2) FEDERAL ROLE.—

13 (A) IN GENERAL.—If the Secretary deter-
14 mines that a State has failed to establish or
15 maintain a reinsurance or allocation of risk
16 mechanism in accordance with paragraph (1),
17 the Secretary shall establish and maintain such
18 a reinsurance or allocation of risk mechanism
19 meeting the requirements of this paragraph.

20 (B) REINSURANCE MECHANISM.—Unless
21 the Secretary determines under subparagraph
22 (C) that an allocation of risk mechanism is the
23 appropriate mechanism to use in a State under
24 this paragraph, the Secretary shall establish
25 and maintain for use under this section for

1 each State an appropriate reinsurance mecha-
2 nism. Such mechanism may require insurers to
3 make contributions in proportion to the
4 amounts received by the insurers for providing
5 health insurance plans in the State.

6 (C) ALLOCATION OF RISK MECHANISM.—If
7 the Secretary determines that, due to the na-
8 ture of the health coverage market in the State
9 (including a relatively small number of health
10 insurance plans offered or a relatively small
11 number of uninsurable small employers), an al-
12 location of risk mechanism would be a better
13 mechanism than a reinsurance mechanism, the
14 Secretary shall establish and maintain for use
15 under this section for a State an allocation of
16 risk mechanism under which uninsurable small
17 employers would be equitably assigned among
18 insurers offering health insurance plans to
19 small employers.

20 (c) CONSTRUCTION.—Nothing in this section shall be
21 construed to prohibit reinsurance or allocation of risk ar-
22 rangements relating to health insurance plans, whether on
23 a State or multi-State basis, not required under this
24 section.

1 **SEC. 1107. DEFINITIONS.**

2 Except as otherwise specifically provided, for pur-
3 poses of this subtitle:

4 (1) **DEPENDENT CHILD.**—The term “dependent
5 child” means a child (including an adopted child)
6 who is under 19 years of age or who is a full-time
7 student and under 25 years of age.

8 (2) **ELIGIBLE EMPLOYEE.**—The term “eligible
9 employee” means, with respect to an employer, an
10 employee who normally performs on a monthly basis
11 at least 30 hours of service per week for that
12 employer.

13 (3) **EMPLOYER.**—The term “employer” shall
14 have the meaning applicable under section 3(5) of
15 the Employee Retirement Income Security Act of
16 1974.

17 (4) **HEALTH INSURANCE PLAN.**—

18 (A) **IN GENERAL.**—Except as provided in
19 subparagraph (B), the term “health insurance
20 plan” means any hospital or medical service
21 policy or certificate, hospital or medical service
22 plan contract, or health maintenance organiza-
23 tion group contract offered by an insurer.

24 (B) **EXCEPTION.**—Such term does not in-
25 clude any of the following—

- 1 (i) coverage only for accident, dental,
2 vision, disability income, or long-term care
3 insurance, or any combination thereof,
4 (ii) medicare supplemental health in-
5 surance,
6 (iii) coverage issued as a supplement
7 to liability insurance,
8 (iv) worker’s compensation or similar
9 insurance, or
10 (v) automobile medical-payment insur-
11 ance,
12 or any combination thereof.

13 (5) HEALTH MAINTENANCE ORGANIZATION.—
14 The term “health maintenance organization” in-
15 cludes, as defined in standards established under
16 section 1103, a health insurance plan that meets
17 specified standards and that offers to provide health
18 services on a prepaid, at-risk basis primarily through
19 a defined set of providers.

20 (6) INSURER.—The term “insurer” means a li-
21 censed insurance company, a prepaid hospital or
22 medical service plan, and a health maintenance orga-
23 nization offering such a plan to an employer, and in-
24 cludes a similar organization regulated under State
25 law for solvency.

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

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

5 (9) SMALL EMPLOYER.—The term “small em-
6 ployer” means, with respect to a calendar year, an
7 employer that normally employs more than 1 but
8 less than 51 eligible employees on a typical business
9 day. For the purposes of this paragraph, the term
10 “employee” includes a self-employed individual. For
11 purposes of determining if an employer is a small
12 employer, rules similar to the rules of subsection (b)
13 and (c) of section 414 of the Internal Revenue Code
14 of 1986 shall apply.

15 (10) STATE.—The term “State” means the 50
16 States, the District of Columbia, Puerto Rico, the
17 Virgin Islands, Guam, and American Samoa.

18 (11) STATE COMMISSIONER OF INSURANCE.—
19 The term “State commissioner of insurance” in-
20 cludes a State superintendent of insurance.

21 **SEC. 1108. OFFICE OF PRIVATE HEALTH CARE COVERAGE;**
22 **ANNUAL REPORTS ON EVALUATION OF**
23 **HEALTH CARE COVERAGE REFORM.**

24 (a) IN GENERAL.—In order to carry out the respon-
25 sibilities of the Secretary under this subtitle, the Secretary

1 shall establish an Office of Private Health Care Coverage,
2 to be headed by a Director (in this section and section
3 1109 referred to as the “Director”) appointed by the Sec-
4 retary.

5 (b) ANNUAL REPORT.—

6 (1) IN GENERAL.—The Director shall submit to
7 Congress an annual report on the implementation of
8 this subtitle.

9 (2) INFORMATION TO BE INCLUDED.—Each an-
10 nual report shall include information concerning at
11 least the following:

12 (A) Implementation and enforcement of
13 the applicable health plan standards and
14 consumer protection standards under this sub-
15 title by the States and by the Secretary.

16 (B) An evaluation of the impact of the re-
17 forms under this subtitle on the availability of
18 affordable health coverage for small employers
19 that purchase group health coverage and for
20 their employees, and, in particular, the impact
21 of—

22 (i) guaranteed availability of health
23 coverage,

24 (ii) limitations of restrictions from
25 coverage of preexisting conditions,

- 1 (iii) requirement for continuity of cov-
2 erage,
3 (iv) risk-management mechanisms for
4 health coverage,
5 (v) limits on premium variations,
6 (vi) limits on annual premium in-
7 creases, and
8 (vii) preemption of State benefit man-
9 dates.

10 In performing such evaluation, the Secretary
11 shall seek to discount the effect of the insur-
12 ance cycle on health insurance premiums.

13 (C) An assessment of the implications of
14 the reforms on adverse selection among health
15 insurance plans and the distribution of risk
16 among health insurance plans.

17 (c) ADVISORY COMMITTEE.—The Secretary shall pro-
18 vide for appointment of an advisory committee to advise
19 the Director concerning activities of the Office under this
20 subtitle. Membership on the committee shall consist of 17
21 individuals and shall include individuals from the general
22 public, small and large business, labor, insurance and
23 other group health plans, and health care providers, and
24 shall include individuals who are experts in the fields of
25 the actuarial science, health economics, and health services

1 research. The Secretary may include, as additional, ex
2 officio members of the committee, such representatives of
3 government agencies as the Secretary deems appropriate.
4 The chairperson of the committee shall not be a health
5 care provider or receive any direct or indirect compensa-
6 tion from an insurer, health insurance plan, or a health
7 care provider.

8 **SEC. 1109. RESEARCH AND DEMONSTRATION PROJECTS;**
9 **DEVELOPMENT OF A HEALTH RISK POOLING**
10 **MODEL.**

11 (a) RESEARCH AND DEMONSTRATIONS.—The Direc-
12 tor is authorized, directly, by contract, and through grants
13 and cooperative agreements within the Department of
14 Health and Human Services and outside the Depart-
15 ment—

16 (1) to conduct research on the impact of this
17 subtitle on the availability of affordable health cov-
18 erage for employees and dependents in the small em-
19 ployers group health care coverage market and other
20 topics described in section 1108(b), and

21 (2) to conduct demonstration projects relating
22 to such topics.

23 (b) DEVELOPMENT OF METHODS OF MEASURING
24 RELATIVE HEALTH RISK.—

1 (1) IN GENERAL.—The Director shall develop
2 methods for measuring, in terms of the expected
3 costs of providing benefits under health insurance
4 plans and, in particular, health plans, the relative
5 health risks of eligible individuals.

6 (2) METHODOLOGY.—The methods—

7 (A) shall rely on diagnosis or other health-
8 related information that is predictive of individ-
9 ual health care needs,

10 (B) may rely upon information routinely
11 collected in the process of making payments
12 under group health plans, and

13 (C) may provide for such random, sample
14 audits of records as may be necessary to verify
15 the accuracy of measurements.

16 (c) DEVELOPMENT OF A HEALTH RISK POOLING
17 MODEL.—

18 (1) IN GENERAL.—The Director shall develop a
19 model, based on the methods of measuring risks
20 under subsection (b), for equitably distributing
21 health risks among insurers in the small employer
22 health care coverage market.

23 (2) REDISTRIBUTION OF RISK.—Under such
24 model, insurers with below average health risks
25 would be required to contribute to a common fund

1 for payment to insurers with above average health
2 risks, each in relation to the degree of their favor-
3 able or adverse risk selection.

4 (3) INCENTIVES.—Such model shall include in-
5 centives to encourage continuous coverage of eligible
6 individuals and small employers.

7 (d) CONSULTATION.—The methods and model under
8 this section shall be developed in consultation with the
9 NAIC and the advisory committee established under sec-
10 tion 1108(c).

11 (e) REPORT.—By not later than January 1, 1996,
12 the Director shall submit to Congress a report on the
13 methods and model developed under this section (as well
14 as on research and demonstration projects conducted
15 under subsection (a)). The Director shall include in the
16 report such recommendations respecting the application of
17 the model to insurers (and, in particular, to health plans)
18 under this subtitle as the Director deems appropriate.

19 (f) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section,
21 such sums as may be necessary in each of fiscal years
22 1995 through 1999.

1 **Subtitle C—Preemption**

2 **PART 1—SCOPE OF STATE REGULATION**

3 **SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES**
4 **FOR GROUP HEALTH PLANS.**

5 In the case of a group health plan, no provision of
6 State or local law shall apply that requires the coverage
7 of one or more specific benefits, services, or categories of
8 health care, or services of any class or type of provider
9 of health care.

10 **SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EM-**
11 **PLOYER GROUPS FROM PURCHASING**
12 **HEALTH INSURANCE.**

13 No provision of State or local law shall apply that
14 prohibits 2 or more employers from obtaining coverage
15 under an insured multiple employer health plan.

16 **SEC. 1203. RESTRICTIONS ON MANAGED CARE.**

17 (a) **PREEMPTION OF STATE LAW PROVISIONS.**—Sub-
18 ject to subsection (c), the following provisions of State law
19 are preempted and may not be enforced:

20 (1) **RESTRICTIONS ON REIMBURSEMENT RATES**
21 **OR SELECTIVE CONTRACTING.**—Any law that re-
22 stricts the ability of a group health plan to negotiate
23 reimbursement rates with providers or to contract
24 selectively with one provider or a limited number of
25 providers.

1 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
2 CIAL INCENTIVES.—Any law that limits the financial
3 incentives that a group health plan may require a
4 beneficiary to pay when a non-plan provider is used
5 on a non-emergency basis.

6 (3) RESTRICTIONS ON UTILIZATION REVIEW
7 METHODS.—Any law that—

8 (A) prohibits utilization review of any or
9 all treatments and conditions,

10 (B) requires that such review be made (i)
11 by a resident of the State in which the treat-
12 ment is to be offered or by an individual li-
13 censed in such State, or (ii) by a physician in
14 any particular specialty or with any board cer-
15 tified specialty of the same medical specialty as
16 the provider whose services are being reviewed,

17 (C) requires the use of specified standards
18 of health care practice in such reviews or re-
19 quires the disclosure of the specific criteria used
20 in such reviews,

21 (D) requires payments to providers for the
22 expenses of responding to utilization review re-
23 quests, or

24 (E) imposes liability for delays in perform-
25 ing such review.

1 Nothing in subparagraph (B) shall be construed as
2 prohibiting a State from (i) requiring a licensed phy-
3 sician or other health care professional be available
4 at some time in the review or appeal process, or (ii)
5 requiring that any decision in an appeal from such
6 a review be made by a licensed physician.

7 (b) GAO STUDY.—

8 (1) IN GENERAL.—The Comptroller General
9 shall conduct a study of the benefits and cost effec-
10 tiveness of the use of managed care in the delivery
11 of health services.

12 (2) REPORT.—By not later than 4 years after
13 the date of the enactment of this Act, the Comptrol-
14 ler General shall submit a report to Congress on the
15 study conducted under paragraph (1) and shall in-
16 clude in the report such recommendations (including
17 whether the provisions of subsection (a) should be
18 extended) as may be appropriate.

19 (c) SUNSET.—Unless otherwise provided, subsection
20 (a) shall not apply 5 years after the date of the enactment
21 of this Act.

22 **SEC. 1204. DEFINITIONS.**

23 For purposes of this part, the terms “dependent”,
24 “employee”, “employer”, “group health plan”, “health in-
25 surance plan”, “insured multiple employer health plan”,

1 and “State” have the meanings given such terms in sec-
2 tion 1023(a).

3 **PART 2—MULTIPLE EMPLOYER HEALTH**

4 **BENEFITS PROTECTIONS**

5 **SEC. 1211. LIMITED EXEMPTION UNDER PREEMPTION**
6 **RULES FOR MULTIPLE EMPLOYER PLANS**
7 **PROVIDING HEALTH BENEFITS SUBJECT TO**
8 **CERTAIN FEDERAL STANDARDS.**

9 (a) IN GENERAL.—Subtitle B of title I of the Em-
10 ployee Retirement Income Security Act of 1974 is amend-
11 ed by adding at the end the following new part:

12 “Part 7—Multiple Employer Health Plans

13 **“SEC. 701. DEFINITIONS.**

14 “For purposes of this part—

15 “(1) INSURER.—The term ‘insurer’ means an
16 insurance company, insurance service, or insurance
17 organization, licensed to engage in the business of
18 insurance by a State.

19 “(2) PARTICIPATING EMPLOYER.—The term
20 ‘participating employer’ means, in connection with a
21 multiple employer welfare arrangement, any em-
22 ployer if any of its employees, or any of the depend-
23 ents of its employees, are or were covered under
24 such arrangement in connection with the employ-
25 ment of the employees.

1 “(3) EXCESS/STOP LOSS COVERAGE.—The term
2 ‘excess/stop loss coverage’ means, in connection with
3 a multiple employer welfare arrangement, a contract
4 under which an insurer provides for payment with
5 respect to claims under the arrangement, relating to
6 participants or beneficiaries individually or other-
7 wise, in excess of an amount or amounts specified in
8 such contract.

9 “(4) QUALIFIED ACTUARY.—The term ‘quali-
10 fied actuary’ means an individual who is a member
11 of the American Academy of Actuaries or meets
12 such reasonable standards and qualifications as the
13 Secretary may provide by regulation.

14 “(5) SPONSOR.—The term ‘sponsor’ means, in
15 connection with a multiple employer welfare arrange-
16 ment, the association or other entity which estab-
17 lishes or maintains the arrangement.

18 “(6) STATE LOCATION OF COVERED INDIVID-
19 UALS.—

20 “(A) IN GENERAL.—A multiple employer
21 welfare arrangement shall be treated as cover-
22 ing individuals located in a State only if the
23 minimum required number of individuals who
24 are covered under the arrangement are located
25 in such State, except that if the minimum re-

1 required number of individuals are not located in
2 any State, such arrangement shall be treated as
3 covering individuals in any State in which any
4 covered individual is located.

5 “(B) MINIMUM REQUIRED NUMBER.—For
6 purposes of subparagraph (A), the minimum re-
7 quired number is the greater of—

8 “(i) 5 percent of the total number of
9 individuals described in subparagraph (A),
10 or

11 “(ii) 50.

12 “(C) LOCATION OF INDIVIDUALS IN
13 STATE.—For purposes of subparagraph (A), an
14 individual shall be treated as located in a State
15 if such individual is employed in such State or
16 the address of such individual last known by
17 the arrangement is located in such State.

18 “(7) STATE INSURANCE COMMISSIONER.—The
19 term ‘State insurance commissioner’ means the in-
20 surance commissioner (or similar official) of a State.

21 “(8) DOMICILE STATE.—The term ‘domicile
22 State’ means, in connection with a multiple employer
23 welfare arrangement, the State in which, according
24 to the application for an exemption under this part,
25 most individuals to be covered under the arrange-

1 ment are located, except that, in any case in which
2 information contained in the latest annual report of
3 the arrangement filed under this part indicates that
4 most individuals covered under the arrangement are
5 located in a different State, such term means such
6 different State.

7 “(9) FULLY INSURED ARRANGEMENT.—A mul-
8 tiple employer welfare arrangement shall be treated
9 as fully insured only if one or more insurers, health
10 maintenance organizations, similar organizations
11 regulated under State law for solvency, or any com-
12 bination thereof are liable under one or more insur-
13 ance policies or contracts for all benefits under the
14 arrangement (irrespective of any recourse they may
15 have against other parties).

16 “(10) MULTIPLE EMPLOYER HEALTH PLAN.—
17 The term ‘multiple employer health plan’ means a
18 multiple employer welfare arrangement treated as an
19 employee welfare benefit plan by reason of an
20 exemption under this part.

21 “(11) INSURED MULTIPLE EMPLOYER HEALTH
22 PLAN.—The term ‘insured multiple employer health
23 plan’ means a fully insured multiple employer wel-
24 fare arrangement under which benefits consist solely
25 of medical care described in section 607(1) (dis-

1 regarding such incidental benefits as the Secretary
2 shall specify by regulations).

3 “(12) PREPAID HEALTH CARE ARRANGE-
4 MENT.—The term ‘prepaid health care arrangement’
5 means a nonprofit entity which—

6 “(A) offers benefits consisting of medical
7 care described in section 607(1) on a prepaid
8 basis, and

9 “(B) is established and controlled by a
10 group medical practice or similar group, by a
11 hospital, or by such a practice (or group) and
12 a hospital.

13 **“SEC. 702. EXEMPTED MULTIPLE EMPLOYER PLANS PRO-**
14 **VIDING BENEFITS IN THE FORM OF MEDICAL**
15 **CARE RELIEVED OF CERTAIN RESTRICTIONS**
16 **ON PREEMPTION OF STATE LAW AND TREAT-**
17 **ED AS EMPLOYEE WELFARE BENEFIT PLANS.**

18 “(a) IN GENERAL.—Subject to subsection (b), a mul-
19 tiple employer welfare arrangement which is not fully in-
20 sured and with respect to which there is in effect an ex-
21 emption granted by the Secretary under this part (or with
22 respect to which there is pending a complete application
23 for such an exemption and the Secretary determines that
24 provisional protection under this part is appropriate)—

1 “(1) shall be treated for purposes of subtitle A
2 and the preceding parts of this subtitle as an em-
3 ployee welfare benefit plan, irrespective of whether
4 such arrangement is an employee welfare benefit
5 plan, and

6 “(2) shall be exempt from section
7 514(b)(6)(A)(ii).

8 “(b) BENEFITS MUST CONSIST OF MEDICAL
9 CARE.—Subsection (a) shall apply to a multiple employer
10 welfare arrangement only if the benefits provided there-
11 under consist solely of medical care described in section
12 607(1) (disregarding such incidental benefits as the
13 Secretary shall specify by regulation).

14 “(c) RESTRICTION ON COMMENCEMENT OF NEW AR-
15 RANGEMENTS.—A multiple employer welfare arrangement
16 providing benefits which consist of medical care described
17 in section 607(1) which has not commenced operations as
18 of January 1, 1995, may commence operations only if an
19 exemption granted to the arrangement under this part is
20 in effect (or there is pending with respect to the arrange-
21 ment a complete application for such an exemption and
22 the Secretary determines that provisional protection under
23 this part is appropriate).

1 **“SEC. 703. EXEMPTION PROCEDURE.**

2 “(a) IN GENERAL.—The Secretary shall grant an ex-
3 emption described in section 702(a) to a multiple employer
4 welfare arrangement if—

5 “(1) an application for such exemption with re-
6 spect to such arrangement, identified individually or
7 by class, has been duly filed in complete form with
8 the Secretary in accordance with this part,

9 “(2) such application demonstrates compliance
10 with the requirements of section 704 with respect to
11 such arrangement, and

12 “(3) the Secretary finds that such exemption
13 is—

14 “(A) administratively feasible,

15 “(B) not adverse to the interests of the in-
16 dividuals covered under the arrangement, and

17 “(C) protective of the rights and benefits
18 of the individuals covered under the arrange-
19 ment.

20 “(b) NOTICE AND HEARING.—Before granting an ex-
21 emption under this section, the Secretary shall publish no-
22 tice in the Federal Register of the pendency of the exemp-
23 tion, shall require that adequate notice be given to inter-
24 ested persons, including the State insurance commissioner
25 of each State in which covered individuals under the ar-
26 rangement are, or are expected to be, located, and shall

1 afford interested persons opportunity to present views.
2 The Secretary may not grant an exemption under this sec-
3 tion unless the Secretary affords an opportunity for a
4 hearing and makes a determination on the record with re-
5 spect to the findings required under subsection (a)(3). The
6 Secretary shall, to the maximum extent practicable, make
7 a final determination with respect to any application filed
8 under this section in the case of a newly established ar-
9 rangement within 90 days after the date which the Sec-
10 retary determines is the date on which such application
11 is filed in complete form.

12 **“SEC. 704. ELIGIBILITY REQUIREMENTS.**

13 “(a) APPLICATION FOR EXEMPTION.—

14 “(1) IN GENERAL.—An exemption may be
15 granted by the Secretary under this part only on the
16 basis of an application filed with the Secretary in
17 such form and manner as shall be prescribed in reg-
18 ulations of the Secretary. Any such application shall
19 be signed by the operating committee and the spon-
20 sor of the arrangement.

21 “(2) FILING FEE.—The arrangement shall pay
22 to the Secretary at the time of filing an application
23 under this section a filing fee in the amount of
24 \$5,000, which shall be available, to the extent pro-
25 vided in appropriation Acts, to the Secretary for the

1 sole purpose of administering the exemption proce-
2 dures under this part.

3 “(3) INFORMATION INCLUDED.—An application
4 filed under this section shall include, in a manner
5 and form prescribed in regulations of the Secretary,
6 at least the following information:

7 “(A) IDENTIFYING INFORMATION.—The
8 names and addresses of—

9 “(i) the sponsor, and

10 “(ii) the members of the operating
11 committee of the arrangement.

12 “(B) STATES IN WHICH ARRANGEMENT IN-
13 TENDS TO DO BUSINESS.—The States in which
14 individuals covered under the arrangement are
15 to be located and the number of such individ-
16 uals expected to be located in each such State.

17 “(C) BONDING REQUIREMENTS.—Evidence
18 provided by the operating committee that the
19 bonding requirements of section 412 will be met
20 as of the date of the application.

21 “(D) PLAN DOCUMENTS.—A copy of the
22 documents governing the arrangement (includ-
23 ing any bylaws and trust agreements), the sum-
24 mary plan description, and other material de-
25 scribing the benefits and coverage that will be

1 provided to individuals covered under the ar-
2 rangement.

3 “(E) AGREEMENTS WITH SERVICE PROVID-
4 ERS.—A copy of any agreements between the
5 arrangement and contract administrators and
6 other service providers.

7 “(F) FUNDING REPORT.—A report setting
8 forth information determined as of a date with-
9 in the 120-day period ending with the date of
10 the application, including the following:

11 “(i) RESERVES.—A statement, cer-
12 tified by the operating committee of the ar-
13 rangement, and a statement of actuarial
14 opinion, signed by a qualified actuary, that
15 all applicable requirements of section 707
16 are or will be met in accordance with regu-
17 lations which the Secretary shall prescribe.

18 “(ii) ADEQUACY OF CONTRIBUTION
19 RATES.—A statement of actuarial opinion,
20 signed by a qualified actuary, which sets
21 forth a description of the extent to which
22 contribution rates are adequate to provide
23 for the payment of all obligations and the
24 maintenance of required reserves under the
25 arrangement for the 12-month period be-

1 ginning with such date within such 120-
2 day period, taking into account the ex-
3 pected coverage and experience of the ar-
4 rangement. If the contribution rates are
5 not fully adequate, the statement of actu-
6 arial opinion shall indicate the extent to
7 which the rates are inadequate and the
8 changes needed to ensure adequacy.

