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103D CONGRESS
1ST SESSION

S. 1533

To improve access to health insurance and contain health care costs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 7 (legislative day, SEPTEMBER 27), 1993

Mr. LOTT introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To improve access to health insurance and contain health care costs, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Care Now Act of 1993''.

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

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.
Sec. 1002. Compliance with applicable requirements through multiple employer health arrangements.
Sec. 1003. Coverage option under State Medical Health Allowance Program.

PART 2—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE; RENEWABILITY

Sec. 1011. Limitation on pre-existing condition clauses.
Sec. 1012. Assurance of continuity of coverage through previous satisfaction of pre-existing 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 MedAccess plans.
Sec. 1102. MedAccess plan defined.
Sec. 1103. Establishment of other MedAccess standards.
Sec. 1104. Limits on premiums and miscellaneous consumer protections.
Sec. 1105. Limitation on annual premium increases.
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 healthcare arrangements.
Sec. 1216. Enforcement provisions relating to multiple employer welfare arrangements and employee leasing healthcare 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.
Sec. 1302. Deduction of health insurance premiums for certain previously uninsured individuals.

SUBTITLE E—IMPROVED ACCESS TO COMMUNITY HEALTH SERVICES

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS

Sec. 1401. Grant program to promote primary health care services for underserved populations.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

Sec. 1411. Projects for coordinating delivery of outpatient primary health services.

SUBTITLE F—IMPROVED ACCESS TO RURAL HEALTH SERVICES

PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE

Sec. 1501. Rural emergency access care hospitals described.
Sec. 1502. Coverage of and payment for services.
Sec. 1503. Effective date.

PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT

Sec. 1511. Grants to States regarding aircraft for transporting rural victims of medical emergencies.

PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS

Sec. 1521. Establishment of Office of Emergency Medical Services.
Sec. 1522. State offices of emergency medical services.
Sec. 1523. Programs for rural areas.
Sec. 1524. Funding.
Sec. 1525. Conforming amendments.
Sec. 1526. Effective date.

SUBTITLE G—STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

Sec. 1601. Establishment of program.
Sec. 1602. Optional use of program to offer coverage to some or all State residents.

SUBTITLE H—MEDICAID PROGRAM FLEXIBILITY

Sec. 1701. Modification of Federal requirements to allow States more flexibility in contracting for coordinated care services under medicaid.
Sec. 1702. Period of certain waivers.

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

SUBTITLE A—MEDICAL MALPRACTICE LIABILITY REFORM

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Sec. 2001. Federal reform of medical malpractice liability actions.
Sec. 2002. Definitions.
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Sec. 2011. Requirement for initial resolution of action through alternative dispute resolution.
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Sec. 2014. Joint and several liability.
Sec. 2015. Statute of limitations.
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Sec. 2017. Special provision for certain obstetric services.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

Sec. 2031. Basic requirements.
Sec. 2032. Certification of State systems; applicability of alternative Federal system.
Sec. 2033. Reports on implementation and effectiveness of alternative dispute resolution systems.

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

Sec. 2041. Permitting State professional societies to participate in disciplinary activities.
Sec. 2042. Study of incentives to encourage voluntary service by physicians.
Sec. 2043. Requirements for risk management programs.
Sec. 2044. Grants for medical safety promotion.

SUBTITLE B—ADMINISTRATIVE COST SAVINGS

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

Sec. 2101. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
Sec. 2102. Application of standards.
Sec. 2103. Periodic review and revision of standards.
Sec. 2104. Health benefit plan defined.

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

Sec. 2111. Medical data standards for hospitals and other providers.
Sec. 2112. Application of electronic data standards to certain hospitals.
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PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

Sec. 2121. State comparative value information programs for health care purchasing.
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PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND DEMONSTRATIONS

Sec. 2131. Standards relating to use of medicare and medicaid magnetized health benefit cards; secondary payor data bank.
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SUBTITLE C—DEDUCTION FOR COST OF CATASTROPHIC HEALTH PLAN; MEDICAL SAVINGS ACCOUNTS

Sec. 2201. Individuals allowed deduction from gross income for cost of catastrophic health plan.
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PART 2—COORDINATION OF HEALTH CARE ANTI-FRAUD AND ABUSE ACTIVITIES

Sec. 2311. Establishment of all-payer anti-fraud and abuse program.
Sec. 2312. Authorization of additional appropriations for investigators and other personnel.
Sec. 2313. Establishment of anti-fraud and abuse trust fund.
Sec. 2314. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health benefit plan.