9 “(iii) CURRENT AND PROJECTED
10 VALUE OF ASSETS AND LIABILITIES.—A
11 statement of actuarial opinion signed by a
12 qualified actuary, which sets forth the cur-
13 rent value of the assets and liabilities accu-
14 mulated under the arrangement and a pro-
15 jection of the assets, liabilities, income,
16 and expenses of the arrangement for the
17 12-month period referred to in clause (ii).
18 The income statement shall identify sepa-
19 rately the arrangement’s administrative ex-
20 penses and claims.

21 “(iv) COSTS OF COVERAGE TO BE
22 CHARGED AND OTHER EXPENSES.—A
23 statement of the costs of coverage to be
24 charged, including an itemization of
25 amounts for administration, reserves, and

1 other expenses associated with the oper-
2 ation of the arrangement.

3 “(v) OTHER INFORMATION.—Any
4 other information which may be prescribed
5 in regulations of the Secretary as nec-
6 essary to carry out the purposes of this
7 part.

8 “(b) OTHER REQUIREMENTS.—A complete applica-
9 tion for an exemption under this part shall include infor-
10 mation which the Secretary determines to be complete and
11 accurate and sufficient to demonstrate that the following
12 requirements are met with respect to the arrangement:

13 “(1) SPONSOR.—

14 “(A) IN GENERAL.—Except as provided in
15 subparagraph (B), the sponsor is, and has been
16 (together with its immediate predecessor, if
17 any) for a continuous period of not less than 3
18 years before the date of the application, orga-
19 nized and maintained in good faith, with a con-
20 stitution and bylaws specifically stating its pur-
21 pose, as a trade association, an industry asso-
22 ciation, a professional association, or a chamber
23 of commerce or other business group, for sub-
24 stantial purposes other than that of obtaining
25 or providing medical care described in section

1 607(1), and the applicant demonstrates to the
2 satisfaction of the Secretary that the sponsor is
3 established as a permanent entity which re-
4 ceives the active support of its members.

5 “(B) SPECIAL RULE FOR PREPAID HEALTH
6 CARE ARRANGEMENTS.—In the case of an ar-
7 rangement that is a prepaid health care ar-
8 rangement (as defined in section 701(12)), the
9 sponsor is the operating committee of the ar-
10 rangement.

11 “(2) OPERATING COMMITTEE.—

12 “(A) IN GENERAL.—Except as provided in
13 subparagraph (B), the arrangement is operated,
14 pursuant to a trust agreement, by an operating
15 committee which has complete fiscal control
16 over the arrangement and which is responsible
17 for all operations of the arrangement, and the
18 operating committee has in effect rules of oper-
19 ation and financial controls, based on a 3-year
20 plan of operation, adequate to carry out the
21 terms of the arrangement and to meet all re-
22 quirements of this title applicable to the ar-
23 rangement. The members of the committee are
24 individuals selected from individuals who are
25 the owners, officers, directors, or employees of

1 the participating employers or who are partners
2 in the participating employers and actively par-
3 ticipate in the business. No such member is an
4 owner, officer, director, or employee of, or part-
5 ner in, a contract administrator or other service
6 provider to the arrangement, except that offi-
7 cers or employees of a sponsor which is a serv-
8 ice provider (other than a contract adminis-
9 trator) to the arrangement may be members of
10 the committee if they constitute not more than
11 25 percent of the membership of the committee
12 and they do not provide services to the arrange-
13 ment other than on behalf of the sponsor. The
14 committee has sole authority to approve appli-
15 cations for participation in the arrangement
16 and to contract with a service provider to ad-
17 minister the day-to-day affairs of the arrange-
18 ment.

19 “(B) SPECIAL RULE FOR PREPAID HEALTH
20 CARE ARRANGEMENTS.—In the case of an ar-
21 rangement that is a prepaid health care ar-
22 rangement (as defined in section 701(12)), the
23 operating committee is the board of the entity
24 that is the arrangement.

1 “(3) CONTENTS OF GOVERNING INSTRU-
2 MENTS.—The instruments governing the arrange-
3 ment include a written instrument, meeting the re-
4 quirements of an instrument required under section
5 1212(a)(1), which—

6 “(A) provides that the committee serves as
7 the named fiduciary required for plans under
8 section 1212(a)(1) and serves in the capacity of
9 a plan administrator (referred to in section
10 3(16)(A)),

11 “(B) provides that the sponsor is to serve
12 as plan sponsor (referred to in section
13 3(16)(B)),

14 “(C) incorporates the requirements of sec-
15 tion 707, and

16 “(D) provides that, effective upon the
17 granting of an exemption under this part—

18 “(i) all participating employers must
19 be members or affiliated members of the
20 sponsor, except that, in the case of a spon-
21 sor which is a professional association or
22 other individual-based association, if at
23 least one of the officers, directors, or em-
24 ployees of an employer, or at least one of
25 the individuals who are partners in an em-

1 ployer and who actively participates in the
2 business, is a member or affiliated member
3 of the sponsor, participating employers
4 may also include such employer, and

5 “(ii) all individuals thereafter com-
6 mencing coverage under the arrangement
7 must be—

8 “(I) active or retired owners, offi-
9 cers, directors, or employees of, or
10 partners in, participating employers,
11 or

12 “(II) the beneficiaries of individ-
13 uals described in subclause (I).

14 “(4) CONTRIBUTION RATES.—The contribution
15 rates referred to in subsection (a)(3)(F)(ii) are
16 adequate.

17 “(5) REGULATORY REQUIREMENTS.—Such
18 other requirements as the Secretary may prescribe
19 by regulation as necessary to carry out the purposes
20 of this part.

21 “(c) TREATMENT OF PARTY SEEKING EXEMPTION
22 WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

23 “(1) IN GENERAL.—In the case of any applica-
24 tion for an exemption under this part with respect
25 to a multiple employer welfare arrangement, if the

1 Secretary determines that the sponsor of the ar-
2 rangement or any other person associated with the
3 arrangement is subject to disqualification under
4 paragraph (2), the Secretary may deny the exemp-
5 tion with respect to such arrangement.

6 “(2) DISQUALIFICATION.—A person is subject
7 to disqualification under this paragraph if such per-
8 son—

9 “(A) has intentionally made a material
10 misstatement in the application for exemption;

11 “(B) has obtained or attempted to obtain
12 an exemption under this part through misrepre-
13 sentation or fraud;

14 “(C) has misappropriated or converted to
15 such person’s own use, or improperly withheld,
16 money held under a plan or any multiple
17 employer welfare arrangement;

18 “(D) is prohibited (or would be prohibited
19 if the arrangement were a plan) from serving in
20 any capacity in connection with the arrange-
21 ment under section 411;

22 “(E) has failed to appear without reason-
23 able cause or excuse in response to a subpoena,
24 examination, warrant, or any other order law-

1 fully issued by the Secretary compelling such
2 response;

3 “(F) has previously been subject to a de-
4 termination under this part resulting in the de-
5 nial, suspension, or revocation of an exemption
6 under this part on similar grounds; or

7 “(G) has otherwise violated any provision
8 of this title with respect to a matter which the
9 Secretary determines of sufficient consequence
10 to merit disqualification for purposes of this
11 part.

12 “(d) FRANCHISE NETWORKS.—In the case of a mul-
13 tiple employer welfare arrangement established and main-
14 tained by a franchisor for a franchise network consisting
15 of its franchisees, such franchisor shall be treated as the
16 sponsor referred to in the preceding provisions of this sec-
17 tion, such network shall be treated as an association re-
18 ferred to in such provisions, and each franchisee shall be
19 treated as a member (of the association and the sponsor)
20 referred to in such provisions, if all participating employ-
21 ers are such franchisees and the requirements of sub-
22 section (b)(1) with respect to a sponsor are met with
23 respect to the network.

24 “(e) CERTAIN COLLECTIVELY BARGAINED ARRANGE-
25 MENTS.—In applying the preceding provisions of this sec-

1 tion in the case of a multiple employer welfare arrange-
2 ment which would be described in section 3(40)(A)(i) but
3 for the failure to meet any requirement of section
4 3(40)(C)—

5 “(1) paragraphs (1) and (2) of subsection (b)
6 and subparagraphs (A), (B), and (D) of paragraph
7 (3) of subsection (b) shall be disregarded, and

8 “(2) the joint board of trustees shall be consid-
9 ered the operating committee of the arrangement.

10 “(f) CERTAIN ARRANGEMENTS NOT MEETING SIN-
11 GLE EMPLOYER REQUIREMENT.—

12 “(1) IN GENERAL.—In any case in which the
13 majority of the employees covered under a multiple
14 employer welfare arrangement are employees of a
15 single employer (within the meaning of clauses (i)
16 and (ii) of section 3(40)(B)), if all other employees
17 covered under the arrangement are employed by em-
18 ployers who are related to such single employer, sub-
19 section (b)(3)(D) shall be disregarded.

20 “(2) RELATED EMPLOYERS.—For purposes of
21 paragraph (1), employers are ‘related’ if there is
22 among all such employers a common ownership in-
23 terest or a substantial commonality of business oper-
24 ations based on common suppliers or customers.

1 **“SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO**
2 **EXEMPTED ARRANGEMENTS.**

3 “(a) NOTICE OF MATERIAL CHANGES.—In the case
4 of any multiple employer welfare arrangement with respect
5 to which there is in effect an exemption granted under
6 this part, descriptions of material changes in any informa-
7 tion which was required to be submitted with the applica-
8 tion for the exemption shall be filed in such form and man-
9 ner as shall be prescribed in regulations of the Secretary.
10 The Secretary may require by regulation prior notice of
11 material changes with respect to specified matters which
12 might serve as the basis for suspension or revocation of
13 the exemption.

14 “(b) REPORTING REQUIREMENTS.—Under regula-
15 tions of the Secretary, the requirements of sections 102,
16 103, and 104 shall apply with respect to any multiple em-
17 ployer welfare arrangement with respect to which there is
18 or has been in effect an exemption granted under this part
19 in the same manner and to the same extent as such re-
20 quirements apply to employee welfare benefit plans, irre-
21 spective of whether such exemption continues in effect.
22 The annual report required under section 103 for any plan
23 year in the case of any such multiple employer welfare ar-
24 rangement shall also include information described in sec-
25 tion 704(a)(3)(F) with respect to the plan year and, not-

1 withstanding section 104(a)(1)(A), shall be filed not later
2 than 90 days after the close of the plan year.

3 “(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The
4 operating committee of each multiple employer welfare ar-
5 rangement with respect to which there is or has been in
6 effect an exemption granted under this part shall engage,
7 on behalf of all covered individuals, a qualified actuary
8 who shall be responsible for the preparation of the mate-
9 rials comprising information necessary to be submitted by
10 a qualified actuary under this part. The qualified actuary
11 shall utilize such assumptions and techniques as are nec-
12 essary to enable such actuary to form an opinion as to
13 whether the contents of the matters reported under this
14 part—

15 “(1) are in the aggregate reasonably related to
16 the experience of the arrangement and to reasonable
17 expectations, and

18 “(2) represent such actuary’s best estimate of
19 anticipated experience under the arrangement.

20 The opinion by the qualified actuary shall be made with
21 respect to, and shall be made a part of, the annual report.

22 “(d) FILING NOTICE OF EXEMPTION WITH
23 STATES.—An exemption granted to a multiple employer
24 welfare arrangement under this part shall not be effective
25 unless written notice of such exemption is filed with the

1 State insurance commissioner of each State in which at
2 least 5 percent of the individuals covered under the ar-
3 rangement are located. For purposes of this paragraph,
4 an individual shall be considered to be located in the State
5 in which a known address of such individual is located or
6 in which such individual is employed. The Secretary may
7 by regulation provide in specified cases for the application
8 of the preceding sentence with lesser percentages in lieu
9 of such 5 percent amount.

10 **“SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY**
11 **ARRANGEMENTS PROVIDING MEDICAL CARE.**

12 “(a) IN GENERAL.—A multiple employer welfare ar-
13 rangement providing benefits consisting of medical care
14 described in section 607(1) shall issue to each participat-
15 ing employer—

16 “(1) a document equivalent to the summary
17 plan description required of plans under part 1,

18 “(2) information describing the contribution
19 rates applicable to participating employers, and

20 “(3) a statement indicating—

21 “(A) whether or not the arrangement is
22 fully insured,

23 “(B) whether or not there is in effect with
24 respect to the arrangement an exemption grant-
25 ed under this part and, if there is in effect such

1 an exemption, that the arrangement is (or is
2 treated as) an employee welfare benefit plan
3 under this title, and

4 “(C) that the arrangement is not a li-
5 censed insurer under the laws of any State.

6 “(b) TIME FOR DISCLOSURE.—Such information
7 shall be issued to employers within such reasonable period
8 of time before becoming participating employers as may
9 be prescribed in regulations of the Secretary.

10 **“SEC. 707. MAINTENANCE OF RESERVES.**

11 “(a) IN GENERAL.—Each multiple employer welfare
12 arrangement with respect to which there is or has been
13 in effect an exemption granted under this part and which
14 is not fully insured shall establish and maintain reserves,
15 consisting of—

16 “(1) a reserve for unearned contributions,

17 “(2) a reserve for payment of claims reported
18 and not yet paid and claims incurred but not yet re-
19 ported, and for expected administrative costs with
20 respect to such claims, and

21 “(3) a reserve, in an amount recommended by
22 the qualified actuary, for any other obligations of
23 the arrangement.

24 “(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—

25 The total of the reserves described in subsection (a)(2)

1 shall not be less than an amount equal to 25 percent of
2 expected incurred claims and expenses for the plan year.

3 “(c) REQUIRED MARGIN.—In determining the
4 amounts of reserves required under this section in connec-
5 tion with any multiple employer welfare arrangement, the
6 qualified actuary shall include a margin for error and
7 other fluctuations taking into account the specific
8 circumstances of such arrangement.

9 “(d) ADDITIONAL REQUIREMENTS.—The Secretary
10 may provide such additional requirements relating to re-
11 serves and excess/stop loss coverage as the Secretary con-
12 siders appropriate. Such requirements may be provided,
13 by regulation or otherwise, with respect to any arrange-
14 ment or any class of arrangements.

15 “(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COV-
16 ERAGE.—The Secretary may provide for adjustments to
17 the levels of reserves otherwise required under subsections
18 (a) and (b) with respect to any arrangement or class of
19 arrangements to take into account excess/stop loss cov-
20 erage provided with respect to such arrangement or ar-
21 rangements.

22 “(f) ALTERNATIVE MEANS OF COMPLIANCE.—The
23 Secretary may permit an arrangement (including a pre-
24 paid health care arrangement) to substitute, for all or part
25 of the reserves required under subsection (a), such secu-

1 rity, guarantee, or other financial arrangement as the Sec-
2 retary determines to be adequate to enable the arrange-
3 ment to fully meet all its financial obligations on a timely
4 basis.

5 **“SEC. 708. CORRECTIVE ACTIONS.**

6 “(a) ACTIONS TO AVOID DEPLETION OF RE-
7 SERVES.—A multiple employer welfare arrangement with
8 respect to which there is or has been in effect an exemp-
9 tion granted under this part shall continue to meet the
10 requirements of section 707, irrespective of whether such
11 exemption continues in effect. The operating committee of
12 such arrangement shall determine semiannually whether
13 the requirements of section 707 are met. In any case in
14 which the committee determines that there is reason to
15 believe that there is or will be a failure to meet such re-
16 quirements, or the Secretary makes such a determination
17 and so notifies the committee, the committee shall imme-
18 diately notify the qualified actuary engaged by the ar-
19 rangement, and such actuary shall, not later than the end
20 of the next following month, make such recommendations
21 to the committee for corrective action as the actuary deter-
22 mines necessary to ensure compliance with section 707.
23 Not later than 10 days after receiving from the actuary
24 recommendations for corrective actions, the committee
25 shall notify the Secretary (in such form and manner as

1 the Secretary may prescribe by regulation) of such rec-
2 ommendations of the actuary for corrective action, to-
3 gether with a description of the actions (if any) that the
4 committee has taken or plans to take in response to such
5 recommendations. The committee shall thereafter report
6 to the Secretary, in such form and frequency as the Sec-
7 retary may specify to the committee, regarding corrective
8 action taken by the committee until the requirements of
9 section 707 are met.

10 “(b) TERMINATION.—

11 “(1) NOTICE OF TERMINATION.—In any case in
12 which the operating committee of a multiple em-
13 ployer welfare arrangement with respect to which
14 there is or has been in effect an exemption granted
15 under this part determines that there is reason to
16 believe that the arrangement will terminate, the
17 committee shall so inform the Secretary, shall de-
18 velop a plan for winding up the affairs of the ar-
19 rangement in connection with such termination in a
20 manner which will result in timely payment of all
21 benefits for which the arrangement is obligated, and
22 shall submit such plan in writing to the Secretary.
23 Actions required under this paragraph shall be taken
24 in such form and manner as may be prescribed in
25 regulations of the Secretary.

1 “(2) ACTIONS REQUIRED IN CONNECTION WITH
2 TERMINATION.—In any case in which—

3 “(A) the Secretary has been notified under
4 subsection (a) of a failure of a multiple em-
5 ployer welfare arrangement with respect to
6 which there is or has been in effect an exemp-
7 tion granted under this part to meet the re-
8 quirements of section 707 and has not been no-
9 tified by the operating committee of the ar-
10 rangement that corrective action has restored
11 compliance with such requirements, and

12 “(B) the Secretary determines that the
13 continuing failure to meet the requirements of
14 section 707 can be reasonably expected to result
15 in a continuing failure to pay benefits for which
16 the arrangement is obligated,

17 the operating committee of the arrangement shall, at
18 the direction of the Secretary, terminate the ar-
19 rangement and, in the course of the termination,
20 take such actions as the Secretary may require as
21 necessary to ensure that the affairs of the arrange-
22 ment will be, to the maximum extent possible, wound
23 up in a manner which will result in timely payment
24 of all benefits for which the arrangement is
25 obligated.

1 **“SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF**
2 **EXEMPTION.**

3 “(a) EXPIRATION AND RENEWAL OF EXEMPTION.—
4 An exemption granted to a multiple employer welfare ar-
5 rangement under this part shall expire 3 years after the
6 date on which the exemption is granted. An exemption
7 which has expired may be renewed by means of application
8 for an exemption in accordance with section 704.

9 “(b) SUSPENSION OR REVOCATION OF EXEMPTION
10 BY SECRETARY.—The Secretary may suspend or revoke
11 an exemption granted to a multiple employer welfare
12 arrangement under this part—

13 “(1) for any cause that may serve as the basis
14 for the denial of an initial application for such an
15 exemption under section 704, or

16 “(2) if the Secretary finds that—

17 “(A) the arrangement, or the sponsor
18 thereof, in the transaction of business while
19 under the exemption, has used fraudulent, coer-
20 cive, or dishonest practices, or has dem-
21 onstrated incompetence, untrustworthiness, or
22 financial irresponsibility,

23 “(B) the arrangement, or the sponsor
24 thereof, is using such methods or practices in
25 the conduct of its operations, so as to render its
26 further transaction of operations hazardous or

1 injurious to participating employers, or covered
2 individuals,

3 “(C) the arrangement, or the sponsor
4 thereof, has refused to be examined in accord-
5 ance with this part or to produce its accounts,
6 records, and files for examination in accordance
7 with this part, or

8 “(D) any of the officers of the arrange-
9 ment, or the sponsor thereof, has refused to
10 give information with respect to the affairs of
11 the arrangement or the sponsor or to perform
12 any other legal obligation relating to such an
13 examination when required by the Secretary in
14 accordance with this part.

15 Any such suspension or revocation under this subsection
16 shall be effective only upon a final decision of the Sec-
17 retary made after notice and opportunity for a hearing
18 is provided in accordance with section 710.

19 “(c) SUSPENSION OR REVOCATION OF EXEMPTION
20 UNDER COURT PROCEEDINGS.—An exemption granted to
21 a multiple employer welfare arrangement under this part
22 may be suspended or revoked by a court of competent ju-
23 risdiction in an action by the Secretary brought under
24 paragraph (2), (5), or (6) of section 502(a), except that
25 the suspension or revocation under this subsection shall

1 be effective only upon notification of the Secretary of such
2 suspension or revocation.

3 “(d) NOTIFICATION OF PARTICIPATING EMPLOY-
4 ERS.—All participating employers in a multiple employer
5 welfare arrangement shall be notified of the expiration,
6 suspension, or revocation of an exemption granted to such
7 arrangement under this part, by such persons and in such
8 form and manner as shall be prescribed in regulations of
9 the Secretary, not later than 20 days after such expiration
10 or after receipt of notice of a final decision requiring such
11 suspension or revocation.

12 “(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS,
13 AND REVOCATIONS.—The Secretary shall publish all expi-
14 rations of, and all final decisions to suspend or revoke,
15 exemptions granted under this part.

16 **“SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.**

17 “(a) IN GENERAL.—Any decision by the Secretary
18 which involves the denial of an application by a multiple
19 employer welfare arrangement for an exemption under this
20 part or the suspension or revocation of such an exemption
21 shall contain a statement of the specific reason or reasons
22 supporting the Secretary’s action, including reference to
23 the specific terms of the exemption and the statutory pro-
24 vision or provisions relevant to the determination.

1 “(b) DENIALS OF APPLICATIONS.—In the case of the
2 denial of an application for an exemption under this part,
3 the Secretary shall send a copy of the decision to the appli-
4 cant by certified or registered mail at the address specified
5 in the records of the Secretary. Such decision shall con-
6 stitute the final decision of the Secretary unless the ar-
7 rangement, or any party that would be prejudiced by the
8 decision, files a written appeal of the denial within 30 days
9 after the mailing of such decision. The Secretary may af-
10 firm, modify, or reverse the initial decision. The decision
11 on appeal shall become final upon the mailing of a copy
12 by certified or registered mail to the arrangement or party
13 that filed the appeal.

14 “(c) SUSPENSIONS OR REVOCATIONS OF EXEMP-
15 TION.—In the case of the suspension or revocation of an
16 exemption granted under this part, the Secretary shall
17 send a copy of the decision to the arrangement by certified
18 or registered mail at its address, as specified in the
19 records of the Secretary. Upon the request of the arrange-
20 ment, or any party that would be prejudiced by the sus-
21 pension or revocation, filed within 15 days of the mailing
22 of the Secretary’s decision, the Secretary shall schedule
23 a hearing on such decision by written notice, sent by cer-
24 tified or registered mail to the arrangement or party
25 requesting such hearing. Such notice shall set forth—

1 “(1) a specific date and time for the hearing,
2 which shall be within the 10-day period commencing
3 20 days after the date of the mailing of the notice,
4 and

5 “(2) a specific place for the hearing, which shall
6 be in the District of Columbia or in the State and
7 county thereof (or parish or other similar political
8 subdivision thereof) in which is located the arrange-
9 ment’s principal place of business.

10 The decision as affirmed or modified in such hearing shall
11 constitute the final decision of the Secretary, unless such
12 decision is reversed in such hearing.”.

13 (b) CONFORMING AMENDMENT TO DEFINITION OF
14 PLAN SPONSOR.—Section 3(16)(B) of such Act (29
15 U.S.C. 1002(16)(B)) is amended by adding at the end the
16 following new sentence: “Such term also includes the spon-
17 sor (as defined in section 701(5)) of a multiple employer
18 welfare arrangement, or a multiple employer health plan
19 (as defined in section 701(10)), with respect to which
20 there is or has been in effect an exemption granted under
21 part 7.”.

22 (c) ALTERNATIVE MEANS OF DISTRIBUTION OF
23 SUMMARY PLAN DESCRIPTIONS.—Section 110 of such
24 Act (29 U.S.C. 1030) is amended by adding at the end
25 the following new subsection:

1 “(c) The Secretary shall prescribe, as an alternative
 2 method for distributing summary plan descriptions in
 3 order to meet the requirements of section 104(b)(1) in the
 4 case of multiple employer welfare arrangements providing
 5 benefits consisting of medical care described in section
 6 607(1), a means of distribution of such descriptions by
 7 participating employers.”.

8 (d) CLERICAL AMENDMENT.—The table of contents
 9 in section 1 of the Employee Retirement Income Security
 10 Act of 1974 is amended by inserting after the item relat-
 11 ing to section 608 the following new items:

“PART 7—MULTIPLE EMPLOYER HEALTH PLANS

“Sec. 701. Definitions.

“Sec. 702. Exempted multiple employer welfare arrangements treated as em-
 ployee welfare benefit plans and exempt from certain restric-
 tions on preemption.

“Sec. 703. Exemption procedure.

“Sec. 704. Eligibility requirements.

“Sec. 705. Additional requirements applicable to exempted arrangements.

“Sec. 706. Disclosure to participating employers by arrangements providing
 medical care.

“Sec. 707. Maintenance of reserves.

“Sec. 708. Corrective actions.

“Sec. 709. Expiration, suspension, or revocation of exemption.

“Sec. 710. Review of actions of the Secretary.”.

12 **SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION**

13 **RULES.**

14 (a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the
 15 Employee Retirement Income Security Act of 1974 (29
 16 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting “, but
 17 only, in the case of an arrangement which provides medi-
 18 cal care described in section 607(1) and with respect to

1 which an exemption under part 7 is not in effect,” before
2 “to the extent not inconsistent with the preceding sections
3 of this title”.

4 (b) CROSS-REFERENCE.—Section 514(b)(6) of such
5 Act (29 U.S.C. 1144(b)(6)) is amended by adding at the
6 end the following new subparagraph:

7 “(E) For additional rules relating to exemption from
8 subparagraph (A)(ii) of multiple employer welfare ar-
9 rangements providing medical care, see part 7.”.

10 **SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EM-**
11 **PLOYER ARRANGEMENTS.**

12 Section 3(40)(B) of the Employee Retirement Income
13 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-
14 ed—

15 (1) in clause (i), by inserting “for any plan year
16 of any such plan, or any fiscal year of any such
17 other arrangement,” after “single employer”, and by
18 inserting “during such year or at any time during
19 the preceding 1-year period” after “common con-
20 trol”;

21 (2) in clause (iii), by striking “common control
22 shall not be based on an interest of less than 25 per-
23 cent” and inserting “an interest of greater than 25
24 percent may not be required as the minimum inter-

1 est necessary for common control”, and by striking
2 “and” at the end,

3 (3) by redesignating clause (iv) as clause (v),
4 and

5 (4) by inserting after clause (iii) the following
6 new clause:

7 “(iv) in determining, after the application of
8 clause (i), whether benefits are provided to employ-
9 ees of two or more employers, the arrangement shall
10 be treated as having only 1 participating employer
11 if, at the time the determination under clause (i) is
12 made, the number of individuals who are employees
13 and former employees of any one participating em-
14 ployer and who are covered under the arrangement
15 is greater than 95 percent of the aggregate number
16 of all individuals who are employees or former em-
17 ployees of participating employers and who are
18 covered under the arrangement.”.

19 **SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN**
20 **COLLECTIVELY BARGAINED ARRANGE-**
21 **MENTS.**

22 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-
23 ployee Retirement Income Security Act of 1974 (29
24 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

1 “(i) under or pursuant to one or more collective
2 bargaining agreements,”.

3 (b) LIMITATIONS.—Section 3(40) of such Act (29
4 U.S.C. 1002(40)) is amended by adding at the end the
5 following new subparagraphs:

6 “(C) Clause (i) of subparagraph (A) shall
7 apply only if—

8 “(i) the plan or other arrangement,
9 and the employee organization or any other
10 entity sponsoring the plan or other ar-
11 rangement, do not—

12 “(I) utilize the services of any li-
13 censed insurance agent or broker for
14 soliciting or enrolling employers or in-
15 dividuals as participating employers or
16 covered individuals under the plan or
17 other arrangement, or

18 “(II) pay a commission or any
19 other type of compensation to a per-
20 son that is related either to the vol-
21 ume or number of employers or indi-
22 viduals solicited or enrolled as partici-
23 pating employers or covered individ-
24 uals under the plan or other arrange-
25 ment, or to the dollar amount or size

1 of the contributions made by partici-
2 pating employers or covered individ-
3 uals to the plan or other arrangement,

4 “(ii) not less than 85 percent of the
5 covered individuals under the plan or other
6 arrangement are individuals who—

7 “(I) are employed within a bar-
8 gaining unit covered by at least one of
9 the collective bargaining agreements
10 with a participating employer (or are
11 covered on the basis of an individual’s
12 employment in such a bargaining
13 unit), or

14 “(II) are present or former em-
15 ployees of the sponsoring employee or-
16 ganization, of an employer who is or
17 was a party to at least one of the col-
18 lective bargaining agreements, or of
19 the plan or other arrangement or a
20 related plan or arrangement (or are
21 covered on the basis of such present
22 or former employment),

23 “(iii) the plan or other arrangement
24 does not provide benefits to individuals
25 (other than individuals described in clause

1 (ii)(II)) who work outside the standard
2 metropolitan statistical area in which the
3 sponsoring employee organization rep-
4 resents employees (or to individuals (other
5 than individuals described in clause
6 (ii)(II)) on the basis of such work by oth-
7 ers), except that in the case of a sponsor-
8 ing employee organization that represents
9 employees who work outside of any stand-
10 ard metropolitan statistical area, this
11 clause shall be applied by reference to the
12 State in which the sponsoring organization
13 represents employees,

14 “(iv) the employee organization or
15 other entity sponsoring the plan or other
16 arrangement certifies to the Secretary each
17 year, in a form and manner which shall be
18 prescribed in regulations of the Sec-
19 retary—

20 “(I) that the plan or other ar-
21 rangement meets the requirements of
22 clauses (i), (ii), and (iii), and

23 “(II) if, for any year, 10 percent
24 or more of the covered individuals
25 under the plan are individuals not de-

1 scribed in subclause (I) or (II) of
2 clause (ii), the total number of cov-
3 ered individuals and the total number
4 of covered individuals not so de-
5 scribed.

6 “(D)(i) Clause (i) of subparagraph (A)
7 shall not apply to a plan or other arrangement
8 that is established or maintained pursuant to
9 one or more collective bargaining agreements
10 which the National Labor Relations Boards de-
11 termines to have been negotiated or otherwise
12 agreed to in a manner or through conduct
13 which violates section 8(a)(2) of the National
14 Labor Relations Act (29 U.S.C. 158(a)(2)).

15 “(ii)(I) Whenever a State insurance com-
16 missioner has reason to believe that this sub-
17 paragraph is applicable to part or all of a plan
18 or other arrangement, the State insurance com-
19 missioner may file a petition with the National
20 Labor Relations Board for a determination
21 under clause (i), along with sworn written testi-
22 mony supporting the petition.

23 “(II) The Board shall give any such peti-
24 tion priority over all other petitions and cases,
25 other than other petitions under subclause (I)

1 or cases given priority under section 10 of the
2 National Labor Relations Act (29 U.S.C. 160).

3 “(III) The Board shall determine, upon
4 the petition and any response, whether, on the
5 facts before it, the plan or other arrangement
6 was negotiated, created, or otherwise agreed to
7 in a manner or through conduct which violates
8 section 8(a)(2) of the National Labor Relations
9 Act (29 U.S.C. 158(a)(2)). Such determination
10 shall constitute a final determination for pur-
11 poses of this subparagraph and shall be binding
12 in all Federal or State actions with respect to
13 the status of the plan or other arrangement
14 under this subparagraph.

15 “(IV) A person aggrieved by the deter-
16 mination of the Board under subclause (III)
17 may obtain review of the determination in any
18 United States court of appeals in the circuit in
19 which the collective bargaining at issue oc-
20 curred. Commencement of proceedings under
21 this subclause shall not, unless specifically or-
22 dered by the court, operate as a stay of any
23 State administrative or judicial action or pro-
24 ceeding related to the status of the plan or
25 other arrangement, except that in no case may

1 the court stay, before the completion of the re-
2 view, an order which prohibits the enrollment of
3 new individuals into coverage under a plan or
4 arrangement.”.

5 **SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGE-**
6 **MENTS.**

7 (a) EMPLOYEE LEASING HEALTHCARE ARRANGE-
8 MENT DEFINED.—Section 3 of the Employee Retirement
9 Income Security Act of 1974 (29 U.S.C. 1002) is amended
10 by adding at the end the following new paragraph:

11 “(43) EMPLOYEE LEASING HEALTHCARE ARRANGE-
12 MENT.—

13 “(A) IN GENERAL.—Subject to subparagraph
14 (B), the term ‘employee leasing healthcare arrange-
15 ment’ means any labor leasing arrangement, staff
16 leasing arrangement, extended employee staffing or
17 supply arrangement, or other arrangement under
18 which—

19 “(i) one business or other entity (herein-
20 after in this paragraph referred to as the ‘les-
21 see’), under a lease or other arrangement en-
22 tered into with any other business or other en-
23 tity (hereinafter in this paragraph referred to
24 as the ‘lessor’), receives from the lessor the

1 services of individuals to be performed under
2 such lease or other arrangement, and

3 “(ii) benefits consisting of medical care de-
4 scribed in section 607(1) are provided to such
5 individuals or such individuals and their de-
6 pendants as participants and beneficiaries.

7 “(B) EXCEPTION.—Such term does not include
8 an arrangement described in subparagraph (A) if,
9 under such arrangement, the lessor retains, both le-
10 gally and in fact, a complete right of direction and
11 control within the scope of employment over the in-
12 dividuals whose services are supplied under such
13 lease or other arrangement, and such individuals
14 perform a specified function for the lessee which is
15 separate and divisible from the primary business or
16 operations of the lessee.”.

17 (b) TREATMENT OF EMPLOYEE LEASING
18 HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER
19 WELFARE ARRANGEMENTS.—Section 3(40) of such Act
20 (29 U.S.C. 1002(40)) (as amended by the preceding provi-
21 sions of this title) is further amended by adding at the
22 end the following new subparagraph:

23 “(E) The term ‘multiple employer welfare arrange-
24 ment’ includes any employee leasing healthcare arrange-
25 ment, except that such term does not include any employee

1 leasing healthcare arrangement which is a multiple em-
2 ployer health plan (as defined in section 701(10)).”.

3 (c) SPECIAL RULES FOR EMPLOYEE LEASING
4 HEALTHCARE ARRANGEMENTS.—

5 (1) IN GENERAL.—Part 7 of subtitle B of title
6 I of such Act (as added by the preceding provisions
7 of this Act) is amended by adding at the end the fol-
8 lowing new section:

9 **“SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING**
10 **HEALTHCARE ARRANGEMENTS.**

11 “(a) IN GENERAL.—The requirements of paragraphs
12 (1), (2), and (3) of section 704(b) shall be treated as satis-
13 fied in the case of a multiple employer welfare arrange-
14 ment that is an employee leasing healthcare arrangement
15 if the application for exemption includes information
16 which the Secretary determines to be complete and accu-
17 rate and sufficient to demonstrate that the following
18 requirements are met with respect to the arrangement:

19 “(1) 3-YEAR TENURE.—The lessor has been in
20 operation for not less than 3 years.

21 “(2) SOLICITATION RESTRICTIONS.—Employee
22 leasing services provided under the arrangement are
23 not solicited, advertised, or marketed through li-
24 censed insurance agents or brokers acting in such
25 capacity.

1 “(3) CREATION OF EMPLOYMENT RELATION-
2 SHIP.—

3 “(A) DISCLOSURE STATEMENT.—Written
4 notice is provided to each applicant for employ-
5 ment subject to coverage under the arrange-
6 ment, at the time of application for employment
7 and before commencing coverage under the ar-
8 rangement, stating that the employer is the les-
9 sor under the arrangement.

10 “(B) INFORMED CONSENT.—Each such
11 applicant signs a written statement consenting
12 to the employment relationship with the lessor.

13 “(C) INFORMED RECRUITMENT OF LES-
14 SEE’S EMPLOYEES.—In any case in which the
15 lessor offers employment to an employee of a
16 lessee under the arrangement, the lessor in-
17 forms each employee in writing that his or her
18 acceptance of employment with the lessor is vol-
19 untary and that refusal of such offer will not be
20 deemed to be resignation from or abandonment
21 of current employment.

22 “(4) REQUISITE EMPLOYER-EMPLOYEE RELA-
23 TIONSHIP UNDER ARRANGEMENT.—Under the em-
24 ployer-employee relationship with the employees of
25 the lessor—

1 “(A) the lessor retains the ultimate author-
2 ity to hire, terminate, and reassign such em-
3 ployees,

4 “(B) the lessor is responsible for the pay-
5 ment of wages, payroll-related taxes, and em-
6 ployee benefits, without regard to payment by
7 the lessee to the lessor for its services,

8 “(C) the lessor maintains the right of di-
9 rection and control over its employees, except to
10 the extent that the lessee is responsible for su-
11 pervision of the work performed consistent with
12 the lessee’s responsibility for its product or
13 service,

14 “(D) in accordance with section 301(a) of
15 the Labor Management Relations Act, 1947 (29
16 U.S.C. 185(a)), the lessor retains in the ab-
17 sence of an applicable collective bargaining
18 agreement, the right to enter into arbitration
19 and to decide employee grievances, and

20 “(E) no owner, officer, or director of, or
21 partner in, a lessee is an employee of the lessor,
22 and not more than 10 percent of the individuals
23 covered under the arrangement consist of own-
24 ers, officers, or directors of, or partners in,
25 such a lessee (or any combination thereof).

1 “(b) DEFINITIONS.—For purposes of this section—

2 “(1) LESSOR.—The term ‘lessor’ means the
3 business or other entity from which services of indi-
4 viduals are obtained under an employee leasing
5 healthcare arrangement.

6 “(2) LESSEE.—The term ‘lessee’ means a busi-
7 ness or other entity which receives the services of in-
8 dividuals provided under an employee leasing
9 healthcare arrangement.”.

10 (2) CLERICAL AMENDMENT.—The table of con-
11 tents in section 1 of such Act (as amended by the
12 preceding provisions of this title) is further amended
13 by inserting after the item relating to section 710
14 the following new item:

“Sec. 711. Employee leasing healthcare arrangements.”.

15 **SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MUL-**
16 **TIPLE EMPLOYER WELFARE ARRANGEMENTS**
17 **AND EMPLOYEE LEASING HEALTHCARE AR-**
18 **RANGEMENTS.**

19 (a) ENFORCEMENT OF FILING REQUIREMENTS.—
20 Section 502 of the Employee Retirement Income Security
21 Act of 1974 (29 U.S.C. 1132) is amended—

22 (1) in subsection (a)(6), by striking “subsection
23 (c)(2) or (i) or (l)” and inserting “paragraph (2) or
24 (4) of subsection (c) or subsection (i) or (l)”; and

1 (2) by adding at the end of subsection (c) the
2 following new paragraph:

3 “(4) The Secretary may assess a civil penalty against
4 any person of up to \$1,000 a day from the date of such
5 person’s failure or refusal to file the information required
6 to be filed with the Secretary under section 101(e).”.

7 (b) ACTIONS BY STATES IN FEDERAL COURT.—Sec-
8 tion 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

9 (1) in paragraph (5), by striking “or” at the
10 end;

11 (2) in paragraph (6), by striking the period and
12 inserting “, or”; and

13 (3) by adding at the end the following:

14 “(7) by a State official having authority under
15 the law of such State to enforce the laws of such
16 State regulating insurance, to enjoin any act or
17 practice which violates any provision of part 7 which
18 such State has the power to enforce under part 7.”.

19 (c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
20 MISREPRESENTATIONS.—Section 501 of such Act (29
21 U.S.C. 1131) is amended—

22 (1) by inserting “(a)” after “SEC. 501.”; and

23 (2) by adding at the end the following new sub-
24 section:

1 “(b) Any person who, either willfully or with willful
2 blindness, falsely represents, to any employee, any employ-
3 ee’s beneficiary, any employer, the Secretary, or any State,
4 an arrangement established or maintained for the purpose
5 of offering or providing any benefit described in section
6 3(1) to employees or their beneficiaries as being a multiple
7 employer welfare arrangement granted an exemption
8 under part 7, as being an employee leasing healthcare ar-
9 rangement under such an exemption, or as having been
10 established or maintained under or pursuant to a collective
11 bargaining agreement shall, upon conviction, be impris-
12 oned not more than five years, be fined under title 18,
13 United States Code, or both.”.

14 (d) CEASE ACTIVITIES ORDERS.—Section 502 of
15 such Act (29 U.S.C. 1132) is amended by adding at the
16 end the following new subsection:

17 “(m)(1) Subject to paragraph (2), upon application
18 by the Secretary showing the operation, promotion, or
19 marketing of a multiple employer welfare arrangement
20 providing benefits consisting of medical care described in
21 section 607(1) that—

22 “(A) is not licensed, registered, or otherwise ap-
23 proved under the insurance laws of the States in
24 which the arrangement offers or provides benefits, or

1 “(B) is not operating in accordance with the
2 terms of an exemption granted by the Secretary
3 under part 7,
4 a district court of the United States shall enter an order
5 requiring that the arrangement cease activities.

6 “(2) Paragraph (1) shall not apply in the case of a
7 multiple employer welfare arrangement if the arrangement
8 shows that it—

9 “(A) is fully insured, within the meaning of
10 section 701(9),

11 “(B) is licensed, registered, or otherwise ap-
12 proved in each State in which it offers or provides
13 benefits, except to the extent that such State does
14 not require licensing, registration, or approval of
15 fully insured multiple employer welfare arrange-
16 ments, and

17 “(C) with respect to each such State, is operat-
18 ing in accordance with applicable State insurance
19 laws that are not superseded under section 514.

20 “(3) The court may grant such additional equitable
21 or remedial relief, including any relief available under this
22 title, as it deems necessary to protect the interests of the
23 public and of persons having claims for benefits against
24 the arrangement.”.

1 (e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
2 Section 503 of such Act (29 U.S.C. 1133) is amended by
3 adding at the end (after and below paragraph (2)) the fol-
4 lowing new sentence: “The terms of each multiple em-
5 ployer welfare arrangement to which this section applies
6 and which provides benefits consisting of medical care de-
7 scribed in section 607(1) shall require the operating com-
8 mittee or the named fiduciary (as applicable) to ensure
9 that the requirements of this section are met in connection
10 with claims filed under the arrangement.”.

11 **SEC. 1217. FILING REQUIREMENTS FOR HEALTH BENEFIT**
12 **MULTIPLE EMPLOYER WELFARE ARRANGE-**
13 **MENTS.**

14 Section 101 of the Employee Retirement Income Se-
15 curity Act of 1974 (29 U.S.C. 1021) is amended—

16 (1) by redesignating subsection (e) as sub-
17 section (f); and

18 (2) by inserting after subsection (d) the follow-
19 ing new subsection:

20 “(e)(1) Each multiple employer welfare arrangement
21 shall file with the Secretary a registration statement de-
22 scribed in paragraph (2) within 60 days before commenc-
23 ing operations (in the case of an arrangement commencing
24 operations on or after January 1, 1995) and no later than
25 February 15 of each year (in the case of an arrangement

1 in operation since the beginning of such year), unless, as
2 of the date by which such filing otherwise must be made,
3 such arrangement provides no benefits consisting of medi-
4 cal care described in section 607(1).

5 “(2) Each registration statement—

6 “(A) shall be filed in such form, and contain
7 such information concerning the multiple employer
8 welfare arrangement and any persons involved in its
9 operation (including whether the arrangement is
10 fully insured), as shall be provided in regulations
11 which shall be prescribed by the Secretary, and

12 “(B) if the arrangement is not fully insured,
13 shall contain a certification that copies of such reg-
14 istration statement have been transmitted by cer-
15 tified mail to—

16 “(i) in the case of an arrangement with re-
17 spect to which an exemption under part 7 is in
18 effect, the State insurance commissioner of the
19 domicile State of such arrangement, or

20 “(ii) in the case of an arrangement which
21 is not so exempt, the State insurance commis-
22 sioner of each State in which the arrangement
23 is located.

24 “(3) The person or persons responsible for filing the
25 annual registration statement are—

1 “(A) the trustee or trustees so designated by
2 the terms of the instrument under which the mul-
3 tiple employer welfare arrangement is established or
4 maintained, or

5 “(B) in the case of a multiple employer welfare
6 arrangement for which the trustee or trustees can-
7 not be identified, or upon the failure of the trustee
8 or trustees of an arrangement to file, the person or
9 persons actually responsible for the acquisition, dis-
10 position, control, or management of the cash or
11 property of the arrangement, irrespective of whether
12 such acquisition, disposition, control, or management
13 is exercised directly by such person or persons or
14 through an agent designated by such person or
15 persons.

16 “(4) Any agreement entered into under section
17 506(c) with a State as the primary domicile State with
18 respect to any multiple employer welfare arrangement
19 shall provide for simultaneous filings of reports required
20 under this subsection with the Secretary and with the
21 State insurance commissioner of such State.”.

1 **SEC. 1218. COOPERATION BETWEEN FEDERAL AND STATE**
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
5 at the end the following new subsection:

6 “(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE
7 EMPLOYER WELFARE ARRANGEMENTS.—

8 “(1) STATE ENFORCEMENT.—

9 “(A) AGREEMENTS WITH STATES.—A
10 State may enter into an agreement with the
11 Secretary for delegation to the State of some or
12 all of the Secretary’s authority under sections
13 502 and 504 to enforce the provisions of this
14 title applicable to multiple employer welfare ar-
15 rangements with respect to which an exemption
16 under part 7 is or has been in effect. The Sec-
17 retary shall enter into the agreement if the Sec-
18 retary determines that the delegation provided
19 for therein would not result in a lower level or
20 quality of enforcement of the provisions of this
21 title.

22 “(B) DELEGATIONS.—Any department,
23 agency, or instrumentality of a State to which
24 authority is delegated pursuant to an agree-
25 ment entered into under this paragraph may, if
26 authorized under State law and to the extent

1 consistent with such agreement, exercise the
2 powers of the Secretary under this title which
3 relate to such authority.

4 “(C) CONCURRENT AUTHORITY OF THE
5 SECRETARY.—If the Secretary delegates author-
6 ity to a State in an agreement entered into
7 under subparagraph (A), the Secretary may
8 continue to exercise such authority concurrently
9 with the State.

10 “(D) RECOGNITION OF PRIMARY DOMICILE
11 STATE.—In entering into any agreement with a
12 State under subparagraph (A), the Secretary
13 shall ensure that, as a result of such agreement
14 and all other agreements entered into under
15 subparagraph (A), only one State will be recog-
16 nized, with respect to any particular multiple
17 employer welfare arrangement, as the primary
18 domicile State to which authority has been dele-
19 gated pursuant to such agreements.

20 “(2) ASSISTANCE TO STATES.—The Secretary
21 shall—

22 “(A) provide enforcement assistance to the
23 States with respect to multiple employer welfare
24 arrangements, including, but not limited to, co-
25 ordinating Federal and State efforts through

1 the establishment of cooperative agreements
2 with appropriate State agencies under which
3 the Pension and Welfare Benefits Administra-
4 tion keeps the States informed of the status of
5 its cases and makes available to the States in-
6 formation obtained by it,

7 “(B) provide continuing technical assist-
8 ance to the States with respect to issues involv-
9 ing multiple employer welfare arrangements
10 and this Act,

11 “(C) assist the States in obtaining from
12 the Office of Regulations and Interpretations
13 timely and complete responses to requests for
14 advisory opinions on issues described in sub-
15 paragraph (B), and

16 “(D) distribute copies of all advisory opin-
17 ions described in subparagraph (C) to the State
18 insurance commissioner of each State.”.

19 **SEC. 1219. EFFECTIVE DATE; TRANSITIONAL RULES.**

20 (a) **EFFECTIVE DATE.**—The amendments made by
21 this part shall take effect January 1, 1995, except that
22 the Secretary of Labor may issue regulations before such
23 date under such amendments. The Secretary shall issue
24 all regulations necessary to carry out the amendments
25 made by this title before the effective date thereof.

1 (b) TRANSITIONAL RULES.—If the sponsor of a mul-
2 tiple employer welfare arrangement which, as of January
3 1, 1995, provides benefits consisting of medical care de-
4 scribed in section 607(1) of the Employee Retirement In-
5 come Security Act of 1974 (29 U.S.C. 1167(1)) files with
6 the Secretary of Labor an application for an exemption
7 under part 7 of subtitle B of title I of such Act within
8 180 days after such date and the Secretary has not, as
9 of 90 days after receipt of such application, found such
10 application to be materially deficient, section 514(b)(6)(A)
11 of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply
12 with respect to such arrangement during the 18-month pe-
13 riod following such date. If the Secretary determines, at
14 any time after the date of enactment of this Act, that any
15 such exclusion from coverage under the provisions of such
16 section 514(b)(6)(A) of such Act of a multiple employer
17 welfare arrangement would be detrimental to the interests
18 of individuals covered under such arrangement, such ex-
19 clusion shall cease as of the date of the determination.
20 Any determination made by the Secretary under this sub-
21 section shall be in the Secretary's sole discretion.