SUBTITLE E—MEDICARE PAYMENT CHANGES; PART B PREMIUM TAX FOR HIGH-INCOME INDIVIDUALS

PART 1—MEDICARE PAYMENT CHANGES

Sec. 2401. Elimination of membership limitation for medicare hmos.
Sec. 2402. Expansion and revision of medicare select policies.
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PART 2—PART B PREMIUM TAX FOR HIGH-INCOME INDIVIDUALS

Sec. 2411. Increase in medicare part B premium for individuals with high income.

SUBTITLE F—REMOVING ANTI-TRUST IMPEDIMENTS

Sec. 2501. Establishment of limited exemption program for health care joint ventures.
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TITLE III—LONG-TERM CARE

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Sec. 3001. Treatment of long-term care insurance or plans.
Sec. 3002. Exclusion for benefits provided under long-term care insurance; inclusion of employer-provided coverage.
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TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

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.

(a) IN GENERAL.—Each employer shall make available with respect to each eligible employee a group health plan under which—

(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year,

(2) subject to subsection (d), coverage is provided for at least the required coverage specified in subsection (c), and

(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

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

(b) SPECIAL RULES.—

(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 2 years,

(B) such employer has no more than 2 eligible employees, or

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

(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as an eligible employee for purposes of applying the requirements of subsection (a). In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludible under this paragraph.

(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan shall not be treated as

failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is required under the plan for coverage under the plan of eligible individuals with respect to such employee.

(c) REQUIRED COVERAGE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the required coverage specified in this subsection is standard coverage (consistent with section 1102(c)).

(2) SPECIAL TREATMENT OF SMALL EMPLOYERS NOT CONTRIBUTING TO EMPLOYEE COVERAGE.—In the case of a small employer (as defined in section 1107(9)) that has not contributed during the previous plan year to the cost of coverage for any eligible employee under any group health plan, the required coverage specified in this subsection for the plan year (with respect to each eligible employee) is—

(A) coverage under a MedAccess standard plan,

(B) coverage under a MedAccess catastrophic plan, and

(C) coverage under a MedAccess medisave plan,

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

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

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

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

(A) the group health plan is in effect in the plan year in which September 1, 1993, occurs, and

(B) the employer makes (or offers to make), in such plan year and the plan year involved, a contribution to the plan on behalf of each employee who is eligible to participate in the plan.

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan for each of the 5 plan years beginning with the first plan year to which the requirement of subsection (a) applies.

SEC. 1002. COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

For provision easing compliance with applicable requirements through multiemployer plans and through other multiple employer health arrangements, see section 1241.

SEC. 1003. COVERAGE OPTION UNDER STATE MEDICAL HEALTH ALLOWANCE PROGRAM.

For a provision permitting a State medical health allowance program under the medicaid program or other State program to offer health insurance coverage to residents of the State without regard to income, see the amendment made by section 1602.

PART 2—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE; RENEWABILITY

SEC. 1011. LIMITATION ON PREEXISTING CONDITION CLAUSES.

A group health plan may not impose (and an insurer may not require an employer under a group health plan to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual if—

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

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

(3) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan; or

(4) the limitation or exclusion relates to pregnancy.

In the case of an individual who is eligible for coverage under a plan but for a waiting period imposed by the employer, in applying paragraphs (1) and (2), the individual shall be treated as having been covered under the plan as of the earliest date of the beginning of the waiting period.

SEC. 1012. ASSURANCE OF CONTINUITY OF COVERAGE THROUGH PREVIOUS SATISFACTION OF PREEXISTING CONDITION REQUIREMENT.

(a) IN GENERAL.—Each group health plan shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual, prior to the date of such individual's enrollment in such plan, was covered for the condition

under any other health plan that was in effect before such date.

(b) CONTINUOUS COVERAGE REQUIRED.—

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

(2) TREATMENT OF WAITING PERIODS.—In applying paragraph (1), any waiting period imposed by an employer before an employee is eligible to be covered under a plan shall be treated as a period in which the employee was covered under a group health plan.

(3) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination of employment.

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

(A) coverage for a specified disease or illness, or

(B) a hospital or fixed indemnity policy, unless the Secretary determines that such a plan provides sufficiently comprehensive coverage of a benefit so that it should be treated as a group health plan under this subsection.

SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIEMPLOYER PLANS AND EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.—A multiemployer plan and an exempted multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

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

(3) for noncompliance with plan provisions,

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

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

(b) INSURERS.—

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

(A) for nonpayment of premiums,

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

(C) for noncompliance with plan provisions,

(D) for misuse of a provider network provision, or

(E) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

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

PART 3—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 1021. ENFORCEMENT.