1 **PART 3—ENCOURAGEMENT OF MULTIPLE EM-**
2 **PLOYER ARRANGEMENTS PROVIDING BASIC**
3 **HEALTH BENEFITS**

4 **SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR**
5 **GEOGRAPHIC LOCATION REQUIREMENT FOR**
6 **TAX EXEMPT TRUST STATUS.**

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

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

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

12 “(B) Any determination of whether a multiple
13 employer health plan (as defined in section 701(10)
14 of the Employee Retirement Income Security Act of
15 1974) or an insured multiple employer health plan
16 (as defined in section 701(11) of such Act) is a vol-
17 untary employees’ beneficiary association meeting
18 the requirements of this paragraph shall be made
19 without regard to any determination of commonality
20 of interest or geographic location if—

21 “(i) such plan provides at least standard
22 coverage (consistent with section 1102(b) of the
23 Health Reform Consensus Act of 1994), and

24 “(ii) in the case of an insured multiple em-
25 ployer health plan, it meets the requirements
26 enforceable under section 514(b)(6)(B)(i) of the

1 Employee Retirement Income Security Act of
2 1974 to the extent not preempted by section
3 1202 of the Health Reform Consensus Act of
4 1994.”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) shall apply with respect to determinations
7 made on or after January 1, 1995.

8 **PART 4—SIMPLIFYING FILING OF REPORTS FOR**
9 **EMPLOYERS COVERED UNDER INSURED**
10 **MULTIPLE EMPLOYER HEALTH PLANS**

11 **SEC. 1231. SINGLE ANNUAL FILING FOR ALL EMPLOYERS**
12 **COVERED UNDER AN INSURED MULTIPLE**
13 **EMPLOYER HEALTH PLAN.**

14 (a) IN GENERAL.—Section 110 of the Employee Re-
15 tirement Income Security Act of 1974 (29 U.S.C. 1030),
16 as amended by section 1211(c) of this subtitle, is amended
17 by adding at the end the following new subsection:

18 “(d) The Secretary shall prescribe by regulation or
19 otherwise an alternative method providing for the filing
20 of a single annual report (as referred to in section
21 104(a)(1)(A)) with respect to all employers who are cov-
22 ered under the same insured multiple employer health plan
23 (as defined in section 701(11)).”

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall take effect on the date of the enact-

1 ment of this Act. The Secretary of Labor shall prescribe
2 the alternative method referred to in section 110(d) of the
3 Employee Retirement Income Security Act of 1974, as
4 added by such amendment, within 90 days after the date
5 of the enactment of this Act.

6 **PART 5—COMPLIANCE WITH COVERAGE OPTION**
7 **REQUIREMENTS**

8 **SEC. 1241. COMPLIANCE WITH COVERAGE REQUIREMENTS**
9 **THROUGH MULTIPLE EMPLOYER HEALTH AR-**
10 **RANGEMENTS.**

11 (a) COMPLIANCE WITH APPLICABLE REQUIREMENTS
12 THROUGH MULTIEMPLOYER PLANS.—In any case in
13 which an eligible employee is, for any plan year, a partici-
14 pant in a group health plan which is a multiemployer plan,
15 the requirements of section 1001(a) shall be deemed to
16 be met with respect to such employee for such plan year
17 if the employer requirements of subsection (c) are met
18 with respect to the eligible employee, irrespective of wheth-
19 er, or to what extent, the employer makes employer con-
20 tributions on behalf of the eligible employee.

21 (b) COMPLIANCE WITH APPLICABLE REQUIREMENTS
22 THROUGH OTHER MULTIPLE EMPLOYER HEALTH AR-
23 RANGEMENTS.—

24 (1) IN GENERAL.—In any case in which an em-
25 ployer is, for any plan year, a participating employer

1 (as defined in paragraph (3)) in an exempted mul-
2 tiple employer health plan or an insured multiple
3 employer health plan, the requirements of section
4 1001(a) shall be deemed to be met (and the ERISA
5 requirements of paragraph (2) shall be deemed to be
6 met by the employer) with respect to an eligible em-
7 ployee of the employer if—

8 (A) the employer requirements of sub-
9 section (c) are met with respect to the eligible
10 employee, and

11 (B) the applicable ERISA requirements of
12 paragraph (2) are met by the plan with respect
13 to the plan,

14 irrespective of whether, or to what extent, the em-
15 ployer makes employer contributions on behalf of the
16 eligible employee.

17 (2) APPLICABLE ERISA REQUIREMENTS.—The
18 applicable ERISA requirements of this paragraph
19 are the requirements of—

20 (A) part 1 of subtitle B of title I of the
21 Employee Retirement Income Security Act of
22 1974 (relating to reporting and disclosure),

23 (B) section 503 of such Act (relating to
24 claims procedure), and

1 (C) part 6 of subtitle B of such title I (re-
2 lating to group health plans),
3 to the extent that such requirements relate to em-
4 ployers as plan sponsors or plan administrators.

5 (3) PARTICIPATING EMPLOYER.—In this sub-
6 section, the term “participating employer” means, in
7 connection with an exempted multiple employer
8 health plan or an insured multiple employer health
9 plan, any employer if any of its employees, or any
10 of the dependents of its employees, are or were cov-
11 ered under such plan in connection with the employ-
12 ment of the employees.

13 (c) EMPLOYER REQUIREMENTS.—The employer re-
14 quirements of this subsection are met under a plan with
15 respect to an eligible employee if—

16 (1) the employee is eligible under the plan to
17 elect coverage on an annual basis and is provided a
18 reasonable opportunity to make the election in such
19 form and manner and at such times as are provided
20 by the plan,

21 (2) subject to section 1001(c), such coverage in-
22 cludes at least the standard coverage (consistent
23 with section 1102(c)),

24 (3) the employer facilitates collection of any
25 employee contributions under the plan and permits

1 the employee to elect to have employee contributions
2 under the plan collected through payroll deduction,
3 and

4 (4) in the case of a plan to which part 1 of sub-
5 title B of title I of the Employee Retirement Income
6 Security Act of 1974 does not otherwise apply, the
7 employer provides to the employee a summary plan
8 description described in section 102(a)(1) of such
9 Act in the form and manner and at such times as
10 are required under such part 1 with respect to em-
11 ployee welfare benefit plans.

12 **Subtitle D—Health Deduction**
13 **Fairness**

14 **SEC. 1301. PERMANENT EXTENSION AND INCREASE IN**
15 **HEALTH INSURANCE TAX DEDUCTION FOR**
16 **SELF-EMPLOYED INDIVIDUALS.**

17 (a) PERMANENT EXTENSION OF DEDUCTION.—

18 (1) IN GENERAL.—Subsection (l) of section 162
19 of the Internal Revenue Code of 1986 (relating to
20 special rules for health insurance costs of self-em-
21 ployed individuals) is amended by striking paragraph
22 (6).

23 (2) EFFECTIVE DATE.—The amendment made
24 by this subsection shall apply to taxable years begin-
25 ning after December 31, 1995.

1 (b) INCREASE IN AMOUNT OF DEDUCTION.—

2 (1) IN GENERAL.—Paragraph (1) of section
3 162(l) of such Code is amended by striking “25 per-
4 cent of” and inserting “100 percent (50 percent in
5 the case of taxable years beginning in 1996 or 1997)
6 of”.

7 (2) EFFECTIVE DATE.—The amendment made
8 by this subsection shall apply to taxable years begin-
9 ning after December 31, 1995.

10 **TITLE II—PREVENTING FRAUD**
11 **AND ABUSE**

12 **Subtitle A—Establishment of All-**
13 **Payer Health Care Fraud and**
14 **Abuse Control Program**

15 **SEC. 2001. ALL-PAYER HEALTH CARE FRAUD AND ABUSE**
16 **CONTROL PROGRAM.**

17 (a) IN GENERAL.—Not later than January 1, 1996,
18 the Attorney General shall establish a program—

19 (1) to coordinate Federal, State, and local law
20 enforcement programs to control fraud and abuse
21 with respect to the delivery of and payment for
22 health care in the United States,

23 (2) to conduct investigations, audits, evalua-
24 tions, and inspections relating to the delivery of and
25 payment for health care in the United States, and

1 (3) in consultation with the Inspector General
2 of the Department of Health and Human Services,
3 to facilitate the enforcement of the provisions of sec-
4 tions 1128, 1128A, and 1128B of the Social Secu-
5 rity Act and other statutes applicable to health care
6 fraud and abuse.

7 (b) COORDINATION WITH LAW ENFORCEMENT
8 AGENCIES.—In carrying out the program under sub-
9 section (a), the Attorney General shall consult with, and
10 arrange for the sharing of data and resources with Fed-
11 eral, State and local law enforcement agencies, State Med-
12 icaid Fraud Control Units, and State agencies responsible
13 for the licensing and certification of health care providers.

14 (c) COORDINATION WITH THIRD PARTY INSUR-
15 ERS.—In carrying out the program established under sub-
16 section (a), the Attorney General shall consult with, and
17 arrange for the sharing of data with representatives of pri-
18 vate sponsors of health benefit plans and other providers
19 of health insurance.

20 (d) REGULATIONS.—

21 (1) IN GENERAL.—The Attorney General shall
22 by regulation establish standards to carry out the
23 program under subsection (a).

24 (2) INFORMATION STANDARDS.—

1 (A) IN GENERAL.—Such standards shall
2 include standards relating to the furnishing of
3 information by health insurers (including self-
4 insured health benefit plans), providers, and
5 others to enable the Attorney General to carry
6 out the program (including coordination with
7 law enforcement agencies under subsection (b)
8 and third party insurers under subsection (c)).

9 (B) CONFIDENTIALITY.—Such standards
10 shall include procedures to assure that such in-
11 formation is provided and utilized in a manner
12 that protects the confidentiality of the informa-
13 tion and the privacy of individuals receiving
14 health care services.

15 (C) QUALIFIED IMMUNITY FOR PROVIDING
16 INFORMATION.—The provisions of section
17 1157(a) of the Social Security Act (relating to
18 limitation on liability) shall apply to a person
19 providing information to the Attorney General
20 under the program under this section, with re-
21 spect to the Attorney General’s performance of
22 duties under the program, in the same manner
23 as such section applies to information provided
24 to organizations with a contract under part B

1 of title XI of such Act, with respect to the per-
2 formance of such a contract.

3 **SEC. 2002. AUTHORIZATION OF ADDITIONAL APPROPRIA-**
4 **TIONS FOR INVESTIGATORS AND OTHER PER-**
5 **SONNEL.**

6 In addition to any other amounts authorized to be
7 appropriated to the Attorney General for health care anti-
8 fraud and abuse activities for a fiscal year, there are au-
9 thorized to be appropriated such sums as may be nec-
10 essary to enable the Attorney General to conduct inves-
11 tigation of allegations of health care fraud and otherwise
12 carry out the program established under section 2001 in
13 a fiscal year.

14 **SEC. 2003. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE**
15 **TRUST FUND.**

16 (a) ESTABLISHMENT.—There is hereby created on
17 the books of the Treasury of the United States a trust
18 fund to be known as the “Anti-Fraud and Abuse Trust
19 Fund” (in this section referred to as the “Trust Fund”).
20 The Trust Fund shall consist of such amounts as may be
21 deposited in, or appropriated to, such Trust Fund as pro-
22 vided in this subtitle and section 1128A(f)(3) of the Social
23 Security Act.

24 (b) MANAGEMENT.—

1 (1) IN GENERAL.—The Trust Fund shall be
2 managed by the Attorney General through a Manag-
3 ing Trustee designated by the Attorney General.

4 (2) INVESTMENT OF FUNDS.—It shall be the
5 duty of the Managing Trustee to invest such portion
6 of the Trust Fund as is not, in the trustee’s judg-
7 ment, required to meet current withdrawals. Such
8 investments may be made only in interest-bearing
9 obligations of the United States or in obligations
10 guaranteed as to both principal and interest by the
11 United States. For such purpose such obligations
12 may be acquired on original issue at the issue price,
13 or by purchase of outstanding obligations at market
14 price. The purposes for which obligations of the
15 United States may be issued under chapter 31 of
16 title 31, United States Code, are hereby extended to
17 authorize the issuance at par of public-debt obliga-
18 tions for purchase by the Trust Fund. Such obliga-
19 tions issued for purchase by the Trust Fund shall
20 have maturities fixed with due regard for the needs
21 of the Trust Fund and shall bear interest at a rate
22 equal to the average market yield (computed by the
23 Managing Trustee on the basis of market quotations
24 as of the end of the calendar month next preceding
25 the date of such issue) on all marketable interest-

1 bearing obligations of the United States then form-
2 ing a part of the public debt which are not due or
3 callable until after the expiration of 4 years from the
4 end of such calendar month, except that where such
5 average is not a multiple of $\frac{1}{8}$ of 1 percent, the rate
6 of interest on such obligations shall be the multiple
7 of $\frac{1}{8}$ of 1 percent nearest such market yield. The
8 Managing Trustee may purchase other interest-bear-
9 ing obligations of the United States or obligations
10 guaranteed as to both principal and interest by the
11 United States, on original issue or at the market
12 price, only where the Trustee determines that the
13 purchase of such other obligations is in the public
14 interest.

15 (3) Any obligations acquired by the Trust Fund
16 (except public-debt obligations issued exclusively to
17 the Trust Fund) may be sold by the Managing
18 Trustee at the market price, and such public-debt
19 obligations may be redeemed at par plus accrued in-
20 terest.

21 (4) The interest on, and the proceeds from the
22 sale or redemption of, any obligations held in the
23 Trust Fund shall be credited to and form a part of
24 the Trust Fund.

1 (5) The receipts and disbursements of the At-
2 torney General in the discharge of the functions of
3 the Attorney General shall not be included in the to-
4 tals of the budget of the United States Government.
5 For purposes of part C of the Balanced Budget and
6 Emergency Deficit Control Act of 1985, the Attor-
7 ney General and the Trust Fund shall be treated in
8 the same manner as the Federal Retirement Thrift
9 Investment Board and the Thrift Savings Fund, re-
10 spectively. The United States is not liable for any
11 obligation or liability incurred by the Trust Fund.

12 (c) USE OF FUNDS.—Amounts in the Trust Fund
13 shall be used to assist the Attorney General in carrying
14 out the all-payor fraud and abuse control program estab-
15 lished under section 2001(a) in the fiscal year involved.

16 (d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD
17 AND ABUSE PENALTIES INTO TRUST FUND.—Section
18 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a-
19 7a(f)(3)) is amended by striking “as miscellaneous re-
20 ceipts of the Treasury of the United States” and inserting
21 “in the Anti-Fraud and Abuse Trust Fund established
22 under section 2003(a) of the Health Reform Consensus
23 Act of 1994”.

24 (e) USE OF FEDERAL HEALTH ANTI-FRAUD AND
25 ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-

1 SHARING.—Section 1128A(f) of the Social Security Act
2 (42 U.S.C. 1320a–7a(f)) is amended in the matter preced-
3 ing paragraph (1) by striking “Secretary and disposed of
4 as follows:” and inserting the following: “Secretary. If the
5 person against whom such a penalty or assessment was
6 assessed collected a payment from an individual for pro-
7 viding to the individual the service that is the subject of
8 the penalty or assessment, the Secretary shall pay a por-
9 tion of the amount recovered to the individual in the na-
10 ture of restitution in an amount equal to the payment so
11 collected. The Secretary shall dispose of any remaining
12 amounts recovered under this section as follows:”.

13 **Subtitle B—Revisions to Current**
14 **Sanctions for Fraud and Abuse**

15 **SEC. 2101. MANDATORY EXCLUSION FROM PARTICIPATION**
16 **IN MEDICARE AND STATE HEALTH CARE PRO-**
17 **GRAMS.**

18 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
19 TO FRAUD.—

20 (1) IN GENERAL.—Section 1128(a) of the So-
21 cial Security Act (42 U.S.C. 1320a–7(a)) is amend-
22 ed by adding at the end the following new para-
23 graph:

24 “(3) FELONY CONVICTION RELATING TO
25 FRAUD.—Any individual or entity that has been con-

1 victed, under Federal or State law, in connection
2 with the delivery of a health care item or service or
3 with respect to any act or omission in a program
4 (other than those specifically described in paragraph
5 (1)) operated by or financed in whole or in part by
6 any Federal, State, or local government agency, of
7 a criminal offense consisting of a felony relating to
8 fraud, theft, embezzlement, breach of fiduciary re-
9 sponsibility, or other financial misconduct.”.

10 (2) CONFORMING AMENDMENT.—Section
11 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))
12 is amended—

13 (A) in the heading, by striking “CONVIC-
14 TION” and inserting “MISDEMEANOR CONVIC-
15 TION”; and

16 (B) by striking “criminal offense” and in-
17 serting “criminal offense consisting of a mis-
18 demeanor”.

19 (b) INDIVIDUAL CONVICTED OF FELONY RELATING
20 TO CONTROLLED SUBSTANCE.—

21 (1) IN GENERAL.—Section 1128(a) of the So-
22 cial Security Act (42 U.S.C. 1320a–7(a)), as amend-
23 ed by subsection (a), is amended by adding at the
24 end the following new paragraph:

1 “(4) FELONY CONVICTION RELATING TO CON-
2 TROLLED SUBSTANCE.—Any individual or entity
3 that has been convicted, under Federal or State law,
4 of a criminal offense consisting of a felony relating
5 to the unlawful manufacture, distribution, prescrip-
6 tion, or dispensing of a controlled substance.”.

7 (2) CONFORMING AMENDMENT.—Section
8 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3))
9 is amended—

10 (A) in the heading, by striking “CONVIC-
11 TION” and inserting “MISDEMEANOR CONVIC-
12 TION”; and

13 (B) by striking “criminal offense” and in-
14 serting “criminal offense consisting of a mis-
15 demeanor”.

16 **SEC. 2102. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
17 **CLUSION FOR CERTAIN INDIVIDUALS AND**
18 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
19 **SION FROM MEDICARE AND STATE HEALTH**
20 **CARE PROGRAMS.**

21 Section 1128(c)(3) of the Social Security Act (42
22 U.S.C. 1320a-7(c)(3)) is amended by adding at the end
23 the following new subparagraphs:

24 “(D) In the case of an exclusion of an individual or
25 entity under paragraph (1), (2), or (3) of subsection (b),

1 the period of the exclusion shall be 3 years, unless the
2 Secretary determines in accordance with published regula-
3 tions that a shorter period is appropriate because of miti-
4 gating circumstances or that a longer period is appro-
5 priate because of aggravating circumstances.

6 “(E) In the case of an exclusion of an individual or
7 entity under subsection (b)(4) or (b)(5), the period of the
8 exclusion shall not be less than the period during which
9 the individual’s or entity’s license to provide health care
10 is revoked, suspended, or surrendered, or the individual
11 or the entity is excluded or suspended from a Federal or
12 State health care program.

13 “(F) In the case of an exclusion of an individual or
14 entity under subsection (b)(6)(B), the period of the exclu-
15 sion shall be not less than 1 year.”.

16 **SEC. 2103. CIVIL MONETARY PENALTIES.**

17 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS
18 TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY
19 PROGRAMS OR PLANS.—

20 (1) INDUCEMENTS TO INDIVIDUALS ENROLLED
21 UNDER MEDICARE.—

22 (A) OFFER OF REMUNERATION.—Section
23 1128A(a) of the Social Security Act (42 U.S.C.
24 1320a-7a(a)) is amended—

1 (i) by striking “or” at the end of
2 paragraph (1)(D);

3 (ii) by striking “, or” at the end of
4 paragraph (2) and inserting a semicolon;

5 (iii) by striking the semicolon at the
6 end of paragraph (3) and inserting “; or”;
7 and

8 (iv) by inserting after paragraph (3)
9 the following new paragraph:

10 “(4) offers to or transfers remuneration to any
11 individual eligible for benefits under title XVIII of
12 this Act, or under a State health care program (as
13 defined in section 1128(h)) that such person knows
14 or should know is likely to significantly influence
15 such individual to order or receive from a particular
16 provider, practitioner, or supplier any item or service
17 for which payment may be made, in whole or in
18 part, under title XVIII, or a State health care pro-
19 gram;”.

20 (B) REMUNERATION DEFINED.—Section
21 1128A(i) is amended by adding the following
22 new paragraph:

23 “(6) The term ‘remuneration’ includes the waiv-
24 er of coinsurance and deductible amounts (or any
25 part thereof), and transfers of items or services for

1 free or for other than fair market value. The term
2 ‘remuneration’ does not include the waiver of coin-
3 surance and deductible amounts by a person, if—

4 “(A) the waiver is not offered as part of
5 any advertisement or solicitation;

6 “(B) the person does not routinely waive
7 coinsurance or deductible amounts; and

8 “(C) the person—

9 “(i) waives the coinsurance and de-
10 ductible amounts after determining in good
11 faith that the individual is in financial
12 need;

13 “(ii) fails to collect coinsurance or de-
14 ductible amounts after making reasonable
15 collection efforts; or

16 “(iii) provides for any permissible
17 waiver as specified in section 1128B(b)(3)
18 or in regulations issued by the Secretary.”.

19 (2) INDUCEMENTS TO EMPLOYEES.—Section
20 1128A(a) of such Act (42 U.S.C. 1320a-7a(a)), as
21 amended by paragraph (1), is further amended—

22 (A) by striking “or” at the end of para-
23 graph (3);

24 (B) by striking the semicolon at the end of
25 paragraph (4) and inserting “; or”; and

1 (C) by inserting after paragraph (4) the
2 following new paragraph:

3 “(5) pays a bonus, reward, or any other remun-
4 eration, directly or indirectly, to an employee to in-
5 duce the employee to encourage individuals to seek
6 or obtain covered items or services for which pay-
7 ment may be made under the medicare program, or
8 a State health care program where the amount of
9 the remuneration is determined in a manner that
10 takes into account (directly or indirectly) the value
11 or volume of any referrals by the employee to the
12 employer for covered items or services;”.

13 (b) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
14 RECT CODING.—Section 1128A(a)(1)(A) of such Act (42
15 U.S.C. 1320a–7a(a)(1)) is amended by striking
16 “claimed,” and inserting the following: “claimed, including
17 any person who presents or causes to be presented a claim
18 for an item or service that is based on a code that the
19 person knows or should know will result in a greater pay-
20 ment to the person than the code the person knows or
21 should know is applicable to the item or service actually
22 provided,”.

1 **SEC. 2104. INTERMEDIATE SANCTIONS FOR MEDICARE**
2 **HEALTH MAINTENANCE ORGANIZATIONS.**

3 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
4 ANY PROGRAM VIOLATIONS.—

5 (1) IN GENERAL.—Section 1876(i)(1) of the
6 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
7 amended by striking “the Secretary may terminate”
8 and all that follows and inserting the following: “in
9 accordance with procedures established under para-
10 graph (9), the Secretary may at any time terminate
11 any such contract or may impose the intermediate
12 sanctions described in paragraph (6)(B) or (6)(C)
13 (whichever is applicable) on the eligible organization
14 if the Secretary determines that the organization—

15 (A) has failed substantially to carry out
16 the contract;

17 (B) is carrying out the contract in a man-
18 ner inconsistent with the efficient and effective
19 administration of this section;

20 (C) is operating in a manner that is not in
21 the best interests of the individuals covered
22 under the contract; or

23 (D) no longer substantially meets the ap-
24 plicable conditions of subsections (b), (c), (e),
25 and (f).”

1 (2) OTHER INTERMEDIATE SANCTIONS FOR
2 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
3 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is
4 amended by adding at the end the following new
5 subparagraph:

6 “(C) In the case of an eligible organization for which
7 the Secretary makes a determination under paragraph (1)
8 the basis of which is not described in subparagraph (A),
9 the Secretary may apply the following intermediate sanc-
10 tions:

11 “(i) Civil money penalties of not more than
12 \$25,000 for each determination under paragraph (1)
13 if the deficiency that is the basis of the determina-
14 tion has directly adversely affected (or has the sub-
15 stantial likelihood of adversely affecting) an individ-
16 ual covered under the organization’s contract.

17 “(ii) Civil money penalties of not more than
18 \$10,000 for each week beginning after the initiation
19 of procedures by the Secretary under paragraph (9)
20 during which the deficiency that is the basis of a de-
21 termination under paragraph (1) exists.

22 “(iii) Suspension of enrollment of individuals
23 under this section after the date the Secretary noti-
24 fies the organization of a determination under para-
25 graph (1) and until the Secretary is satisfied that

1 the deficiency that is the basis for the determination
2 has been corrected and is not likely to recur.”.

3 (3) PROCEDURES FOR IMPOSING SANCTIONS.—
4 Section 1876(i) of such Act (42 U.S.C. 1395mm(i))
5 is amended by adding at the end the following new
6 paragraph:

7 “(9) The Secretary may terminate a contract with an
8 eligible organization under this section or may impose the
9 intermediate sanctions described in paragraph (6) on the
10 organization in accordance with formal investigation and
11 compliance procedures established by the Secretary under
12 which—

13 “(A) the Secretary provides the organization
14 with the opportunity to develop and implement a
15 corrective action plan to correct the deficiencies that
16 were the basis of the Secretary’s determination
17 under paragraph (1);

18 “(B) in deciding whether to impose sanctions,
19 the Secretary considers aggravating factors such as
20 whether an entity has a history of deficiencies or has
21 not taken action to correct deficiencies the Secretary
22 has brought to their attention;

23 “(C) there are no unreasonable or unnecessary
24 delays between the finding of a deficiency and the
25 imposition of sanctions; and

1 “(D) the Secretary provides the organization
2 with reasonable notice and opportunity for hearing
3 (including the right to appeal an initial decision) be-
4 fore imposing any sanction or terminating the con-
5 tract.”.

6 (4) CONFORMING AMENDMENTS.—

7 (A) IN GENERAL.—Section 1876(i)(6)(B)
8 of such Act (42 U.S.C. 1395mm(i)(6)(B)) is
9 amended by striking the second sentence.

10 (B) PROCEDURAL PROVISIONS.—Section
11 1876(i)(6) of such Act (42 U.S.C.
12 1395mm(i)(6)) is further amended by adding at
13 the end the following new subparagraph:

14 “(D) The provisions of section 1128A (other than
15 subsections (a) and (b)) shall apply to a civil money pen-
16 alty under subparagraph (A) or (B) in the same manner
17 as they apply to a civil money penalty or proceeding under
18 section 1128A(a).”.

19 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
20 TIONS.—

21 (1) REQUIREMENT FOR WRITTEN AGREE-
22 MENT.—Section 1876(i)(7)(A) of the Social Security
23 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by
24 striking “an agreement” and inserting “a written
25 agreement”.

1 (2) DEVELOPMENT OF MODEL AGREEMENT.—
2 Not later than July 1, 1995, the Secretary shall de-
3 velop a model of the agreement that an eligible orga-
4 nization with a risk-sharing contract under section
5 1876 of the Social Security Act must enter into with
6 an entity providing peer review services with respect
7 to services provided by the organization under sec-
8 tion 1876(i)(7)(A) of such Act.

9 (3) REPORT BY GAO.—

10 (A) STUDY.—The Comptroller General
11 shall conduct a study of the costs incurred by
12 eligible organizations with risk-sharing con-
13 tracts under section 1876(b) of such Act of
14 complying with the requirement of entering into
15 a written agreement with an entity providing
16 peer review services with respect to services pro-
17 vided by the organization, together with an
18 analysis of how information generated by such
19 entities is used by the Secretary to assess the
20 quality of services provided by such eligible or-
21 ganizations.

22 (B) REPORT TO CONGRESS.—Not later
23 than July 1, 1997, the Comptroller General
24 shall submit a report to the Committee on
25 Ways and Means and the Committee on Energy

1 and Commerce of the House of Representatives
2 and the Committee on Finance and the Special
3 Committee on Aging of the Senate on the study
4 conducted under subparagraph (A).

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply with respect to contract years be-
7 ginning on or after January 1, 1995.

8 **SEC. 2105. EFFECTIVE DATE.**

9 The amendments made by this subtitle shall take ef-
10 fect January 1, 1996.

11 **Subtitle C—Administrative and**
12 **Miscellaneous Provisions**

13 **SEC. 2201. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
14 **AND ABUSE DATA COLLECTION PROGRAM.**

15 (a) FINDINGS.—The Congress finds the following:

16 (1) Fraud and abuse with respect to the deliv-
17 ery of and payment for health care services is a sig-
18 nificant contributor to the growing costs of the
19 Nation's health care.

20 (2) Control of fraud and abuse in health care
21 services warrants greater efforts of coordination
22 than those that can be undertaken by individual
23 States or the various Federal, State, and local law
24 enforcement programs.

1 (3) There is a national need to coordinate infor-
2 mation about health care providers and entities that
3 have engaged in fraud and abuse in the delivery of
4 and payment for health care services.

5 (4) There is no comprehensive national data
6 collection program for the reporting of public infor-
7 mation about final adverse actions against health
8 care providers, suppliers, or licensed health care
9 practitioners that have engaged in fraud and abuse
10 in the deliver of and payment for health care
11 services.

12 (5) A comprehensive national data collection
13 program for the reporting of public information
14 about final adverse actions will facilitate the enforce-
15 ment of the provisions of the Social Security Act and
16 other statutes applicable to health care fraud and
17 abuse.

18 (b) GENERAL PURPOSE.—Not later than January 1,
19 1995, the Secretary shall establish a national health care
20 fraud and abuse data collection program for the reporting
21 of final adverse actions (not including settlements where
22 no finding of liability has been made) against health care
23 providers, suppliers, or practitioners as required by sub-
24 section (c), with access as set forth in subsection (d).

25 (c) REPORTING OF INFORMATION.—

1 (1) IN GENERAL.—Each government agency
2 and health care plan shall report any final adverse
3 action (not including settlements where no finding of
4 liability has been made) taken against a health care
5 provider, supplier, or practitioner.

6 (2) INFORMATION TO BE REPORTED.—The in-
7 formation to be reported under paragraph (1)
8 includes:

9 (A) The name of any health care provider,
10 supplier, or practitioner who is the subject of a
11 final adverse action.

12 (B) The name (if known) of any health
13 care entity with which a health care provider,
14 supplier, or practitioner is affiliated or associ-
15 ated.

16 (C) The nature of the final adverse action.

17 (D) A description of the acts or omissions
18 and injuries upon which the final adverse action
19 was based, and such other information as the
20 Secretary determines by regulation is required
21 for appropriate interpretation of information re-
22 ported under this section.

23 (3) CONFIDENTIALITY.—In determining what
24 information is required, the Secretary shall include
25 procedures to assure that the information is pro-

1 vided and utilized in a manner that protects the con-
2 fidentiality of the information and the privacy of in-
3 dividuals receiving health care services.

4 (4) TIMING AND FORM OF REPORTING.—The
5 information required to be reported under this sub-
6 section shall be reported regularly (but not less often
7 than monthly) and in such form and manner as the
8 Secretary prescribes. Such information shall first be
9 required to be reported on a date specified by the
10 Secretary.

11 (5) TO WHOM REPORTED.—The information re-
12 quired to be reported under this subsection shall be
13 reported to the Secretary.

14 (d) DISCLOSURE AND CORRECTION OF INFORMA-
15 TION.—

16 (1) DISCLOSURE.—With respect to the informa-
17 tion about final adverse actions (not including settle-
18 ments where no findings of liability has been made)
19 reported to the Secretary under this section respect-
20 ing a health care provider, supplier, or practitioner,
21 the Secretary shall, by regulation, provide for—

22 (A) disclosure of the information, upon re-
23 quest, to the health care provider, supplier, or
24 licensed practitioner, and

1 (B) procedures in the case of disputed ac-
2 curacy of the information.

3 (2) CORRECTIONS.—Each Government agency
4 and health care plan shall report corrections of in-
5 formation already reported about any final adverse
6 action taken against a health care provider, supplier,
7 or practitioner, in such form and manner that the
8 Secretary prescribes by regulation.

9 (e) ACCESS TO REPORTED INFORMATION.—

10 (1) AVAILABILITY.—The information in this
11 database shall be available to the public, Federal
12 and State government agencies, and health care
13 plans pursuant to procedures that the Secretary
14 shall provide by regulation.

15 (2) FEES FOR DISCLOSURE.—The Secretary
16 may establish or approve reasonable fees for the dis-
17 closure of information in this database. The amount
18 of such a fee may not exceed the costs of processing
19 the requests for disclosure and of providing such in-
20 formation. Such fees shall be available to the Sec-
21 retary or, in the Secretary's discretion to the agency
22 designated under this section to cover such costs.

23 (f) PROTECTION FROM LIABILITY FOR REPORT-
24 ING.—No person or entity, including the agency des-
25 ignated by the Secretary in subsection (c)(5) shall be held

1 liable in any civil action with respect to any report made
2 as required by this section, without knowledge of the fal-
3 sity of the information contained in the report.

4 (g) DEFINITIONS AND SPECIAL RULES.—For pur-
5 poses of this section:

6 (1) The term “final adverse action” includes:

7 (A) Civil judgments against a health care
8 provider in Federal or State court related to the
9 delivery of a health care item or service.

10 (B) Federal or State criminal convictions
11 related to the delivery of a health care item or
12 service, as determined in accordance with sec-
13 tion 1128(j) of the Social Security Act.

14 (C) Actions by State or Federal agencies
15 responsible for the licensing and certification of
16 health care providers, suppliers, and licensed
17 health care practitioners, including—

18 (i) formal or official actions, such as
19 revocation or suspension of a license (and
20 the length of any such suspension), rep-
21 rimand, censure or probation, or

22 (ii) any other loss of license of the
23 provider, supplier, or practitioner, by oper-
24 ation of law.

1 (D) Exclusion from participation in Fed-
2 eral or State health care programs.

3 (2) The term “Government agency” includes:

4 (A) The Department of Justice.

5 (B) The Department of Health and
6 Human Services.

7 (C) Any other Federal agency that either
8 administers or provides payment for the deliv-
9 ery of health care services, including, but not
10 limited to the Department of Defense and the
11 Department of Veterans Affairs.

12 (D) State law enforcement agencies.

13 (E) State medicaid fraud and abuse units.

14 (F) State or Federal agencies responsible
15 for the licensing and certification of health care
16 providers and licensed health care practitioners.

17 (3) The term “health care plan” means a public
18 or private program for the delivery of or payment
19 for health care services other than the medicare pro-
20 gram or a State health care program described in
21 section 1128(h) of the Social Security Act.

22 (4) The term “health care provider” means a
23 provider of services as defined in section 1861(u) of
24 the Social Security Act, and any entity, including a
25 health maintenance organization, group medical

1 practice, or any other entity listed by the Secretary
2 in regulation, that provides health care services.

3 (5) The terms “licensed health care practi-
4 tioner”, “licensed practitioner”, and “practitioner”
5 mean, with respect to a State, an individual who is
6 licensed or otherwise authorized by the State to pro-
7 vide health care services (or any individual who,
8 without authority holds himself or herself out to be
9 so licensed or authorized).

10 (6) The term “supplier” means a supplier of
11 health care items and services described in sections
12 1819 (a) and (b), and section 1861 of the Social
13 Security Act.

14 (h) CONFORMING AMENDMENT.—Section 1921(d) of
15 the Social Security Act is amended by inserting “and sec-
16 tion 2201 of the Health Reform Consensus Act of 1994”
17 after “section 422 of the Health Care Quality Improve-
18 ment Act of 1986”.

19 **SEC. 2202. QUARTERLY PUBLICATION OF FINAL ADVERSE**
20 **ACTIONS TAKEN.**

21 (a) IN GENERAL.—Part A of title XI of the Social
22 Security Act (42 U.S.C. 1301 et seq.) is amended by
23 adding at the end the following new section:

1 “QUARTERLY PUBLICATION OF FINAL ADVERSE ACTIONS
2 TAKEN

3 “SEC. 1144. (a) IN GENERAL.—Not later than 30
4 days after the end of each calendar quarter, the Secretary
5 shall publish in the Federal Register a listing of all final
6 adverse actions taken during the quarter under this part
7 (including penalties imposed under section 1107, exclu-
8 sions under section 1128, the imposition of civil monetary
9 penalties under section 1128A, and the imposition of
10 criminal penalties under section 1128B) and under section
11 1156.

12 “(b) FINAL ADVERSE ACTION DEFINED.—In sub-
13 section (a), the term ‘final adverse action’ has the meaning
14 given such term under section 2201(g)(1) of the Health
15 Reform Consensus Act of 1994.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to calendar quarters beginning
18 on or after January 1, 1996.

19 **Subtitle D—Amendments to**
20 **Criminal Law**

21 **SEC. 2301. PENALTIES FOR HEALTH CARE FRAUD.**

22 (a) IN GENERAL.—

23 (1) FINES AND IMPRISONMENT FOR HEALTH
24 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,

1 United States Code, is amended by adding at the
2 end the following:

3 **“§ 1347. Health care fraud**

4 “(a) Whoever knowingly executes, or attempts to exe-
5 cute, a scheme or artifice—

6 “(1) to defraud any health care plan or other
7 person, in connection with the delivery of or pay-
8 ment for health care benefits, items, or services; or

9 “(2) to obtain, by means of false or fraudulent
10 pretenses, representations, or promises, any of the
11 money or property owned by, or under the custody
12 or control of, any health care plan, or person in con-
13 nection with the delivery of or payment for health
14 care benefits, items, or services;

15 shall be guilty of a felony, and fined under this title or
16 imprisoned not more than 5 years, or both.

17 “(b) In determining the amount or scope of any pen-
18 alty or assessment, the court shall take into account:

19 “(1) the nature of the false or fraudulent
20 claims and the circumstances under which they are
21 presented;

22 “(2) the degree of culpability and history of
23 prior offenses by the convicted health care provider;

24 “(3) the extent to which restitution is paid; and

25 “(4) such other matters as justice may require.

1 “(c) A principal is liable for penalties and assess-
2 ments under this section for the acts of the principal’s
3 agents acting within the scope of the agency.

4 “(d) For purposes of this section, the term ‘health
5 care plan’ means a Federally-funded public program or
6 private program for the delivery of or payment for health
7 care items or services.”.

8 (2) CLERICAL AMENDMENT.—The table of sec-
9 tions at the beginning of chapter 63 of title 18,
10 United States Code, is amended by adding at the
11 end the following:

“1347. Health care fraud.”.

12 **SEC. 2302. REWARDS FOR INFORMATION LEADING TO**
13 **PROSECUTION AND CONVICTION.**

14 Section 3059 of title 18, United States Code, is
15 amended by adding at the end the following new sub-
16 section:

17 “(c)(1) In special circumstances and in the Attorney
18 General’s sole discretion, the Attorney General may make
19 a payment of up to \$10,000 to a person who furnishes
20 information unknown to the Government relating to a pos-
21 sible prosecution under section 1347.

22 “(2) A person is not eligible for a payment under
23 paragraph (1) if—

24 “(A) the person is a current or former officer
25 or employee of a Federal or State government agen-

1 cy or instrumentality who furnishes information dis-
2 covered or gathered in the course of government em-
3 ployment.

4 “(B) the person knowingly participated in the
5 offense;

6 “(C) the information furnished by the person
7 consists of allegations or transactions that have been
8 disclosed to the public—

9 “(i) in a criminal, civil, or administrative
10 proceeding;

11 “(ii) in a congressional, administrative or
12 General Accounting Office report, hearing,
13 audit or investigation; or

14 “(iii) by the news media, unless the person
15 is the original source of the information; or

16 “(D) when, in the judgment of the Attorney
17 General, it appears that a person whose illegal ac-
18 tivities are being prosecuted or investigated could
19 benefit from the award.

20 “(3) For the purposes of paragraph (2)(C)(iii), the
21 term ‘original source’ means a person who has direct and
22 independent knowledge of the information that is fur-
23 nished and has voluntarily provided the information to the
24 Government prior to disclosure by the news media.

1 “(4) Neither the failure of the Attorney General to
2 authorize a payment under paragraph (1) nor the amount
3 authorized shall be subject to judicial review.”.

4 **TITLE III—MALPRACTICE**
5 **REFORM**
6 **Subtitle A—Findings; Purpose;**
7 **Definitions**

8 **SEC. 3001. FINDINGS; PURPOSE.**

9 (a) FINDINGS.—Congress finds that—

10 (1) the costs of health care consume more than
11 14 percent of the Gross Domestic Product of the
12 United States, significantly affecting interstate com-
13 merce and the budget of the Federal Government;

14 (2) claims for medical malpractice are a signifi-
15 cant factor in the cost of health care and cause phy-
16 sicians, hospitals, and other health care providers to
17 undertake diagnostic tests and procedures partly as
18 defensive measures against the possibility of mal-
19 practice claims;

20 (3) the health care and insurance industries are
21 industries affecting interstate commerce and the
22 medical malpractice litigation systems existing
23 throughout the United States affect interstate com-
24 merce by contributing to the high cost of health care

1 and premiums for malpractice insurance purchased
2 by health care providers; and

3 (4) the Federal Government has a major inter-
4 est in health care as a direct provider of health care
5 and as a source of payment for health care, and has
6 a demonstrated interest in assessing the quality of
7 care, access to care, and the costs of care through
8 the evaluative activities of several Federal agencies.

9 (b) PURPOSE.—It is the purpose of this title to—

10 (1) provide grants to States to develop alter-
11 native dispute resolution procedures to attain a more
12 efficient, expeditious, and equitable resolution of
13 health care malpractice disputes;

14 (2) enhance general knowledge concerning the
15 benefits of different forms of alternative dispute res-
16 olution mechanisms; and

17 (3) establish uniformity and curb excesses in
18 the State-based medical liability systems through
19 Federally mandated reforms.

20 **SEC. 3002. DEFINITIONS.**

21 As used in this title:

22 (1) ADR ADVISORY BOARD.—The term “ADR
23 Advisory Board” means the Alternative Dispute
24 Resolution Advisory Board established by the Sec-

1 retary of Health and Human Services under section
2 3202(a).

3 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-
4 TEM.—The term “alternative dispute resolution sys-
5 tem” means a system that is enacted or adopted by
6 a State to resolve medical malpractice claims other
7 than through a medical malpractice liability action.

8 (3) CLAIMANT.—The term “claimant” means
9 any person who brings a medical malpractice liability
10 claim and, in the case of an individual who is de-
11 ceased, incompetent, or a minor, the person on
12 whose behalf such a claim is brought.

13 (4) CLEAR AND CONVINCING EVIDENCE.—The
14 term “clear and convincing evidence” is that meas-
15 ure or degree of proof that will produce in the mind
16 of the trier of fact a firm belief or conviction as to
17 the truth of the allegations sought to be established,
18 except that such measure or degree of proof is more
19 than that required under preponderance of the evi-
20 dence, but less than that required for proof beyond
21 a reasonable doubt.

22 (5) ECONOMIC DAMAGES.—The term “economic
23 damages” means damages paid to compensate an in-
24 dividual for losses for hospital and other medical ex-

1 penses, lost wages, lost employment, and other pecu-
2 niary losses.

3 (6) HEALTH CARE PROFESSIONAL.—The term
4 “health care professional” means any individual who
5 provides health care services in a State and who is
6 required by State law or regulation to be licensed or
7 certified by the State to provide such services in the
8 State.

9 (7) HEALTH CARE PROVIDER.—The term
10 “health care provider” means any organization or
11 institution that is engaged in the delivery of health
12 care services in a State that is required by State law
13 or regulation to be licensed or certified by the State
14 to engage in the delivery of such services in the
15 State.

16 (8) INJURY.—The term “injury” means any ill-
17 ness, disease, or other harm that is the subject of
18 a medical malpractice claim.

19 (9) MEDICAL MALPRACTICE LIABILITY AC-
20 TION.—The term “medical malpractice liability ac-
21 tion” means any civil action brought pursuant to
22 State law in which a plaintiff alleges a medical mal-
23 practice claim against a health care provider or
24 health care professional, but does not include any

1 action in which the plaintiff's sole allegation is an al-
2 legation of an intentional tort.

3 (10) MEDICAL MALPRACTICE CLAIM.—The term
4 “medical malpractice claim” means any claim relat-
5 ing to the provision of (or the failure to provide)
6 health care services or the use of a medical product,
7 without regard to the theory of liability asserted,
8 and includes any third-party claim, cross-claim,
9 counterclaim, or contribution claim in a medical
10 malpractice liability action.

11 (11) MEDICAL PRODUCT.—

12 (A) IN GENERAL.—The term “medical
13 product” means, with respect to the allegation
14 of a claimant, a drug (as defined in section
15 201(g)(1) of the Federal Food, Drug, and Cos-
16 metic Act (21 U.S.C. 321(g)(1)) or a medical
17 device (as defined in section 201(h) of the Fed-
18 eral Food, Drug, and Cosmetic Act (21 U.S.C.
19 321(h))) if—

20 (i) such drug or device was subject to
21 premarket approval under section 505,
22 507, or 515 of the Federal Food, Drug,
23 and Cosmetic Act (21 U.S.C. 355, 357, or
24 360e) or section 351 of the Public Health
25 Service Act (42 U.S.C. 262) with respect

1 to the safety of the formulation or per-
2 formance of the aspect of such drug or de-
3 vice which is the subject of the claimant's
4 allegation or the adequacy of the packag-
5 ing or labeling of such drug or device, and
6 such drug or device is approved by the
7 Food and Drug Administration; or

8 (ii) the drug or device is generally rec-
9 ognized as safe and effective under regula-
10 tions issued by the Secretary of Health
11 and Human Services under section 201(p)
12 of the Federal Food, Drug, and Cosmetic
13 Act (21 U.S.C. 321(p)).

14 (B) EXCEPTION IN CASE OF MISREPRE-
15 SENTATION OR FRAUD.—Notwithstanding sub-
16 paragraph (A), the term “medical product”
17 shall not include any product described in such
18 subparagraph if the claimant shows that the
19 product is approved by the Food and Drug Ad-
20 ministration for marketing as a result of with-
21 held information, misrepresentation, or an ille-
22 gal payment by manufacturer of the product.

23 (12) NONECONOMIC DAMAGES.—The term
24 “noneconomic damages” means damages paid to
25 compensate an individual for losses for physical and

1 emotional pain, suffering, inconvenience, physical
2 impairment, mental anguish, disfigurement, loss of
3 enjoyment of life, loss of consortium, and other
4 nonpecuniary losses, but does not include punitive
5 damages.

6 (13) PUNITIVE DAMAGES.—The term “punitive
7 damages” means compensation, in addition to com-
8 pensation for actual harm suffered, that is awarded
9 for the purpose of punishing a person for conduct
10 deemed to be malicious, wanton, willful, or exces-
11 sively reckless.

12 (14) SECRETARY.—The term “Secretary”
13 means the Secretary of Health and Human Services.

14 (15) STATE.—The term “State” means each of
15 the several States, the District of Columbia, the
16 Commonwealth of Puerto Rico, the Virgin Islands,
17 and Guam.

18 **Subtitle B—Uniform Standards for** 19 **Malpractice Claims**

20 **SEC. 3101. APPLICABILITY.**

21 Except as provided in section 3111, this subtitle shall
22 apply to any medical malpractice liability action brought
23 in a Federal or State court, and to any medical mal-
24 practice claim subject to an alternative dispute resolution
25 system, that is initiated on or after January 1, 1996.

1 **SEC. 3102. REQUIREMENT FOR INITIAL RESOLUTION OF AC-**
2 **TION THROUGH ALTERNATIVE DISPUTE RES-**
3 **OLUTION.**

4 (a) IN GENERAL.—

5 (1) STATE CASES.—A medical malpractice li-
6 ability action may not be brought in any State court
7 during a calendar year unless the medical mal-
8 practice liability claim that is the subject of the ac-
9 tion has been initially resolved under an alternative
10 dispute resolution system certified for the year by
11 the Secretary under section 3202(a), or, in the case
12 of a State in which such a system is not in effect
13 for the year, under the alternative Federal system
14 established under section 3202(b).

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

24 (3) CLAIMS AGAINST UNITED STATES.—

25 (A) ESTABLISHMENT OF PROCESS FOR
26 CLAIMS.—The Attorney General shall establish

1 an alternative dispute resolution process for the
2 resolution of tort claims consisting of medical
3 malpractice liability claims brought against the
4 United States under chapter 171 of title 28,
5 United States Code. Under such process, the
6 resolution of a claim shall occur after the com-
7 pletion of the administrative claim process ap-
8 plicable to the claim under section 2675 of such
9 title.

10 (B) REQUIREMENT FOR INITIAL RESOLU-
11 TION UNDER PROCESS.—A medical malpractice
12 liability action based on a medical malpractice
13 liability claim described in subparagraph (A)
14 may not be brought in any Federal court unless
15 the claim has been initially resolved under the
16 alternative dispute resolution process estab-
17 lished by the Attorney General under such sub-
18 paragraph.