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

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts 1 and 2 of this subtitle shall be deemed to be provi-

sions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

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

(b) ENFORCEMENT BY EXCISE TAX FOR INSURERS.—

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

"SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under part 2 of subtitle A of title I of the Affordable Health Care Now Act of 1993.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement

mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to a health insurance plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

''(d) EXCEPTIONS.—

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

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected within the 30-day period beginning on the earliest date the

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

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

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance plan' and 'insurer' have the respective meanings given such terms in section 1023 of the Affordable Health Care Now Act of 1993.''

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

''Sec. 4980C. Failure of insurer to comply with health insurance standards.''

SEC. 1022. EFFECTIVE DATES.

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

(b) PART 2.—The requirements of part 2 with respect to—

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

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

SEC. 1023. DEFINITIONS AND SPECIAL RULES.

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

(1) DEPENDENT.—The term ''dependent'' means, with respect to any individual, any person who is—

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

(B) under regulations of the Secretary, a child (including an adopted child) of such individual and—

(i) under 19 years of age, or

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

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

(3) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to an eligible employee, such employee, and any dependent of such employee.

(4) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(5) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''exempted multiple employer health plan'' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 2 of subtitle C of this title).

(6) GROUP HEALTH PLAN; PLAN.—(A) The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan under section 1107(4)(B).

(B) The term ''plan'' means, unless used with a modifying term or the context specifically indicates otherwise, a group health plan (including any such plan which is a multiemployer plan), an exempted

multiple employer health plan, or an insured multiple employer health plan.

(7) HEALTH INSURANCE PLAN.—The term ''health insurance plan'' has the meaning given such term in section 1107(4).

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

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

(b) SPECIAL RULES.—

(1) GENERAL RULE.—Except as otherwise provided in this subtitle, for definitions of terms used in this subtitle, see section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

(2) SECRETARY.—Except with respect to references specifically to the Secretary of Labor, the term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle B—Reform of Health Insurance Marketplace for Small Business

SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER MEDACCESS PLANS.

(a) REQUIREMENT.—

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

(A) a MedAccess standard plan (as defined in section 1102(a)(2)),

(B) a MedAccess catastrophic plan (as defined in section 1102(a)(2)), and

(C) a MedAccess medisave plan (as defined in section 1102(a)(2)).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraphs (1)(B) and (1)(C) shall not apply with respect to a health insurance plan that—

(A) is a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not such an organization but is recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

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

(A) access to each small employer in the State to a MedAccess standard plan, to a MedAccess catastrophic plan, and to a MedAccess medisave plan, and

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

(b) GUARANTEED ISSUE OF MEDACCESS PLANS.—Subject to subsection (c)—

(1) IN GENERAL.—Subject to paragraph (2), each insurer that offers a MedAccess plan to a small employer in a State—

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

(B) must accept for enrollment under the plan every eligible individual (as defined in

paragraph (4)) who applies for enrollment on a timely basis (consistent with paragraph (3)) and may not place any restriction on the eligibility of an individual to enroll so long as such individual is an eligible individual.

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

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

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

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

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

(ii) it is applying this subparagraph uniformly to all employers without regard

to the health status, claims experience, or duration of coverage of those employers and their employees.

In this paragraph, the term ''health maintenance organization'' includes an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) CLARIFICATION OF TIMELY ENROLLMENT.—

(A) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in this paragraph, a MedAccess plan may consider enrollment of an eligible individual not to be timely if the eligible employee or dependent fails to enroll in the plan during an initial enrollment period, if such period is at least 30 days long.

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS EMPLOYER COVERAGE.—Enrollment in a MedAccess plan is considered to be timely in the case of an eligible individual who—

(i) was covered under another health insurance plan or group health plan at the time of the individual's initial enrollment period,

(ii) stated at the time of the initial enrollment period that coverage under a health insurance plan or a group health plan was the reason for declining enrollment,

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

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

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each MedAccess plan shall provide for at least one period (of not less than 30 days) each year during which enrollment under the plan shall be considered to be timely.

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

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

(ii) a request for enrollment is made within 30 days after the date the court issues the order.

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse) and any dependent child of an eligible employee shall be considered to be timely if a request for enrollment is made either—

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

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If a plan makes family coverage available and enrollment is made under the plan on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date

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

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

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

(1) each insurer offering a health insurance plan to a small employer in the State must participate in a program for assigning high-risk small employer groups (or individuals within such a group) among some or all such insurers, and

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

SEC. 1102. MEDACCESS PLAN DEFINED.