19 (b) INITIAL RESOLUTION OF CLAIMS UNDER
20 ADR.—For purposes of subsection (a), an action is “ini-
21 tially resolved” under an alternative dispute resolution
22 system if—

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

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

4 (c) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—If no party files a notice of intent to contest a decision reached under an alternative dispute resolution system pursuant to section 3103(a)(1), the decision shall be enforced by a court of competent jurisdiction in the same manner as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court.

11 **SEC. 3103. PROCEDURAL REQUIREMENTS FOR FILING OF**
12 **ACTIONS.**

13 (a) PROCEDURES FOR FILING ACTIONS AFTER DECISION.—

15 (1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

23 (2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought with respect to a medical malpractice liability claim that

1 is the subject of a decision under an alternative dis-
2 pute resolution system unless—

3 (A) a party has filed a notice of intent to
4 contest the decision under the alternative dis-
5 pute resolution system pursuant to paragraph
6 (1); and

7 (B) the party files the action in a court of
8 competent jurisdiction not later than 60 days
9 after the notice of intent is filed pursuant to
10 paragraph (1) (or, if such notice of intent is
11 filed by a party other than the claimant, not
12 later than 90 days after such notice is filed).

13 (3) COURT OF COMPETENT JURISDICTION.—
14 For purposes of this subsection, the term “court of
15 competent jurisdiction” means—

16 (A) with respect to actions filed in a State
17 court, the appropriate State trial court; and

18 (B) with respect to actions filed in a Fed-
19 eral court, the appropriate United States dis-
20 trict court.

21 (b) CERTIFICATE OF MERIT.—

22 (1) IN GENERAL.—Each individual who files a
23 notice of intent to contest a decision under the alter-
24 native dispute resolution system pursuant to sub-
25 section (a)(1) shall, not later than 90 days after the

1 applicable medical malpractice liability action is
2 filed—

3 (A) submit a certificate of merit described
4 in subsection (b); or

5 (B) post a surety (or equivalent security)
6 bond of \$4,000 (or, during the 45-day period
7 that begins on the date the action is filed, a
8 cost bond of \$2,000) with the court.

9 (2) EXTENSION OF DEADLINE.—On the motion
10 of any party to the action or upon a written agree-
11 ment of the parties filed with the court, the court
12 may extend the deadline specified in paragraph (1)
13 for a period not to exceed 30 days.

14 (3) WAIVER FOR GOOD CAUSE.—The court may
15 waive the application of paragraph (1) to a plaintiff
16 if the plaintiff shows good cause that such para-
17 graph should not apply.

18 (4) CERTIFICATE OF MERIT DESCRIBED.—In
19 this subsection, a “certificate of merit” means—

20 (A) with respect to a plaintiff, an affidavit
21 declaring that the individual (or the individual’s
22 attorney) has obtained a written opinion from a
23 medical expert who is knowledgeable of the rel-
24 evant medical issues involved in the action that
25 the defendant was negligent and the defend-

1 ant's conduct was a proximate cause of the al-
2 leged injury that is the subject of the action;
3 and

4 (B) with respect to a defendant, an affida-
5 vit declaring that the individual (or the individ-
6 ual's attorney) has obtained a written opinion
7 from a medical expert who is knowledgeable of
8 the relevant medical issues involved in the ac-
9 tion that the defendant followed the appropriate
10 standards or procedures and exercised due care,
11 and that the defendant's conduct was not the
12 proximate cause of the alleged injury that is the
13 subject of the action.

14 (c) EFFECT OF FAILURE TO MEET REQUIREMENT
15 TO FILE CERTIFICATE.—If an individual fails to file a cer-
16 tificate of merit with respect to a medical malpractice li-
17 ability action under subsection (b)—

18 (1) if the individual is a plaintiff, the court
19 shall dismiss the action without prejudice to the
20 refiling of the action by the individual;

21 (2) if the individual is a defendant, the court
22 shall award judgment to the plaintiff based on the
23 plaintiff's pleadings; and

1 (3) the court shall require the individual to pay
2 any court costs incurred by the opposing parties as
3 a result of the filing of the action.

4 (d) JUDICIAL NOTICE OF DECISION UNDER ADR
5 SYSTEM.—A medical malpractice liability action brought
6 after a decision on the claim that is the subject of the
7 action has been reached under an alternative dispute reso-
8 lution system shall be tried de novo, except that the court
9 shall take judicial notice of such decision and (in the case
10 of an action tried by a jury) shall read the decision to
11 the jury prior to any opening statements and make the
12 decision available to the jury during the trial.

13 **SEC. 3104. TREATMENT OF NONECONOMIC AND PUNITIVE**
14 **DAMAGES.**

15 (a) LIMITATION ON NONECONOMIC DAMAGES.—The
16 total amount of noneconomic damages that may be award-
17 ed to a claimant and the members of the claimant's family
18 for losses resulting from the injury which is the subject
19 of a medical malpractice liability action may not exceed
20 \$250,000, regardless of the number of parties against
21 whom the action is brought or the number of actions
22 brought with respect to the injury.

23 (b) TREATMENT OF PUNITIVE DAMAGES AWARDED
24 AGAINST MANUFACTURER OF MEDICAL PRODUCT.—

1 (1) LIMITATION ON AMOUNT OF AWARD.—The
2 total amount of punitive or exemplary damages that
3 may be awarded with respect to an injury which is
4 the subject of a medical malpractice liability action
5 may not exceed twice the total amount of other dam-
6 ages awarded with respect to the injury.

7 (2) DISTRIBUTION OF AWARD.—Of the total
8 amount of any punitive damages awarded in a medi-
9 cal malpractice liability action, 50 percent shall be
10 paid to the claimant and 50 percent shall be paid to
11 the State in which the action is brought (or, in a
12 case brought in Federal court, in the State in which
13 the health care services that caused the injury that
14 is the subject of the action were provided) for the
15 purposes of carrying out the activities described in
16 paragraph (3).

17 (3) ACTIVITIES DESCRIBED.—A State shall use
18 amounts paid pursuant to paragraph (2) to carry
19 out activities to assure the safety and quality of
20 health care services provided in the State, including
21 (but not limited to)—

22 (A) implementing health care quality as-
23 surance programs;

24 (B) carrying out programs to reduce mal-
25 practice-related costs for providers volunteering

1 to provide services in medically underserved
2 areas; and

3 (C) implementing and operating a State al-
4 ternative dispute resolution system certified by
5 the Secretary under section 3203.

6 (4) MAINTENANCE OF EFFORT.—A State shall
7 use any amounts paid pursuant to paragraph (2) to
8 supplement and not to replace amounts spent by the
9 State for the activities described in paragraph (3).

10 (c) SEVERAL LIABILITY FOR NONECONOMIC DAM-
11 AGES.—The liability of each defendant for noneconomic
12 damages shall be several only and shall not be joint, and
13 each defendant shall be liable only for the amount of non-
14 economic damages allocated to the defendant in direct pro-
15 portion to the defendant's percentage of responsibility (as
16 determined by the trier of fact).

17 **SEC. 3105. PERIODIC PAYMENTS FOR FUTURE LOSSES.**

18 (a) PERIODIC PAYMENTS PERMITTED.—

19 (1) IN GENERAL.—In any medical malpractice
20 liability action in which the damages awarded for fu-
21 ture economic loss exceeds \$100,000, a defendant
22 may not be required to pay such damages in a sin-
23 gle, lump-sum payment, but may be permitted to
24 make such payments on a periodic basis if the
25 court—

1 (A) determines that economic damages in-
2 curred through the date of the award shall be
3 paid;

4 (B) bases the periods for such payments
5 upon projections of when such expenses are
6 likely to be incurred; and

7 (C) determines that the periodic payments
8 are adequately secured.

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

13 **SEC. 3106. TREATMENT OF ATTORNEY'S FEES AND OTHER**
14 **COSTS.**

15 (a) LIMITATION ON AMOUNT OF CONTINGENCY
16 FEES.—

17 (1) IN GENERAL.—An attorney who represents,
18 on a contingency fee basis, a claimant in a medical
19 malpractice liability claim may not charge, demand,
20 receive, or collect for services rendered in connection
21 with such claim in excess of the following amount re-
22 covered by judgment or settlement under such claim:

23 (A) 25 percent of the first \$100,000 (or
24 portion thereof) recovered.

1 (B) 20 percent of the next \$150,000 (or
2 portion thereof) recovered.

3 (C) 15 percent of the next \$250,000 (or
4 portion thereof) recovered.

5 (D) 10 percent of any amount in excess of
6 \$500,000 recovered.

7 (2) CALCULATION OF PERIODIC PAYMENTS.—In
8 the event that a judgment or settlement includes
9 periodic or future payments of damages, the amount
10 recovered for purposes of computing the limitation
11 on the contingency fee under paragraph (1) shall be
12 based on the cost of the annuity or trust established
13 to make the payments. In any case in which an an-
14 nuity or trust is not established to make such pay-
15 ments, such amount shall be based on the present
16 value of the payments.

17 (b) CONTINGENCY FEE DEFINED.—As used in this
18 section, the term “contingency fee” means any fee for pro-
19 fessional legal services which is, in whole or in part, con-
20 tingent upon the recovery of any amount of damages,
21 whether through judgment or settlement.

22 **SEC. 3107. UNIFORM STATUTE OF LIMITATIONS.**

23 (a) IN GENERAL.—No medical malpractice claim
24 may be initiated after the expiration of the 2-year period
25 that begins on the date on which the alleged injury that

1 is the subject of such claim was discovered or the date
2 on which such injury should reasonably have been discov-
3 ered, whichever is earlier.

4 (b) EXCEPTION FOR MINORS.—In the case of an al-
5 leged injury suffered by a minor who has not attained 6
6 years of age, a medical malpractice claim may be initiated
7 after the expiration of the period described in subsection
8 (a) if the claim is initiated before the minor attains 8
9 years of age.

10 **SEC. 3108. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**
11 **SERVICES.**

12 (a) IN GENERAL.—In the case of a medical mal-
13 practice claim relating to services provided during labor
14 or the delivery of a baby, if the health care professional
15 or health care provider against whom the claim is brought
16 did not previously treat the claimant for the pregnancy,
17 the trier of fact may not find that such professional or
18 provider committed malpractice and may not assess dam-
19 ages against such professional or provider unless the mal-
20 practice is proven by clear and convincing evidence.

21 (b) APPLICABILITY TO GROUP PRACTICES OR
22 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-
23 section (a), a health care professional shall be considered
24 to have previously treated an individual for a pregnancy
25 if the professional is a member of a group practice whose

1 members previously treated the individual for the preg-
2 nancy or is providing services to the individual during
3 labor or the delivery of a baby pursuant to an agreement
4 with another professional.

5 **SEC. 3109. APPLICATION OF MEDICAL PRACTICE PARAM-**
6 **ETERS IN MALPRACTICE LIABILITY ACTIONS.**

7 (a) USE OF PARAMETERS AS AFFIRMATIVE DE-
8 FENSE.—In any medical malpractice liability action, it
9 shall be a complete defense to any allegation that the de-
10 fendant was negligent that, in the provision of (or the fail-
11 ure to provide) the services that are the subject of the
12 action, the defendant followed the appropriate practice pa-
13 rameter.

14 (b) RESTRICTION ON PARAMETERS CONSIDERED AP-
15 PROPRIATE.—

16 (1) PARAMETERS SANCTIONED BY SEC-
17 RETARY.—For purposes of subsection (a), a practice
18 parameter may not be considered appropriate with
19 respect to actions brought during a year unless the
20 Secretary has sanctioned the use of the parameter
21 for purposes of an affirmative defense to medical
22 malpractice liability actions brought during the year
23 in accordance with paragraph (2) or (3).

24 (2) PROCESS FOR SANCTIONING PARAM-
25 ETERS.—Not less frequently than October 1 of each

1 year (beginning with 1995), the Secretary shall re-
2 view the practice guidelines and standards developed
3 by the Administrator for Health Care Policy and Re-
4 search pursuant to section 1142 of the Social Secu-
5 rity Act, and shall sanction those guidelines which
6 the Secretary considers appropriate for purposes of
7 an affirmative defense to medical malpractice liabil-
8 ity actions brought during the next calendar year as
9 appropriate practice parameters for purposes of sub-
10 section (a).

11 (3) USE OF STATE PARAMETERS.—Upon the
12 application of a State, the Secretary may sanction
13 practice parameters selected by the State for pur-
14 poses of an affirmative defense to medical mal-
15 practice liability actions brought in the State as ap-
16 propriate practice parameters for purposes of sub-
17 section (a) if the parameters meet such requirements
18 as the Secretary may impose.

19 (c) PROHIBITING APPLICATION OF FAILURE TO FOL-
20 LOW PARAMETERS AS PRIMA FACIE EVIDENCE OF NEG-
21 LIGENCE.—No plaintiff in a medical malpractice liability
22 action may be deemed to have presented prima facie evi-
23 dence that a defendant was negligent solely by showing
24 that the defendant failed to follow the appropriate practice
25 parameter.

1 **SEC. 3110. JURISDICTION OF FEDERAL COURTS.**

2 Nothing in this subtitle shall be construed to estab-
3 lish jurisdiction over any medical malpractice liability ac-
4 tion in the district courts of the United States on the basis
5 of sections 1331 or 1337 of title 28, United States Code.

6 **SEC. 3111. PREEMPTION.**

7 (a) **IN GENERAL.**—This subtitle supersedes any State
8 law only to the extent that the State law permits the recov-
9 ery by a claimant or the assessment against a defendant
10 of a greater amount of damages or establishes a less strict
11 standard of proof for determining whether a defendant has
12 committed malpractice, than the provisions of this sub-
13 title.

14 (b) **EFFECT ON SOVEREIGN IMMUNITY AND CHOICE**
15 **OF LAW OR VENUE.**—Nothing in this subtitle shall be con-
16 strued to—

17 (1) waive or affect any defense of sovereign im-
18 munity asserted by any State under any provision of
19 law;

20 (2) waive or affect any defense of sovereign im-
21 munity asserted by the United States;

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

24 (4) preempt State choice-of-law rules with re-
25 spect to claims brought by a foreign nation or a citi-
26 zen of a foreign nation; or

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

6 **Subtitle C—Requirements for State**
7 **Alternative Dispute Resolution**
8 **Systems (ADR)**

9 **SEC. 3201. BASIC REQUIREMENTS.**

10 (a) IN GENERAL.—A State’s alternative dispute reso-
11 lution system meets the requirements of this section if the
12 system—

13 (1) applies to all medical malpractice liability
14 claims under the jurisdiction of the courts of that
15 State;

16 (2) requires that a written opinion resolving the
17 dispute be issued not later than 6 months after the
18 date by which each party against whom the claim is
19 filed has received notice of the claim (other than in
20 exceptional cases for which a longer period is re-
21 quired for the issuance of such an opinion), and that
22 the opinion contain—

23 (A) findings of fact relating to the dispute,
24 and

1 (B) a description of the costs incurred in
2 resolving the dispute under the system (includ-
3 ing any fees paid to the individuals hearing and
4 resolving the claim), together with an appro-
5 priate assessment of the costs against any of
6 the parties;

7 (3) requires individuals who hear and resolve
8 claims under the system to meet such qualifications
9 as the State may require (in accordance with regula-
10 tions of the Secretary);

11 (4) is approved by the State or by local govern-
12 ments in the State;

13 (5) with respect to a State system that consists
14 of multiple dispute resolution procedures—

15 (A) permits the parties to a dispute to se-
16 lect the procedure to be used for the resolution
17 of the dispute under the system, and

18 (B) if the parties do not agree on the pro-
19 cedure to be used for the resolution of the dis-
20 pute, assigns a particular procedure to the par-
21 ties;

22 (6) provides for the transmittal to the State
23 agency responsible for monitoring or disciplining
24 health care professionals and health care providers
25 of any findings made under the system that such a

1 professional or provider committed malpractice, un-
2 less, during the 90-day period beginning on the date
3 the system resolves the claim against the profes-
4 sional or provider, the professional or provider
5 brings an action contesting the decision made under
6 the system; and

7 (7) provides for the regular transmittal to the
8 Administrator for Health Care Policy and Research
9 of information on disputes resolved under the sys-
10 tem, in a manner that assures that the identity of
11 the parties to a dispute shall not be revealed.

12 (b) APPLICATION OF MALPRACTICE LIABILITY
13 STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—
14 The provisions of subtitle B (other than sections 3102 and
15 3103) shall apply with respect to claims brought under
16 a State alternative dispute resolution system or the alter-
17 native Federal system in the same manner as such provi-
18 sions apply with respect to medical malpractice liability
19 actions brought in the State.

20 **SEC. 3202. ALTERNATIVE DISPUTE RESOLUTION ADVISORY**
21 **BOARD.**

22 (a) ESTABLISHMENT.—Not later than 1 year after
23 the date of the enactment of this Act, the Secretary shall
24 establish an Alternative Dispute Resolution Advisory
25 Board to advise the Secretary regarding the establishment

1 of alternative dispute resolution systems at the State and
2 Federal levels.

3 (b) COMPOSITION.—The ADR Advisory Board shall
4 be composed of members appointed by the Secretary from
5 among representatives of the following:

6 (1) Physicians.

7 (2) Hospitals.

8 (3) Patient advocacy groups.

9 (4) State governments.

10 (5) Academic experts from applicable disciplines
11 (including medicine, law, public health, and econom-
12 ics) and specialists in arbitration and dispute resolu-
13 tion.

14 (6) Health insurers and medical malpractice in-
15 surers.

16 (7) Medical product manufacturers.

17 (8) Pharmaceutical companies.

18 (9) Other professions and groups determined
19 appropriate by the Secretary.

20 (c) DUTIES.—The ADR Advisory Board shall—

21 (1) examine various dispute resolution systems
22 and provide advice and assistance to States regard-
23 ing the establishment of such systems;

24 (2) not later than 1 year after the appointment
25 of its members, submit to the Secretary—

1 (A) a model alternative dispute resolution
2 system that may be used by a State for pur-
3 poses of this subtitle, and

4 (B) a model alternative Federal system
5 that may be used by the Secretary pursuant to
6 section 3203(b)(1); and

7 (3) review the applications of States for certifi-
8 cation of State alternative dispute resolution systems
9 and make recommendations to the Secretary regard-
10 ing whether the systems should be certified under
11 section 3203.

12 **SEC. 3203. CERTIFICATION OF STATE SYSTEMS; APPLICA-**
13 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

14 (a) CERTIFICATION.—

15 (1) APPLICATION BY STATE.—Each State shall
16 submit an application to the ADR Advisory Board
17 describing its alternative dispute resolution system
18 and containing such information as the ADR Advi-
19 sory Board may require to make a recommendation
20 regarding whether the system meets the require-
21 ments of this subtitle.

22 (2) BASIS FOR CERTIFICATION.—Not later than
23 October 1 of each year (beginning with 1995), the
24 Secretary, taking into consideration the rec-
25 ommendations of the ADR Advisory Board, shall

1 certify a State's alternative dispute resolution sys-
2 tem under this subsection for the following calendar
3 year if the Secretary determines that the system
4 meets the requirements of section 3201.

5 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-
6 TEM.—

7 (1) ESTABLISHMENT AND APPLICABILITY.—
8 Not later than October 1, 1995, the Secretary, tak-
9 ing into consideration the model alternative Federal
10 system submitted by the ADR Advisory Board under
11 section 3202(c)(2)(B), shall establish by rule an al-
12 ternative Federal ADR system for the resolution of
13 medical malpractice liability claims during a cal-
14 endar year in States that do not have in effect an
15 alternative dispute resolution system certified under
16 subsection (a) for the year.

17 (2) REQUIREMENTS FOR SYSTEM.—Under the
18 alternative Federal ADR system established under
19 paragraph (1)—

20 (A) paragraphs (1), (2), (6), and (7) of
21 section 3201(a) shall apply to claims brought
22 under the system;

23 (B) if the system provides for the resolu-
24 tion of claims through arbitration, the claims
25 brought under the system shall be heard and

1 resolved by arbitrators appointed by the Sec-
2 retary in consultation with the Attorney Gen-
3 eral; and

4 (C) with respect to a State in which the
5 system is in effect, the Secretary may (at the
6 State's request) modify the system to take into
7 account the existence of dispute resolution pro-
8 cedures in the State that affect the resolution
9 of medical malpractice liability claims.

10 (3) TREATMENT OF STATES WITH ALTER-
11 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
12 eral ADR system established under this subsection is
13 applied with respect to a State for a calendar year,
14 the State shall make a payment to the United States
15 (at such time and in such manner as the Secretary
16 may require) in an amount equal to 110 percent of
17 the costs incurred by the United States during the
18 year as a result of the application of the system with
19 respect to the State.

20 **SEC. 3204. REPORTS ON IMPLEMENTATION AND EFFEC-**
21 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**
22 **LUTION SYSTEMS.**

23 (a) IN GENERAL.—Not later than 5 years after the
24 date of the enactment of this Act, the Secretary shall pre-
25 pare and submit to the Congress a report describing and

1 evaluating State alternative dispute resolution systems op-
2 erated pursuant to this subtitle and the alternative Fed-
3 eral system established under section 3203(b).

4 (b) CONTENTS OF REPORT.—The Secretary shall in-
5 clude in the report prepared and submitted under sub-
6 section (a)—

7 (1) information on—

8 (A) the effect of the alternative dispute
9 resolution systems on the cost of health care
10 within each State,

11 (B) the impact of such systems on the ac-
12 cess of individuals to health care within the
13 State, and

14 (C) the effect of such systems on the qual-
15 ity of health care provided within the State; and

16 (2) to the extent that such report does not pro-
17 vide information on no-fault systems operated by
18 States as alternative dispute resolution systems pur-
19 suant to this part, an analysis of the feasibility and
20 desirability of establishing a system under which
21 medical malpractice liability claims shall be resolved
22 on a no-fault basis.

1 **TITLE IV—PAPERWORK REDUC-**
2 **TION AND ADMINISTRATIVE**
3 **SIMPLIFICATION**

4 **SEC. 4001. PREEMPTION OF STATE QUILL PEN LAWS.**

5 After 1995, 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. 4002. CONFIDENTIALITY OF ELECTRONIC HEALTH**
10 **CARE INFORMATION.**

11 (a) PROMULGATION OF REQUIREMENTS.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services shall promulgate, and may modify
14 from time to time, requirements to facilitate and en-
15 sure the uniform, confidential treatment of individ-
16 ually identifiable health care information in elec-
17 tronic environments.

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 Secretary shall consult with a work-
16 ing group of knowledgeable individuals representing
17 all interested parties (including third-party payers,
18 providers, consumers, employers, information man-
19 agers, and technical experts).

20 (4) DEADLINE.—The Secretary shall first pro-
21 mulgate requirements under this subsection by not
22 later than six months after the date of the enact-
23 ment 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 Secretary
6 for a determination that the State has in effect
7 a law that provides for the application of re-
8 quirements with respect to such information
9 (and enforcement provisions with respect to
10 such requirements) consistent with such re-
11 quirements (and with the enforcement provi-
12 sions of subsection (c)), and

13 (B) the Secretary determines that the
14 State has such a law in effect.

15 (2) APPLICATION TO CURRENT INFORMA-
16 TION.—The Secretary shall specify the extent to
17 which (and manner in which) the requirements pro-
18 mulgated under subsection (a) apply to information
19 collected before the effective date of the require-
20 ments.

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 Secretary.

7 **SEC. 4003. STANDARDIZATION FOR THE ELECTRONIC RE-**
8 **CEIPT AND TRANSMISSION OF HEALTH PLAN**
9 **INFORMATION.**

10 (a) GOALS.—The Secretary shall establish national
11 goals, and time frameworks, respecting the progress to be
12 made by the health care industry in eliminating unneces-
13 sary paperwork and achieving appropriate standardization
14 in the areas of electronic receipt and transmission of
15 health care claims and health plan information and eligi-
16 bility verification (consistent with the requirements pro-
17 mulgated under section 4002(a)).

18 (b) CONTINGENT REQUIREMENTS.—If the Secretary
19 determines that the health care industry has failed to meet
20 the goals established under subsection (a) by the deadlines
21 established by the Secretary under such subsection, the
22 Secretary shall promulgate (and may, from time to time,
23 modify) standards and requirements concerning the elec-
24 tronic receipt and transmission of health plan claims
25 forms and other health plan information.

1 (c) COMPLIANCE.—

2 (1) IN GENERAL.—The Secretary may impose a
3 civil money penalty on any health plan (other than
4 a health plan described in paragraph (2)) that fails
5 to comply with standards and requirements promul-
6 gated under subsection (b) in an amount not to ex-
7 ceed \$100 for each such failure. The provisions of
8 section 1128A of the Social Security Act (other than
9 the first sentence of subsection (a) and other than
10 subsection (b)) shall apply to a civil money penalty
11 under this paragraph in the same manner as such
12 provisions apply to a penalty or proceeding under
13 section 1128A(a) of such Act.

14 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
15 ULATION.—A plan described in this paragraph is a
16 health plan that is subject to regulation by a State,
17 if the Secretary finds that—

18 (A) the State provides for application of
19 the standards and requirements promulgated
20 under subsection (b), and

21 (B) the State regulatory program provides
22 for the appropriate and effective enforcement of
23 such standards and requirements with respect
24 to such plans.

1 (d) CONSULTATION.—The Secretary shall conduct
2 activities under this section in consultation with the Ac-
3 credited Standards Committee X-12 of the American Na-
4 tional Standards Institute, insurers, providers, and others.

5 **SEC. 4004. USE OF UNIFORM HEALTH CLAIMS FORMS AND**
6 **IDENTIFICATION NUMBERS.**

7 (a) GOALS.—The Secretary shall establish national
8 goals, and time frameworks, respecting the progress to be
9 made by the health care industry in achieving uniform-
10 ity—

11 (1) in the format and content of basic claims
12 forms under health plans, and

13 (2) in the use of common identification num-
14 bers for beneficiaries and providers of health care
15 items or services under health plans.

16 (b) CONTINGENT REQUIREMENTS.—If the Secretary
17 determines that the health care industry has failed to meet
18 the goals established under subsection (a) by the deadlines
19 established by the Secretary under such subsection, the
20 Secretary shall promulgate (and may, from time to time,
21 modify) standards and requirements concerning—

22 (1) the format and content of basic claims
23 forms under health plans, and

1 (2) the common identification numbers to be
2 used by health plans to identify health plan bene-
3 ficiaries and health care providers.

4 (c) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health plan (other than
7 a health plan described in paragraph (2)) that fails
8 to comply with standards and requirements promul-
9 gated under subsection (b) in an amount not to ex-
10 ceed \$100 for each such failure. The provisions of
11 section 1128A of the Social Security Act (other than
12 the first sentence of subsection (a) and other than
13 subsection (b)) shall apply to a civil money penalty
14 under this paragraph in the same manner as such
15 provisions apply to a penalty or proceeding under
16 section 1128A(a) of such Act.

17 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
18 ULATION.—A plan described in this paragraph is a
19 health plan that is subject to regulation by a State,
20 if the Secretary finds that—

21 (A) the State provides for application of
22 the standards and requirements promulgated
23 under subsection (b), and

24 (B) the State regulatory program provides
25 for the appropriate and effective enforcement of

1 such standards and requirements with respect
2 to such plans.

3 (d) CONSULTATION.—The Secretary shall conduct
4 activities under this section in consultation with the
5 Workgroup for Electronic Data Interchange and with in-
6 surers, providers, and others.

7 **SEC. 4005. PRIORITY AMONG INSURERS.**

8 (a) GOALS.—The Secretary shall establish national
9 goals, and time frameworks, respecting the progress to be
10 made by the health care industry in achieving uniformity
11 in the rules for determining the liability of insurers when
12 benefits are payable under two or more health plans.

13 (b) CONTINGENT REQUIREMENTS.—If the Secretary
14 determines that the health care industry has failed to meet
15 the goals established under subsection (a) by the deadlines
16 established by the Secretary under such subsection, the
17 Secretary shall promulgate (and may, from time to time,
18 modify) rules for determining the liability of health plans
19 when benefits are payable under two or more health plans.

20 (c) COMPLIANCE.—

21 (1) IN GENERAL.—The Secretary may impose a
22 civil money penalty on any health plan (other than
23 a health plan described in paragraph (2)) that fails
24 to comply with rules promulgated under subsection

25 (b) in an amount not to exceed \$100 for each such

1 failure. The provisions of section 1128A of the So-
2 cial Security Act (other than the first sentence of
3 subsection (a) and other than subsection (b)) shall
4 apply to a civil money penalty under this paragraph
5 in the same manner as such provisions apply to a
6 penalty or proceeding under section 1128A(a) of
7 such Act.

8 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
9 ULATION.—A plan described in this paragraph is a
10 health plan that is subject to regulation by a State,
11 if the Secretary finds that—

12 (A) the State provides for application of
13 the rules established under subsection (b), and

14 (B) the State regulatory program provides
15 for the appropriate and effective enforcement of
16 such rules with respect to such plans.

17 (d) CONSULTATION.—The Secretary shall conduct
18 activities under this section in consultation with health
19 plans.

20 **SEC. 4006. FURNISHING OF INFORMATION AMONG HEALTH**
21 **PLANS.**

22 (a) GOALS.—The Secretary shall establish national
23 goals, and time frameworks, respecting the progress to be
24 made by the health care industry in achieving uniformity

1 in the availability of information among health plans when
2 benefits are payable under two or more health plans.

3 (b) CONTINGENT REQUIREMENTS.—If the Secretary
4 determines that the health care industry has failed to meet
5 the goals established under subsection (a) by the deadlines
6 established by the Secretary under such subsection, the
7 Secretary shall promulgate (and may, from time to time,
8 modify) requirements concerning the transfer among
9 health plans (and annual updating) of appropriate infor-
10 mation (which may include requirements for the use of
11 unique identifiers, and for the listing of all individuals cov-
12 ered under a health plan).

13 (c) COMPLIANCE.—

14 (1) IN GENERAL.—The Secretary may impose a
15 civil money penalty on any health plan (other than
16 a health plan described in paragraph (2)) that fails
17 to comply with requirements promulgated under sub-
18 section (b) in an amount not to exceed \$100 for
19 each such failure. The provisions of section 1128A
20 of the Social Security Act (other than the first sen-
21 tence of subsection (a) and other than subsection
22 (b)) shall apply to a civil money penalty under this
23 paragraph in the same manner as such provisions
24 apply to a penalty or proceeding under section
25 1128A(a) of such Act.

1 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
2 ULATION.—A plan described in this paragraph is a
3 health plan that is subject to regulation by a State,
4 if the Secretary finds that—

5 (A) the State provides for application of
6 the requirements promulgated under subsection
7 (b), and

8 (B) the State regulatory program provides
9 for the appropriate and effective enforcement of
10 such requirements with respect to such plans.

11 (d) CONSULTATION.—The Secretary shall conduct
12 activities under this section in consultation with health
13 plans.

14 **SEC. 4007. DEFINITIONS.**

15 For purposes of this title—

16 (1) The term “health plan” means any contract
17 or arrangement under which an entity bears all or
18 part of the cost of providing health care items and
19 services, including a hospital or medical expense in-
20 curred policy or certificate, hospital or medical serv-
21 ice plan contract, or health maintenance subscriber
22 contract (including any closed accountable health
23 plan), but does not include (except for purposes of
24 sections 4005 and 4006)—

1 (A) coverage only for accident, dental, vi-
2 sion, disability, or long term care, medicare
3 supplemental health insurance, or any combina-
4 tion thereof,

5 (B) coverage issued as a supplement to li-
6 ability insurance,

7 (C) workers' compensation or similar in-
8 surance, or

9 (D) automobile medical-payment insur-
10 ance.

11 (2) The term "provider" means a physician,
12 hospital, pharmacy, laboratory, or other person li-
13 censed or otherwise authorized under applicable
14 State laws to furnish health care items or services.

15 (3) The term "Secretary" means the Secretary
16 of Health and Human Services.

1 **TITLE V—EXPANDING ACCESS/
2 PREVENTIVE CARE**
3 **Subtitle A—Expanding Access**
4 **Through Community Health Au-**
5 **thorities**

6 **SEC. 5001. COMMUNITY HEALTH AUTHORITIES DEM-**
7 **ONSTRATION PROJECTS.**

8 (a) IN GENERAL.—Title XIX of the Social Security
9 Act, as amended by section 13631(b) of the Omnibus
10 Budget Reconciliation Act of 1993, is amended—

11 (1) by redesignating section 1931 as section
12 1932; and

13 (2) by inserting after section 1930 the following
14 new section:

15 “COMMUNITY HEALTH AUTHORITIES DEMONSTRATION
16 PROJECTS

17 “SEC. 1931. (a) IN GENERAL.—In order to test the
18 effectiveness of various innovative health care delivery ap-
19 proaches through the operation of community health au-
20 thorities, the Secretary shall operate a program under
21 which States establish projects to demonstrate the effec-
22 tiveness of such approaches in providing access to cost-
23 effective preventive and primary care and related services
24 for various areas and populations, including low-income
25 residents of medically underserved areas or for medically

1 underserved populations. A State may operate more than
2 one such project.

3 “(b) SELECTION OF STATE PROJECTS.—

4 “(1) IN GENERAL.—A State is eligible to par-
5 ticipate in the program, and establish a demonstra-
6 tion project, under this section only if—

7 “(A) the State submits to the Secretary an
8 application, at such time and in such form as
9 the Secretary may require, for participation in
10 the program; and

11 “(B) the Secretary finds that—

12 “(i) the application contains assur-
13 ances that the State will support the devel-
14 opment of a community health authority
15 that meets the requirements of this sec-
16 tion,

17 “(ii) the community health authority
18 will meet the requirements for such an au-
19 thority under subsection (c),

20 “(iii) the State provides sufficient as-
21 surances that the demonstration project of
22 a community health authority meets (or,
23 when operational, will meet) the require-
24 ments of subsection (d), and

1 “(iv) the State will comply with the
2 requirements of subsections (g) and (h).

3 “(2) CONTENTS OF APPLICATION.—Each appli-
4 cation submitted under paragraph (1) for a dem-
5 onstration project shall include at least the follow-
6 ing:

7 “(A) A description of the proposed commu-
8 nity health authority and of the area or popu-
9 lation that the authority will serve.

10 “(B) A demonstration that the CHA will
11 serve at least one geographic area or population
12 group that is designated as medically under-
13 served under section 330 of the Public Health
14 Service Act or as having a shortage of health
15 professionals under section 332 of such Act.

16 “(C) An assessment of the area’s or popu-
17 lation’s need for services and an assurance that
18 the services of the CHA will be responsive to
19 those needs.

20 “(D) A list of the items and services to be
21 furnished by the CHA under the project, bro-
22 ken down by those items and services that are
23 treated as medical assistance under the State
24 plan under this title and other items and serv-
25 ices that will be provided by the CHA (either

1 directly or through coordination with other enti-
2 ties).

3 “(E) An assurance that the CHA has en-
4 tered into (or plans to enter into) written par-
5 ticipation agreements with a sufficient number
6 of providers to enable the CHA to furnish all of
7 such items and services to enrolled individuals.

8 “(F) An assurance that the State plan
9 under this title will provide payment to the au-
10 thority in accordance with subsection (e).

11 “(G) Evidence of support and assistance
12 from other State agencies with responsibility for
13 providing or supporting the provision of preven-
14 tive and primary care services to underserved
15 and at-risk populations.

16 “(H) A proposed budget for the CHA.

17 “(3) PRIORITY.—The Secretary shall give prior-
18 ity to those applications proposing to support a
19 CHA that includes as participating providers all
20 Federally-qualified health centers serving the area or
21 population or (in areas for which there are no Fed-
22 erally-qualified health centers) all entities that would
23 be Federally-qualified health centers but for the fail-
24 ure to meet the requirement described in section
25 329(f)(2)(G)(i) of the Public Health Service Act or

1 the requirement described in section 330(e)(3)(G)(i)
2 of such Act (relating to the composition of the enti-
3 ty's governing board).

4 “(4) PERIOD OF APPROVAL.—Each project ap-
5 proved under this section shall be approved for a pe-
6 riod of not less than 5 years, subject to renewal for
7 subsequent periods unless such approval is with-
8 drawn for cause by the Secretary or at the request
9 of the State.

10 “(c) COMMUNITY HEALTH AUTHORITY (CHA) DE-
11 FINED.—In this section, the terms ‘community health au-
12 thority’ and ‘CHA’ mean a nonprofit entity that meets the
13 following requirements:

14 “(1) The entity serves (or will serve at the time
15 it becomes operational under a project) a geographic
16 area or population group that includes those des-
17 ignated—

18 “(A) under section 330 of the Public
19 Health Service Act as medically underserved, or

20 “(B) under section 332 of such Act as a
21 health professions shortage area.

22 “(2) The entity enrolls—

23 “(A) individuals and families who are med-
24 icaid-eligible;

1 “(B) within the limits of its available re-
2 sources and capacity, other individuals who
3 have incomes below 200 percent of the Federal
4 official poverty level; and

5 “(C) within the limits of its available re-
6 sources and capacity, other individuals and
7 families who are able to pay the costs of enroll-
8 ment.

9 “(3) Through its participating providers, the
10 entity provides or, through contracts, arranges for
11 the provision of (or, by the time it become oper-
12 ational, will so provide or arrange for the provision
13 of) at least preventive services, primary care serv-
14 ices, inpatient and outpatient hospital services, and
15 any other service provided by a participating pro-
16 vider for which payment may be made under the
17 State plan under this title to enrolled individuals.

18 “(4) The entity must include (to the maximum
19 extent practicable) as participating providers any of
20 the following providers that furnish services provided
21 by (or arranged by) the entity that are located in or
22 serve the area or population to be covered:

23 “(A) Federally-qualified health centers.

24 “(B) Rural health clinics.

1 “(C) Local public health agencies that fur-
2 nish such services.

3 “(D) A hospital (or other provider of inpa-
4 tient or outpatient hospital services) which has
5 a participation agreement in effect with the
6 State under its plan under this title, which is
7 located in or serving the area or population to
8 be served.

9 “(5) The entity may include as participating
10 providers other providers (which may include private
11 physicians or group practice offices, other commu-
12 nity clinics, limited service providers (such as pre-
13 natal clinics), and health professionals teaching pro-
14 grams (such as area health educational centers))
15 and take other appropriate steps, to the extent need-
16 ed to assure that the network is reasonable in size
17 and able to provide (or arrange for the provision of)
18 the services it proposes to furnish to its enrollees.

19 “(6) The entity must maintain written agree-
20 ments with each participating provider under which
21 the provider agrees to participate in the CHA and
22 agrees to accept payment from the CHA as payment
23 in full for services furnished to individuals enrolled
24 with the CHA (subject to the requirements of sub-
25 section (g)(4), in the case of services furnished by a

1 provider that are described in subparagraph (B) or
2 (C) of section 1905(a)(2)).

3 “(7) Under the written agreements described in
4 paragraph (6), if a majority of the board of directors
5 of the entity has determined that a participating
6 provider is failing to meet any of the requirements
7 of the participation agreement, the board may termi-
8 nate the provider’s participation agreement in ac-
9 cordance with the following requirements:

10 “(A) Subject to subparagraph (B), prior to
11 any termination of a provider’s participation
12 agreement, the provider shall be entitled to 30
13 days prior notice, a reasonable opportunity to
14 correct any deficiencies, and an opportunity for
15 a full and fair hearing conducted by the entity
16 to dispute the reasons for termination. The pro-
17 vider shall be entitled to appeal the board of di-
18 rectors’ decision directly to a committee consist-
19 ing of representatives of all of the entity’s par-
20 ticipating providers.

21 “(B) If a majority of the board of directors
22 of the entity determines that the continued par-
23 ticipation of a provider presents an immediate
24 threat to the health and safety of patients or a
25 substantial risk of improper diversion of funds,

1 the board may suspend the provider's participa-
2 tion agreement (including the receipt of funds
3 under the agreement) for a period of up to 60
4 days. During this period, the entity shall take
5 steps to ensure that patients who were assigned
6 to or cared for by the suspended provider are
7 appropriately assigned or referred to alternative
8 participating providers. The suspended provider
9 shall be entitled to a hearing within the period
10 of the suspension to show cause why the sus-
11 pension should be lifted and its participation
12 agreement restored. If dissatisfied with the
13 board's decision, the provider shall be entitled
14 to appeal the decision directly to a committee
15 consisting of representatives of all of the enti-
16 ty's participating providers.

17 "(C) For all other disputes between the en-
18 tity and its participating providers (including
19 disputes over the amounts due or interim rates
20 to be paid to a provider), the entity shall pro-
21 vide an opportunity for a full and fair hearing.

22 "(8) The entity must be governed by a board of
23 directors that includes representatives of the partici-
24 pating providers and, as appropriate, other health
25 professionals, civic or business leaders, elected offi-

1 cials, and residents of the area or population served.
2 Not less than 51 percent of such board shall be com-
3 posed of individuals who are enrolled in the CHA
4 and who are representatives of the community
5 served.

6 “(d) DEMONSTRATION PROJECT REQUIREMENTS.—
7 The requirements of this subsection, with respect to a
8 demonstration project of a CHA under this section, are
9 as follows:

10 “(1)(A) All services furnished by the CHA
11 under the project shall be available and accessible to
12 all enrolled individuals and, except as provided in
13 subparagraph (B), must be available without regard
14 to an individual’s ability to pay for such services.

15 “(B) A CHA shall prepare a schedule of dis-
16 counts to be applied to the payment of premiums by
17 individuals who are not medicaid-eligible individuals
18 which shall be adjusted on the basis of the individ-
19 ual’s ability to pay.

20 “(2) The CHA shall take appropriate steps to
21 emphasize the provision of preventive and primary
22 care services, and shall ensure that each enrolled in-
23 dividual is assigned to a primary care physician (to
24 the greatest extent appropriate and feasible), except
25 that the CHA shall establish a process through

1 which an enrolled individual may be assigned to an-
2 other primary care physician for good cause shown.

3 “(3) The CHA must make reasonable efforts to
4 reduce the unnecessary or inappropriate use of hos-
5 pital or other high-cost services through an emphasis
6 on preventive and primary care services, the imple-
7 mentation of utilization review or other appropriate
8 methods.

9 “(4) The State must regularly provide the CHA
10 with information on other medical, health, and relat-
11 ed benefits that may be available to individuals en-
12 rolled with the CHA under programs other than the
13 State plan under this title, and the CHA must pro-
14 vide its enrolled individuals with enrollment informa-
15 tion and other assistance to assist them in obtaining
16 such benefits.

17 “(5) The State and the CHA must meet such
18 financial standards and requirements and reporting
19 requirements as the Secretary specifies and must
20 prepare and submit to the Secretary an annual inde-
21 pendent financial audit conducted in accordance with
22 requirements specified by the Secretary.

23 “(6) In collaboration with the State, the CHA
24 must adopt and use community-oriented, patient-re-
25 sponsive quality assurance and control systems in

1 accordance with requirements specified by the Sec-
2 retary. Such systems must include at least an ongo-
3 ing quality assurance program that measures
4 consumer satisfaction with the care provided under
5 the network, stresses improved health outcomes, and
6 operates a community health status improvement
7 process that identifies and investigates community
8 health problems and implements measures designed
9 to remedy them.

10 “(e) CAPITATION PAYMENTS.—

11 “(1) IN GENERAL.—Under a demonstration
12 project under this section, the State shall enter into
13 an annual contract with the CHA under which the
14 State shall make monthly payments to the CHA for
15 covered services furnished through the CHA to indi-
16 viduals entitled to medical assistance under this title
17 in the amount specified in paragraph (2). Payment
18 shall be made at the beginning of each month on the
19 basis of estimates of the amounts payable and
20 amounts subsequently paid are subject to adjust-
21 ment to reflect the amounts by which previous pay-
22 ments were greater or less than the amount of pay-
23 ments that should have been made.

24 “(2) AMOUNT OF CAPITATION PAYMENT.—The
25 amount of a monthly payment under paragraph (1)

1 during a contract year, shall be not less than $\frac{1}{12}$ of
2 the product of—

3 “(A)(i) the average per capita amounts ex-
4 pended under this title under the State plan for
5 covered services to be furnished under the dem-
6 onstration project for similar Medicaid-eligible
7 individuals for the most recent 12-month period
8 ending before the date of the enactment of this
9 section, increased by (ii) the percentage change
10 in the consumer price index for all urban con-
11 sumers (all items; U.S. city average) during the
12 period that begins upon the expiration of such
13 12-month period and ends upon the expiration
14 of the most recent 12-month period ending be-
15 fore the first month of the contract year for
16 which complete financial data on such index is
17 available, and

18 “(B) the number of Medicaid-eligible indi-
19 viduals enrolled under the project as of the
20 15th day of the month prior to the first month
21 of the contract year (or, in the case of the first
22 year for which a contract is in effect under this
23 subsection, the CHA’s reasonable estimate of
24 the number of such individuals who will be en-

1 rolled in the project as of the 15th day of such
2 month).

3 “(f) ADDITIONAL STATE ASSISTANCE FOR PLAN-
4 NING, DEVELOPMENT, AND OPERATIONS.—

5 “(1) IN GENERAL.—Subject to paragraph (2),
6 in addition to the payments under subsection (e),
7 demonstration projects approved under this section
8 are eligible to have approved expenditures described
9 in paragraph (3) treated, for purposes of section
10 1903(a)(7), as expenditures found necessary by the
11 Secretary for the proper and efficient administration
12 of the State plan under this title.

13 “(2) SPECIAL RULES.—

14 “(A) LIMITATION WITH RESPECT TO ANY
15 COMMUNITY HEALTH AUTHORITY.—The total
16 amount of expenditures with respect to any
17 CHA that may be treated as expenditures for
18 medical assistance under paragraph (1) for any
19 12-month period shall not exceed \$250,000.

20 “(B) LIMITATION ON NUMBER OF
21 YEARS.—The number of 12-month periods for
22 which expenditures are treated as expenditures
23 for medical assistance under paragraph (1) for
24 a CHA shall not exceed—

1 “(i) 2 for expenditures for planning
2 and development assistance, described in
3 paragraph (3)(A), and

4 “(ii) 2 for expenditures for oper-
5 ational assistance, described in paragraph
6 (3)(B).

7 “(C) NO RESULTING REDUCTION IN
8 AMOUNTS PROVIDED UNDER PHSA GRANTS.—
9 No grant to a CHA or one of its participating
10 providers under the Public Health Service Act
11 or this Act may be reduced on the ground that
12 activities of the CHA that are considered ap-
13 proved expenditures under paragraph (3) are
14 activities for which the CHA or the participat-
15 ing providers received funds under such Act.

16 “(3) APPROVED EXPENDITURES.—The ap-
17 proved expenditures described in this paragraph are
18 as follows:

19 “(A) PLANNING AND DEVELOPMENT.—Ex-
20 penditures for planning and development with
21 respect to a CHA, including—

22 “(i) developing internal management,
23 legal and financial and clinical, informa-
24 tion, and reporting systems for the CHA,

1 and carrying out other operating activities
2 of the CHA;

3 “(ii) recruiting, training and com-
4 pensating management staff of the CHA
5 and, as appropriate and necessary, man-
6 agement and clinical staff of any partici-
7 pating provider;

8 “(iii) purchasing essential equipment
9 and acquiring, modernizing, expanding, or
10 (if cost-effective) constructing facilities for
11 the CHA and for participating providers
12 (including amortization costs and payment
13 of interest on loans); and

14 “(iv) entering into arrangements to
15 obtain or participate in emerging medical
16 technologies, including telemedicine.

17 “(B) OPERATIONS.—Expenditures in sup-
18 port of the operations of a CHA, including—

19 “(i) the ongoing management of the
20 CHA, including daily program administra-
21 tion, recordkeeping and reporting, assur-
22 ance of proper financial management (in-
23 cluding billings and collections) and over-
24 sight of program quality;

1 “(ii) developing and operating systems
2 to enroll eligible individuals in the CHA;

3 “(iii) data collection, in collaboration
4 with the State medicaid agency and the
5 State health department, designed to
6 measure changes in patient access to care,
7 the quality of care furnished, and patient
8 health status, and health care outcomes;

9 “(iv) ongoing community outreach
10 and community education to all residents
11 of the area or population served, to pro-
12 mote the enrollment of eligible individuals
13 and the appropriate utilization of health
14 services by such individuals;

15 “(v) the establishment of necessary
16 reserves or purchase of stop-loss coverage;
17 and

18 “(vi) activities relating to health pro-
19 fessions training, including residency train-
20 ing at participating provider sites.