(a) MEDACCESS PLAN DEFINED.—In this subtitle:

(1) IN GENERAL.—The term ''MedAccess plan'' means a health insurance plan (whether a managed-

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

(A) The plan—

(i) is designed to provide standard coverage (consistent with subsection (c)) with substantial cost-sharing,

(ii) is designed to provide only catastrophic coverage (consistent with subsection (d)), or

(iii) is designed to provide medisave coverage (consistent with subsection (e)).

(B) The plan includes only essential and medically necessary services, including medical, surgical, hospital, and preventive services; except that no specific procedure or treatment, or classes thereof, is required to be covered in such a plan, by this Act or through regulations.

(C) The plan meets the applicable requirements of section 1101(b) (relating to guaranteed issue).

(D) The plan meets the consumer protection standards established under section 1103(a)(1)(B).

(2) MEDACCESS STANDARD, CATASTROPHIC, AND MEDISAVE PLANS.—The terms ''MedAccess

standard plan'', ''MedAccess catastrophic plan'', ''MedAccess medisave plan'' mean a MedAccess plan that provides for at least standard coverage (referred to in paragraph (1)(A)(i)), for only catastrophic coverage (referred to in paragraph (1)(A)(ii)), or medisave coverage (referred to in paragraph (1)(A)(iii)), respectively.

(b) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules which the NAIC determines is sufficient for determining, in the case of any health insurance plan and for purposes of this section, the actuarial value of the coverage offered by the plan.

(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this subtitle. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

(c) STANDARD COVERAGE.—

(1) IN GENERAL.—For purposes of this Act, a health insurance plan is considered to provide standard coverage consistent with this subsection if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (2).

(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for standard coverage equal to the average actuarial value of a representative range of the different types of health benefits provisions (which include cost-sharing) typically offered as standard coverage in the small employer health coverage market. In determining the actuarial value, the plan benefits considered should be sufficient to cover only essential and medically necessary services, including medical, surgical, hospital, and preventive services. However, no specific procedure or treatment, or classes thereof, is required to

be considered in such determination by this Act or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for standard coverage that comply with the requirements of subparagraph (A), the Secretary shall certify such value for use under this subtitle. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

(d) CATASTROPHIC COVERAGE.—

(1) IN GENERAL.—For purposes of subsection (a)(1)(B), a health insurance plan is considered to provide catastrophic coverage consistent with this subsection if—

(A) benefits are available under the plan for a year only to the extent that expenses for covered services in a year exceed a deductible

amount that is consistent with the requirement for a catastrophic health plan under section 220(c)(2)(A) of the Internal Revenue Code of 1986, as added by section 2202, and

(B) the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the target actuarial value for catastrophic coverage established under paragraph (2).

(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR CATASTROPHIC COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for catastrophic coverage equal to the actuarial value that would have been computed under subsection (c)(2)(A) if a deductible that represents the midpoint of the range of deductibles permitted consistent with subsections (b)(2) and (c)(2)(A) of section 220 of the Internal Revenue Code of 1986 were used in place of any deductible that otherwise would be applicable.

(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for catastrophic coverage that comply with the requirements of subparagraph (A), the Secretary shall certify such value for use under this subtitle. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

(e) MEDISAVE COVERAGE.—

(1) IN GENERAL.—For purposes of subsection (a)(1)(C), a health insurance plan is considered to provide medisave coverage consistent with this subsection if such plan consists of—

(A) a catastrophic health plan (within the meaning of section 220(c)(2) of the Internal Revenue Code of 1986, as inserted by section 2202 of this Act), and

(B) a medical savings account described in section 220(d)(1)(B) of such Code.

(f) SUBSEQUENT REVISIONS.—

(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules

of actuarial equivalence and target actuarial values previously established or determined under this section if the NAIC determines such revision necessary to take into account changes in the relevant types of health benefits provisions, in deductible levels for catastrophic coverage, or in demographic conditions which form the basis for such set of rules or values. The provisions of subsection (b)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

(2) SECRETARY.—The Secretary may by regulation revise such set or rules and values from time to time if the Secretary determines such revision necessary to take into account changes described in paragraph (1).

SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STANDARDS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A)(i) The requirement, under section 1101(a), that insurers make available MedAccess plans.

(ii) The requirements of guaranteed availability of MedAccess plans to small employers under section 1101(b).

(B)(i) The requirements of section 1104 (relating to limits on premiums and miscellaneous consumer protections).

(ii) The requirement of section 1105 (relating to limitation on annual premium increases).

If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements de-

scribed in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

(3) EFFECTIVE DATE.—The MedAccess standards and consumer protection standards (as defined in paragraph (5)) shall apply to MedAccess plans and health insurance plans in a State on or after the respective date the standards are implemented in the State under subsections (b) and (c).

(4) NONPREEMPTION OF STATE LAW.—A State may implement standards for health insurance plans made available to small employers that are more stringent than the requirements under this part; except that a State may not implement standards that prevent the offering by an insurer of at least one MedAccess standard plan, one MedAccess catastrophic plan, and one MedAccess medical plan.

(5) DEFINITIONS.—In this section:

(A) CONSUMER PROTECTION STANDARDS.—The term ''consumer protection standards'' means the standards established under paragraph (1)(B).

(B) MEDACCESS STANDARDS.—The term ''MedAccess standards'' means the standards established under paragraph (1)(A) (relating to

the requirements of section 1101), and includes the consumer protection standards insofar as they relate to MedAccess plans.

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF MEDACCESS STANDARDS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to implement and enforce the consumer protection standards with respect to insurers, and MedAccess plans offered, not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the MedAccess standards are established under subsection (a).

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

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and MedAccess plans offered to meet the MedAccess standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1994 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the MedAccess standards

under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and MedAccess plans offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected. In exercising authority under this subparagraph, the Secretary shall determine whether the use of a risk-allocation mechanism, described in section 1101(c), would be more consistent with the small employer group health coverage market in the State than the guaranteed availability provisions of section 1101(b).

(2) APPLICATION OF CONSUMER PROTECTION STANDARDS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified

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

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the consumer protection standards are established under subsection (a).

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

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and health insurance plans offered to meet the consumer protection standards established under subsection (a), but

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

legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the consumer protection standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards

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

SEC. 1104. LIMITS ON PREMIUMS AND MISCELLANEOUS CONSUMER PROTECTIONS.

(a) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF INDEX RATES BETWEEN CLASSES OF BUSINESS.—

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

(B) EXCEPTION.—The limitation of subparagraph (A) shall not apply to a class of business if—

(i) the class is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the class

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

(ii) the insurer does not involuntarily transfer, and never has involuntarily transferred, a health insurance plan into or out of the class of business, and

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

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A CLASS OF BUSINESS.—For a class of business of an insurer, as a standard under section 1103(a)(1)(B)(i), the highest premium rates charged during a rating period to small employers with similar demographic and other similar objective characteristics (and not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for the same or similar coverage, or the highest rates which could be charged to such employers under the rating system for that class of business, shall not exceed an amount that is 1.5 times the base premium rate for the class of business for a rating period (or portion thereof) that occurs in the first 3 years in which this section is

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

(3) OBJECTIVE BASIS FOR DIFFERENCES IN PREMIUMS FOR STANDARD AND CATASTROPHIC MEDACCESS PLANS.—The difference between the index rates for MedAccess catastrophic plans and the index rates for MedAccess standard plans shall be reasonable and shall reflect the difference in plan design and shall not take into account differences due to the nature of the groups assumed to select particular health plans.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG CLASSES OF BUSINESS.—As a standard under section 1103(a)(1)(B)(i), an insurer may not involuntarily transfer a small employer into or out of a class of business. An insurer may not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to demographic characteristics, claim experience, health status, industry, occupation, or duration since issue.

(5) DEFINITIONS.—In this subsection:

(A) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each class of

business for each rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the insurer to small employers with similar demographic characteristics and other similar objective characteristics (not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for health insurance plans with the same or similar coverage.

(B) CLASS OF BUSINESS.—The term ''class of business'' means, with respect to an insurer, all (or a distinct group of) small employers as shown on the records of the insurer.

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

(i) an insurer may establish, subject to clause (ii), a distinct group of small employers on the basis that the applicable health insurance plans either—

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

groups of small employers for the insurer,

(II) have been acquired from another insurer as a distinct group, or

(III) are provided through an association that has a membership of not less than 100 small employers and that has been formed for purposes other than obtaining health coverage;

(ii) an insurer may not establish more than 2 groupings under each class of business based on the insurer's use of managed-care techniques if the techniques are expected to produce substantial variation in health care costs; and

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

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

mium rate and the corresponding highest premium rate for the class.