21 “(g) ADDITIONAL REQUIREMENTS.—

22 “(1) MANDATORY ENROLLMENT OF MEDICAID-
23 ELIGIBLE INDIVIDUALS.—Notwithstanding any pro-
24 vision of section 1903(m), a State participating in a
25 demonstration project under this section may require

1 that each medicaid-eligible resident in the service
2 area of a CHA operating under the project is not eli-
3 gible to receive any medical assistance under the
4 State plan that may be obtained through enrollment
5 with the CHA unless the individual receives such as-
6 sistance through enrollment with the CHA.

7 “(2) CONTINUED ENTITLEMENT TO ADDI-
8 TIONAL BENEFITS.—In the case of a medicaid-eli-
9 ble individual enrolled with a CHA under a dem-
10 onstration project under this section, the individual
11 shall remain entitled to medical assistance for serv-
12 ices which are not covered services under the project.

13 “(3) HMO-RELATED REQUIREMENTS.—A CHA
14 under this section shall be deemed to meet the re-
15 quirements of section 1903(m) (subject to paragraph
16 (1)) in the same manner as an entity listed under
17 section 1903(m)(2)(G).

18 “(4) TREATMENT OF FEDERALLY-QUALIFIED
19 HEALTH CENTERS AND RURAL HEALTH CLINICS.—
20 Payments under a demonstration project under this
21 section to a Federally qualified health center or
22 rural health clinic which is a participating provider
23 shall be made consistent with section
24 1902(a)(13)(E) for all services offered by the CHA
25 which are provided by such a center or clinic.

1 “(5) OUTSTATIONING ELIGIBILITY WORKERS.—

2 Under the project, the State may (in addition to
3 meeting the requirements of section 1902(a)(55))
4 provide for, or pay the reasonable costs of, station-
5 ing eligibility workers at appropriate service sites
6 under the project, and may permit medicaid-eligible
7 individuals to be enrolled under the State plan at
8 such a CHA or at such a site.

9 “(6) PURCHASE OF STOP-LOSS COVERAGE.—

10 The State shall ensure that the CHA has purchased
11 stop-loss coverage to protect against default on its
12 obligations under the project. If an entity otherwise
13 qualified to serve as a CHA is prohibited under
14 State law from purchasing such coverage, the State
15 shall waive the application of such law to the extent
16 necessary to permit the entity to purchase such cov-
17 erage.

18 “(h) EVALUATION AND REPORTING.—

19 “(1) CHA.—Each CHA in a State with a dem-
20 onstration project approved under this section shall
21 prepare and submit to the State an annual report on
22 its activities during the previous year.

23 “(2) STATE.—Taking into account the reports
24 submitted pursuant to paragraph (1), each State
25 with a demonstration project approved under this

1 section shall prepare and submit to the Secretary an
2 annual evaluation of its activities and services under
3 this section. Such evaluation shall include an analy-
4 sis of the effectiveness of the project in providing
5 cost-effective health care to enrolled individuals.

6 “(3) REPORT TO CONGRESS.—Not later than 3
7 years after the date of the enactment of this section,
8 the Secretary shall submit to Congress a report on
9 the demonstration projects conducted under this sec-
10 tion. Such report shall include an analysis of the ef-
11 fectiveness of such projects in providing cost-effec-
12 tive health care for the areas or populations served.

13 “(i) COLLABORATION IN ADMINISTRATION.—In car-
14 rying out this section, the Secretary shall assure the high-
15 est possible level of collaboration between the Health Care
16 Financing Administration and the Public Health Service.
17 Such collaboration may include (if appropriate and fea-
18 sible) any of the following:

19 “(1) The provision by the Public Health Service
20 of new or increased grant support to eligible entities
21 participating in a CHA, in order to expand the avail-
22 ability of services (particularly preventive and pri-
23 mary care services).

24 “(2) The placement of health professionals at
25 eligible locations and collaboration with Federally-as-

1 sisted health professions training programs located
2 in or near the areas served by community health au-
3 thorities.

4 “(3) The provision of technical and other non-
5 financial assistance.

6 “(j) DEFINITIONS.—In this section:

7 “(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The
8 term ‘medicaid-eligible individual’ means an individ-
9 ual described in section 1902(a)(10)(A) and entitled
10 to medical assistance under the State plan.

11 “(2) PARTICIPATING PROVIDER.—The term
12 ‘participating provider’ means, with respect to a
13 CHA, a provider that has entered into an agreement
14 with the CHA for the provision of covered services
15 under a project under this section.

16 “(3) PREVENTIVE AND PRIMARY CARE SERV-
17 ICES.—‘Preventive’ and ‘primary’ services include
18 those services described in section 1905(l)(2)(A) and
19 included as Federally-qualified health center serv-
20 ices.”.

21 (b) CONTINUED MEDICAID ELIGIBILITY FOR UP TO
22 1 YEAR.—Section 1902(e)(2) of such Act (42 U.S.C.
23 1396a(e)(2)) is amended—

24 (1) in subparagraph (A)—

1 (A) by inserting “or with a community
2 health authority under a demonstration project
3 under section 1931” after “section 1876”, and

4 (B) by striking “such organization or en-
5 tity” and inserting “such organization, entity,
6 or authority”; and

7 (2) in subparagraph (B), by striking “effec-
8 tive.” and inserting the following: “effective (or, in
9 the case of an individual enrolled with a community
10 health authority under a demonstration project
11 under section 1931, of not more than 1 year begin-
12 ning on the date the individual’s enrollment with the
13 authority becomes effective).”.

14 (c) EXCEPTION TO ANTI-KICKBACK LAW.—Section
15 1128B(b)(3) of such Act (42 U.S.C. 1320a–7b(b)(3)) is
16 amended—

17 (1) by striking “and” at the end of subpara-
18 graph (D),

19 (2) by striking the period at the end of sub-
20 paragraph (E) and inserting “; and”, and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(F) any remuneration paid, or received, by a
24 Federally qualified health center, rural health clinic,
25 or other entity which is a participating provider

1 under a demonstration project under section 1931 as
2 part of an arrangement for the procurement of
3 goods or services or the referral of patients or the
4 lease or purchase of space or equipment.”.

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to calendar quarters beginning on
7 or after October 1, 1994.

8 **SEC. 5002. HEALTH CENTER PROGRAM AMENDMENTS.**

9 (a) AUTHORIZATION OF GRANTS FOR NETWORK DE-
10 VELOPMENT.—

11 (1) MIGRANT HEALTH CENTERS.—Section 329
12 of the Public Health Service Act (42 U.S.C. 254b)
13 is amended by adding at the end the following:

14 “(j)(1) The Secretary may make a grant, to an entity
15 receiving a grant under this section or to a group of such
16 entities, to support the planning and development of
17 health service networks (as defined in paragraph (3))
18 which will serve high impact areas, medically underserved
19 areas, or medically underserved populations within the
20 area they serve (or propose to serve).

21 “(2) A grant under this subsection for the planning
22 and development of a health service network may be used
23 for the following costs:

1 “(A) The costs of developing the network cor-
2 porate entity, including planning and needs assess-
3 ment.

4 “(B) The costs of developing internal manage-
5 ment for the network, as well as costs of developing
6 legal, financial, clinical, information, billing, and re-
7 porting systems, and other costs necessary to
8 achieve operational status.

9 “(C) The costs of recruitment, training, and
10 compensation of management staff of the network
11 and, as appropriate and necessary, the management
12 and clinical staff of any participating provider.

13 “(D) The costs of developing additional primary
14 health and related service sites, including costs relat-
15 ed to purchase of essential equipment, acquisition,
16 modernization, expansion, or, if cost-effective, con-
17 struction of facilities.

18 “(3) In this subsection, the term ‘health service net-
19 work’ means a nonprofit private entity that—

20 “(A) through its participating providers (which
21 may provide services directly or through contract)
22 assures the provision of primary health and related
23 services and, as appropriate, supplemental health
24 services to residents of the high impact area or

1 medically underserved area or members of the medi-
2 cally underserved population covered by the network,

3 “(B) includes, as participating providers, at
4 least all recipients of grants under this section or
5 section 330, 340, or 340A that provide primary
6 health and related services to the residents of the
7 area it serves (or proposes to serve), and that may
8 include, at the entity’s option, any other providers of
9 primary health or supplemental health services to
10 residents of the high impact area or medically un-
11 derserved area or members of the medically under-
12 served population covered by the network, but only
13 if such participating providers agree to provide serv-
14 ices without regard to an individual’s ability to pay,
15 and

16 “(C) is governed by individuals a majority of
17 whom are patients, employees, or board members of
18 its participating providers that receive grants under
19 this section or section 330, 340, or 340A.”.

20 (2) COMMUNITY HEALTH CENTERS.—Section
21 330 of such Act (42 U.S.C. 254c) is amended by
22 adding at the end the following:

23 “(l)(1) The Secretary may make a grant, to an entity
24 receiving a grant under this section or to a group of such
25 entities, to support the planning and development of

1 health service networks (as defined in section 329(j)(3))
2 which will serve high impact areas, medically underserved
3 areas, or medically underserved populations within the
4 area they serve (or propose to serve).

5 “(2) A grant under this subsection for the planning
6 and development of a health service network may be used
7 for the costs described in section 329(j)(2).”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this subsection shall take effect on the date of the
10 enactment of this Act.

11 (b) EXTENSION OF AUTHORIZATION OF APPROPRIA-
12 TIONS.—

13 (1) MIGRANT HEALTH CENTERS.—Section
14 329(h)(1)(A) of such Act (42 U.S.C. 254b(h)(1)(A))
15 is amended—

16 (A) by inserting “and subsection (j)” after
17 “through (e)”, and

18 (B) by striking “1994” and inserting
19 “1999”.

20 (2) COMMUNITY HEALTH CENTERS.—Section
21 330(g)(1)(A) of such Act (42 U.S.C. 254c(g)(1)(A))
22 is amended by striking “1994” and inserting
23 “1999”.

1 **Subtitle B—Expansion of Public**
2 **Health Programs on Preventive**
3 **Health**

4 **SEC. 5101. IMMUNIZATIONS AGAINST VACCINE-PREVENT-**
5 **ABLE DISEASES.**

6 Section 317(j)(1) of the Public Health Service Act
7 (42 U.S.C. 247b(j)(1)), as redesignated by section
8 301(b)(1) of Public Law 103–183 (107 Stat. 2235), is
9 amended by striking “through 1995” and inserting
10 “through 1999”.

11 **SEC. 5102. PREVENTION, CONTROL, AND ELIMINATION OF**
12 **TUBERCULOSIS.**

13 Section 317E(g) of the Public Health Service Act (42
14 U.S.C. 247b–6(g)), as added by section 301(a) of Public
15 Law 103–183 (107 Stat. 2234), is amended—

16 (1) in paragraph (1)(A), by striking “through
17 1998” and inserting “through 1999”; and

18 (2) in paragraph (2), by striking “through
19 1998” and inserting “through 1999”.

20 **SEC. 5103. LEAD POISONING PREVENTION.-**

21 Section 317A(l)(1) of the Public Health Service Act
22 (42 U.S.C. 247b–1(l)(1)) is amended by striking “through
23 1997” and inserting “through 1999”.

1 **SEC. 5104. PREVENTIVE HEALTH MEASURES WITH RE-**
2 **SPECT TO BREAST AND CERVICAL CANCERS.**

3 Section 1510(a) of the Public Health Service Act (42
4 U.S.C. 300n-5(a)), as redesignated by section 102(a)(1)
5 of Public Law 103-183 (107 Stat. 2229) and amended
6 by section 103 of such Public Law (107 Stat. 2230), is
7 amended by striking “through 1998” and inserting
8 “through 1999.”.

9 **SEC. 5105. OFFICE OF DISEASE PREVENTION AND HEALTH**
10 **PROMOTION.**

11 (a) IN GENERAL.—Section 1701(b) of the Public
12 Health Service Act (42 U.S.C. 300u(b)) is amended by
13 striking “through 1996” and inserting “through 1999”.

14 (b) PROMOTION OF INDIVIDUAL RESPONSIBILITY.—
15 Section 1701(a)(11) of such Act (42 U.S.C. 300u(a)(11))
16 is amended—

17 (1) by striking “and” at the end of subpara-
18 graph (C),

19 (2) by redesignating subparagraph (D) as sub-
20 paragraph (E), and

21 (3) by inserting after subparagraph (C) the fol-
22 lowing new subparagraph:

23 “(D) promote individual responsibility in
24 personal health care and in the use of valuable
25 health care resources; and”.

1 (c) MINORITY HEALTH.—Section 1707(f) of such Act
2 (42 U.S.C. 300u–6(f)) is amended by striking “1993.”
3 and inserting “1993, \$35,000,000 for each of the fiscal
4 years 1994 through 1996, and such sums as may be nec-
5 essary for each of the fiscal years 1997 through 1999.”.

6 **SEC. 5106. PREVENTIVE HEALTH AND HEALTH SERVICES**
7 **BLOCK GRANT.**

8 Section 1901(a) of the Public Health Service Act (42
9 U.S.C. 300w(a)) is amended by striking “through 1997”
10 and inserting “through 1999”.

11 **TITLE VI—ANTITRUST**
12 **PROVISIONS**

13 **SEC. 6001. PUBLICATION OF ANTITRUST GUIDELINES ON**
14 **ACTIVITIES OF HEALTH PLANS.**

15 (a) IN GENERAL.—The Attorney General shall pro-
16 vide for the development and publication of explicit guide-
17 lines on the application of antitrust laws to the activities
18 of health plans. The guidelines shall be designed to facili-
19 tate the development and operation of plans, consistent
20 with the antitrust laws.

21 (b) REVIEW PROCESS.—The Attorney General shall
22 establish a review process under which the administrator
23 or sponsor of a health plan (or organization that proposes
24 to administer or sponsor a health plan) may submit a re-
25 quest to Attorney General to obtain a prompt opinion (but

1 in no event later than 90 days after the Attorney General
2 receives the request) from the Department of Justice on
3 the plan's conformity with the Federal antitrust laws.

4 (c) DEFINITIONS.—In this section—

5 (1) the term “antitrust laws”—

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

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

14 (2) the term “health plan” means any contract
15 or arrangement under which an entity bears all or
16 part of the cost of providing health care items and
17 services, including a hospital or medical expense in-
18 curred policy or certificate, hospital or medical serv-
19 ice plan contract, or health maintenance subscriber
20 contract, but does not include—

21 (A) coverage only for accident, dental, vi-
22 sion, disability, or long term care, medicare
23 supplemental health insurance, or any combina-
24 tion thereof,

1 (B) coverage issued as a supplement to li-
2 ability insurance,

3 (C) workers' compensation or similar in-
4 surance, or

5 (D) automobile medical-payment insur-
6 ance.

7 **SEC. 6002. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
8 **PUBLIC ADVANTAGE.**

9 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
10 Attorney General, after consultation with the Secretary of
11 Health and Human Services, shall issue in accordance
12 with this section a certificate of public advantage to each
13 eligible health care collaborative activity that complies
14 with the requirements in effect under this section on or
15 after the expiration of the 1-year period that begins on
16 the date of the enactment of this Act (without regard to
17 whether or not the Attorney General has promulgated reg-
18 ulations to carry out this section by such date). Such ac-
19 tivity, and the parties to such activity, shall not be liable
20 under any of the antitrust laws for conduct described in
21 such certificate and engaged in by such activity if such
22 conduct occurs while such certificate is in effect.

23 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
24 CERTIFICATES.—

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

5 (A) the benefits that are likely to result
6 from carrying out the activity outweigh the re-
7 duction in competition (if any) that is likely to
8 result from the activity, and

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

11 (2) FACTORS TO BE CONSIDERED.—

12 (A) WEIGHING OF BENEFITS AGAINST RE-
13 DUCTION IN COMPETITION.—For purposes of
14 making the finding described in paragraph
15 (1)(A), the Attorney General shall consider
16 whether the activity is likely—

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

19 (ii) to increase access to health care,

20 (iii) to achieve cost efficiencies that
21 will be passed on to health care consumers,
22 such as economies of scale, reduced trans-
23 action costs, and reduced administrative
24 costs,

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

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

6 (vi) to reduce inefficient health care
7 resource duplication.

8 (B) NECESSITY OF REDUCTION IN COM-
9 PETITION.—For purposes of making the finding
10 described in paragraph (1)(B), the Attorney
11 General shall consider—

12 (i) the ability of the providers of
13 health care services that are (or likely to
14 be) affected by the health care collabo-
15 rative activity and the entities responsible
16 for making payments to such providers to
17 negotiate societally optimal payment and
18 service arrangements,

19 (ii) the effects of the health care col-
20 laborative activity on premiums and other
21 charges imposed by the entities described
22 in clause (i), and

23 (iii) the availability of equally effi-
24 cient, less restrictive alternatives to achieve

1 the benefits that are intended to be
2 achieved by carrying out the activity.

3 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
4 DURES.—Subject to subsections (d) and (e), not later than
5 1 year after the date of the enactment of this Act, the
6 Attorney General and the Secretary shall establish jointly
7 by rule the criteria and procedures applicable to the issu-
8 ance of certificates under subsection (a). The rules shall
9 specify the form and content of the application to be sub-
10 mitted to the Attorney General to request a certificate,
11 the information required to be submitted in support of
12 such application, the procedures applicable to denying and
13 to revoking a certificate, and the procedures applicable to
14 the administrative appeal (if such appeal is authorized by
15 rule) of the denial and the revocation of a certificate. Such
16 information may include the terms of the health care col-
17 laborative activity (in the case of an activity in existence
18 as of the time of the application) and implementation plan
19 for the collaborative activity.

20 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-
21 TIVITY.—To be an eligible health care collaborative activ-
22 ity for purposes of this section, a health care collaborative
23 activity shall submit to the Attorney General an applica-
24 tion that complies with the rules in effect under subsection
25 (c) and that includes—

1 (1) an agreement by the parties to the activity
2 that the activity will not foreclose competition by en-
3 tering into contracts that prevent health care provid-
4 ers from providing health care in competition with
5 the activity,

6 (2) an agreement that the activity will submit
7 to the Attorney General annually a report that de-
8 scribes the operations of the activity and information
9 regarding the impact of the activity on health care
10 and on competition in health care, and

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

15 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
16 Not later than 30 days after an eligible health care col-
17 laborative activity submits to the Attorney General an ap-
18 plication that complies with the rules in effect under sub-
19 section (c) and with subsection (d), the Attorney General
20 shall issue or deny the issuance of such certificate. If, be-
21 fore the expiration of such 30-day period, the Attorney
22 General fails to issue or deny the issuance of such certifi-
23 cate, the Attorney General shall be deemed to have issued
24 such certificate.

1 (f) REVOCATION OF CERTIFICATE.—Whenever the
2 Attorney General finds that a health care collaborative ac-
3 tivity with respect to which a certificate is in effect does
4 not meet the standards specified in subsection (b), the At-
5 torney General shall revoke such certificate.

6 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

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

13 (2) JUDICIAL REVIEW.—

14 (A) AFTER ADMINISTRATIVE PROCEED-
15 ING.—(i) If the Attorney General denies an ap-
16 plication submitted or revokes a certificate is-
17 sued under this section after an opportunity for
18 hearing on the record, then any party to the
19 health care collaborative activity involved may
20 commence a civil action, not later than 60 days
21 after receiving notice of the denial or revoca-
22 tion, in an appropriate district court of the
23 United States for review of the record of such
24 denial or revocation.

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

8 (B) DENIAL OR REVOCATION WITHOUT AD-
9 MINISTRATIVE PROCEEDING.—If the Attorney
10 General denies an application submitted or re-
11 vokes a certificate issued under this section
12 without an opportunity for hearing on the
13 record, then any party to the health care col-
14 laborative activity involved may commence a
15 civil action, not later than 60 days after receiv-
16 ing notice of the denial or revocation, in an ap-
17 propriate district court of the United States for
18 de novo review of such denial or revocation.

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

21 (1) to prepare, agree to prepare, or attempt to
22 agree to prepare an application to request a certifi-
23 cate under this section, or

1 (2) to attempt to enter into any health care col-
2 laborative activity with respect to which such a cer-
3 tificate is in effect.

4 (i) DEFINITIONS.—In this section:

5 (1) The term “antitrust laws” has the meaning
6 given it in section 6001(c)(1).

7 (2) The term “certificate” means a certificate
8 of public advantage authorized to be issued under
9 subsection (a).

10 (3) The term “health care collaborative activ-
11 ity” means an agreement (whether existing or pro-
12 posed) between 2 or more providers of health care
13 services that is entered into solely for the purpose of
14 sharing in the provision of health care services and
15 that involves substantial integration or financial
16 risk-sharing between the parties, but does not in-
17 clude the exchanging of information, the entering
18 into of any agreement, or the engagement in any
19 other conduct that is not reasonably required to
20 carry out such agreement.

21 (4) The term “health care services” includes
22 services related to the delivery or administration of
23 health care services.

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

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

7 **TITLE VII—PREFUNDING GOV-**
8 **ERNMENT HEALTH BENEFITS**
9 **FOR CERTAIN ANNUITANTS**

10 **SEC. 7001. REQUIREMENT THAT CERTAIN AGENCIES**
11 **PREFUND GOVERNMENT HEALTH BENEFITS**
12 **CONTRIBUTIONS FOR THEIR ANNUITANTS.**

13 (a) DEFINITIONS.—For the purpose of this section—

14 (1) the term “agency” means any agency or
15 other instrumentality within the executive branch of
16 the Government, the receipts and disbursements of
17 which are not generally included in the totals of the
18 budget of the United States Government submitted
19 by the President;

20 (2) the term “health benefits plan” means, with
21 respect to an agency, a health benefits plan, estab-
22 lished by or under Federal law, in which employees
23 or annuitants of such agency may participate;

24 (3) the term “health-benefits coverage” means
25 coverage under a health benefits plan”;

1 (4) an individual shall be considered to be an
2 “annuitant of an agency” if such individual is enti-
3 tled to an annuity, under a retirement system estab-
4 lished by or under Federal law, by virtue of—

5 (A) such individual’s service with, and sep-
6 aration from, such agency; or

7 (B) being the survivor of an annuitant
8 under subparagraph (A) or of an individual who
9 died while employed by such agency; and

10 (5) the term “Office” means the Office of Per-
11 sonnel Management.

12 (b) PREFUNDING REQUIREMENT.—

13 (1) IN GENERAL.—Effective as of October 1,
14 1994, each agency (or February 1, 1995, in the case
15 of the agency with the greatest number of employ-
16 ees, as determined by the Office) shall be required
17 to prepay the Government contributions which are
18 or will be required in connection with providing
19 health-benefits coverage for annuitants of such
20 agency.

21 (2) REGULATIONS.—The Office shall prescribe
22 such regulations as may be necessary to carry out
23 this section. The regulations shall be designed to en-
24 sure at least the following:

1 (A) Amounts paid by each agency shall be
2 sufficient to cover the amounts which would
3 otherwise be payable by such agency (on a
4 “pay-as-you-go” basis), on or after the applica-
5 ble effective date under paragraph (1), on be-
6 half of—

7 (i) individuals who are annuitants of
8 the agency as of such effective date; and

9 (ii) individuals who are employed by
10 the agency as of such effective date, or
11 who become employed by the agency after
12 such effective date, after such individuals
13 have become annuitants of the agency (in-
14 cluding their survivors).

15 (B)(i) For purposes of determining any
16 amounts payable by an agency—

17 (I) this section shall be treated as if
18 it had taken effect at the beginning of the
19 20-year period which ends on the effective
20 date applicable under paragraph (1) with
21 respect to such agency; and

22 (II) in addition to any amounts pay-
23 able under subparagraph (A), each agency
24 shall also be responsible for paying any
25 amounts for which it would have been re-

1 sponsible, with respect to the 20-year pe-
2 riod described in subclause (I), in connec-
3 tion with any individuals who are annu-
4 itants or employees of the agency as of the
5 applicable effective date under paragraph
6 (1).

7 (ii) Any amounts payable under this sub-
8 paragraph for periods preceding the applicable
9 effective date under paragraph (1) shall be pay-
10 able in equal installments over the 20-year pe-
11 riod beginning on such effective date.

12 (c) FASB STANDARDS.—Regulations under sub-
13 section (b) shall be in conformance with the provisions of
14 Standard 106 of the Financial Accounting Standards
15 Board, issued in December 1990.

16 (d) CLARIFICATION.—Nothing in this section shall be
17 considered to permit or require duplicative payments on
18 behalf of any individuals.

19 (e) DRAFT LEGISLATION.—The Office shall prepare
20 and submit to Congress any draft legislation which may
21 be necessary in order to carry out this section.

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