(E) DEMOGRAPHIC CHARACTERISTICS.—Except as otherwise permitted under the standard under section 1103(b)(1)(B)(i), the term ''demographic characteristics'' means age, gender, geographic area, family composition, and group size.

(b) FULL DISCLOSURE OF RATING PRACTICES.—At the time an insurer offers a health insurance plan to a small employer, the insurer shall fully disclose to the employer rating practices for health insurance plans, including rating practices for different populations and benefit designs.

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

(1) the insurer is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

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

(d) REGISTRATION AND REPORTING.—Each insurer that issues any health insurance plan to a small employer in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such a plan.

SEC. 1105. LIMITATION ON ANNUAL PREMIUM INCREASES.

An insurer may not provide for an increase in the premium charged a small employer for a health insurance plan in a percentage that exceeds the percentage change in the premium charged under the plan for a newly covered small employer within the same class of business rate plus 15 percentage points.

SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS FOR HIGH RISK INDIVIDUALS IN MARKETPLACE FOR SMALL BUSINESS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after

the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (each in this section referred to as a ''reinsurance or allocation of risk mechanism'') for health insurance plans made available to small employers and for whom an insurer is at risk of incurring high costs under the plan. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance or allocation of risk mechanism, such remaining models shall serve as the models under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance or allocation of risk mechanism, the Secretary shall specify, within 15 months after the date of the enactment of this Act, models to carry out this section.

(b) IMPLEMENTATION OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

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

(2) FEDERAL ROLE.—

(A) IN GENERAL.—If the Secretary determines that a State has failed to establish or maintain a reinsurance or allocation of risk mechanism in accordance with paragraph (1), the Secretary shall establish and maintain such a reinsurance or allocation of risk mechanism meeting the requirements of this paragraph.

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

(C) ALLOCATION OF RISK MECHANISM.—If the Secretary determines that, due to the nature of the health coverage market in the State (including a relatively small number of health insurance plans offered or a relatively small number of uninsurable small employers), an allocation of risk mechanism would be a better mechanism than a reinsurance mechanism, the Secretary shall establish and maintain for use under this section for a State an allocation of risk mechanism under which uninsurable small employers would be equitably assigned among insurers offering health insurance plans to small employers.

(D) FINANCING DEFICIT FOR REINSURANCE MECHANISMS.—

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

"SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN STATES UNDER FEDERAL REINSURANCE.

''(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the providing of any health insurance plan which covers any employee in a Federal reinsurance State.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The tax imposed by subsection (a) shall be equal to the applicable percentage of the amount received by the insurer for providing such plan in such Federal reinsurance State.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means, with respect to any State for any period, the lowest percentage estimated by the Secretary as generating sufficient revenues to carry out section 1106(b)(2) of the Affordable Health Care Now Act of 1993 in such State for such period.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

''(d) DEFINITIONS.—For purposes of this section—

''(1) INSURER.—The term 'insurer' has the meaning given such term in section 1107(6) of the Affordable Health Care Now Act of 1993.

''(2) FEDERAL REINSURANCE STATE.—The term 'Federal reinsurance State' means any State with respect to which a determination is in effect

under section 1106(b)(2) of the Affordable Health Care Now Act of 1993 and for which the Secretary of Health and Human Services has established and is maintaining a reinsurance mechanism under subparagraph (B) of such section for the State.''

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

''Sec. 4980D. Additional tax to fund reinsurance in States under Federal reinsurance.''

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

SEC. 1107. DEFINITIONS.

Except as otherwise specifically provided, for purposes of this subtitle:

(1) DEPENDENT CHILD.—The term ''dependent child'' means a child (including an adopted child) who is under 19 years of age or who is a full-time student and under 25 years of age.

(2) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, an employee who normally performs on a monthly basis

at least 30 hours of service per week for that employer.

(3) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(5) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes, as defined in standards established under section 1103, a health insurance plan that meets specified standards and that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(6) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

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

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

(9) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term

''employee'' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

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

(11) STATE COMMISSIONER OF INSURANCE.—The term ''State commissioner of insurance'' includes a State superintendent of insurance.

SEC. 1108. OFFICE OF PRIVATE HEALTH CARE COVERAGE; ANNUAL REPORTS ON EVALUATION OF HEALTH CARE COVERAGE REFORM.

(a) IN GENERAL.—In order to carry out the responsibilities of the Secretary under this subtitle, the Secretary shall establish an Office of Private Health Care Coverage, to be headed by a Director (in this section and section 1109 referred to as the ''Director'') appointed by the Secretary.

(b) ANNUAL REPORT.—

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

(2) INFORMATION TO BE INCLUDED.—Each annual report shall include information concerning at least the following:

(A) Implementation and enforcement of the applicable MedAccess standards and consumer protection standards under this subtitle by the States and by the Secretary.

(B) An evaluation of the impact of the reforms under this subtitle on the availability of affordable health coverage for small employers that purchase group health coverage and for their employees, and, in particular, the impact of—

(i) guaranteed availability of health coverage,

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

(iii) requirement for continuity of coverage,

(iv) risk-management mechanisms for health coverage,

(v) limits on premium variations,

(vi) limits on annual premium increases, and

(vii) preemption of State benefit mandates.

In performing such evaluation, the Secretary shall seek to discount the effect of the insurance cycle on health insurance premiums.

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

(c) ADVISORY COMMITTEE.—The Secretary shall provide for appointment of an advisory committee to advise the Director concerning activities of the Office under this subtitle. Membership on the committee shall consist of 17 individuals and shall include individuals from the general public, small and large business, labor, insurance and other group health plans, and health care providers, and shall include individuals who are experts in the fields of the actuarial science, health economics, and health services research. The Secretary may include, as additional, ex officio members of the committee, such representatives of government agencies as the Secretary deems appropriate. The chairperson of the committee shall not be a health care provider or receive any direct or indirect compensation from an insurer, health insurance plan, or a health care provider.

SEC. 1109. RESEARCH AND DEMONSTRATION PROJECTS; DEVELOPMENT OF A HEALTH RISK POOLING MODEL.

(a) RESEARCH AND DEMONSTRATIONS.—The Director is authorized, directly, by contract, and through grants and cooperative agreements within the Department of Health and Human Services and outside the Department—

(1) to conduct research on the impact of this subtitle on the availability of affordable health coverage for employees and dependents in the small employers group health care coverage market and other topics described in section 1108(b), and

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

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

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

(2) METHODOLOGY.—The methods—

(A) shall rely on diagnosis or other health-related information that is predictive of individual health care needs,

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

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

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

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

(2) REDISTRIBUTION OF RISK.—Under such model, insurers with below average health risks would be required to contribute to a common fund for payment to insurers with above average health risks, each in relation to the degree of their favorable or adverse risk selection.

(3) INCENTIVES.—Such model shall include incentives to encourage continuous coverage of eligible individuals and small employers.

(d) CONSULTATION.—The methods and model under this section shall be developed in consultation with the

NAIC and the advisory committee established under section 1108(c).

(e) REPORT.—By not later than January 1, 1995, the Director shall submit to Congress a report on the methods and model developed under this section (as well as on research and demonstration projects conducted under subsection (a)). The Director shall include in the report such recommendations respecting the application of the model to insurers (and, in particular, to MedAccess plans) under this subtitle as the Director deems appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 in each of fiscal years 1994 through 1998.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

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

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

SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

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

SEC. 1203. RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

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

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

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

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

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

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effec-

tiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

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

SEC. 1204. DEFINITIONS.

For purposes of this part, the terms ''dependent'', ''employee'', ''employer'', ''group health plan'', ''health insurance plan'', ''insured multiple employer health plan'', and ''State'' have the meanings given such terms in section 1023(a).

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.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

''PART 7—MULTIPLE EMPLOYER HEALTH PLANS

"SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

''(2) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

''(3) EXCESS/STOP LOSS COVERAGE.—The term 'excess/stop loss coverage' means, in connection with a multiple employer welfare arrangement, a contract

under which an insurer provides for payment with respect to claims under the arrangement, relating to participants or beneficiaries individually or otherwise, in excess of an amount or amounts specified in such contract.

''(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(5) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

''(6) STATE LOCATION OF COVERED INDIVIDUALS.—

''(A) IN GENERAL.—A multiple employer welfare arrangement shall be treated as covering individuals located in a State only if the minimum required number of individuals who are covered under the arrangement are located in such State, except that if the minimum required number of individuals are not located in any State, such arrangement shall be treated as

covering individuals in any State in which any covered individual is located.

''(B) MINIMUM REQUIRED NUMBER.—For purposes of subparagraph (A), the minimum required number is the greater of—

''(i) 5 percent of the total number of individuals described in subparagraph (A), or

''(ii) 50.

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

''(7) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

''(8) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this part, most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of

the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

''(9) FULLY INSURED ARRANGEMENT.—A multiple employer welfare arrangement shall be treated as fully insured only if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective of any recourse they may have against other parties).

''(10) MULTIPLE EMPLOYER HEALTH PLAN.—The term 'multiple employer health plan' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under this part.

''(11) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'insured multiple employer health plan' means a fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulations).

"(12) PREPAID HEALTH CARE ARRANGEMENT.—The term 'prepaid health care arrangement' means a nonprofit entity which—

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

"(B) is established and controlled by a group medical practice or similar group, by a hospital, or by such a practice (or group) and a hospital.

"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.

"(a) IN GENERAL.—Subject to subsection (b), a multiple employer welfare arrangement which is not fully insured and with respect to which there is in effect an exemption granted by the Secretary under this part (or with respect to which there is pending a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate)—

"(1) shall be treated for purposes of subtitle A and the preceding parts of this subtitle as an employee welfare benefit plan, irrespective of whether

such arrangement is an employee welfare benefit plan, and

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

''(b) BENEFITS MUST CONSIST OF MEDICAL CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided thereunder consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation).

''(c) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care described in section 607(1) which has not commenced operations as of January 1, 1994, may commence operations only if an exemption granted to the arrangement under this part is in effect (or there is pending with respect to the arrangement a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate).

''SEC. 703. EXEMPTION PROCEDURE.

''(a) IN GENERAL.—The Secretary shall grant an exemption described in section 702(a) to a multiple employer welfare arrangement if—

"(1) an application for such exemption with respect to such arrangement, identified individually or by class, has been duly filed in complete form with the Secretary in accordance with this part,

"(2) such application demonstrates compliance with the requirements of section 704 with respect to such arrangement, and

"(3) the Secretary finds that such exemption is—

"(A) administratively feasible,

"(B) not adverse to the interests of the individuals covered under the arrangement, and

"(C) protective of the rights and benefits of the individuals covered under the arrangement.

"(b) NOTICE AND HEARING.—Before granting an exemption under this section, the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this section unless the Secretary affords an opportunity for a

hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

''(a) APPLICATION FOR EXEMPTION.—

''(1) IN GENERAL.—An exemption may be granted by the Secretary under this part only on the basis of an application filed with the Secretary in such form and manner as shall be prescribed in regulations of the Secretary. Any such application shall be signed by the operating committee and the sponsor of the arrangement.

''(2) FILING FEE.—The arrangement shall pay to the Secretary at the time of filing an application under this section a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures under this part.

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

"(A) IDENTIFYING INFORMATION.—The names and addresses of—

"(i) the sponsor, and

"(ii) the members of the operating committee of the arrangement.

"(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

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

"(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

"(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

"(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

"(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

"(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the ex-

pected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

''(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

"(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

"(b) OTHER REQUIREMENTS.—A complete application for an exemption under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

"(1) SPONSOR.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce or other business group, for substantial purposes other than that of obtaining or providing medical care described in section 607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is

established as a permanent entity which receives the active support of its members.

''(B) SPECIAL RULE FOR PREPAID HEALTH CARE ARRANGEMENTS.—In the case of an arrangement that is a prepaid health care arrangement (as defined in section 701(12)), the sponsor is the operating committee of the arrangement.

''(2) OPERATING COMMITTEE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively par-

ticipate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(B) SPECIAL RULE FOR PREPAID HEALTH CARE ARRANGEMENTS.—In the case of an arrangement that is a prepaid health care arrangement (as defined in section 701(12)), the operating committee is the board of the entity that is the arrangement.

''(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the re-

quirements of an instrument required under section 1212(a)(1), which—

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

''(B) provides that the sponsor is to serve as plan sponsor (referred to in section 3(16)(B)),

''(C) incorporates the requirements of section 707, and

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

''(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member

of the sponsor, participating employers may also include such employer, and

''(ii) all individuals thereafter commencing coverage under the arrangement must be—

''(I) active or retired owners, officers, directors, or employees of, or partners in, participating employers, or

''(II) the beneficiaries of individuals described in subclause (I).

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

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

''(c) TREATMENT OF PARTY SEEKING EXEMPTION WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

''(1) IN GENERAL.—In the case of any application for an exemption under this part with respect to a multiple employer welfare arrangement, if the Secretary determines that the sponsor of the arrangement or any other person associated with the

arrangement is subject to disqualification under paragraph (2), the Secretary may deny the exemption with respect to such arrangement.

''(2) DISQUALIFICATION.—A person is subject to disqualification under this paragraph if such person—

''(A) has intentionally made a material misstatement in the application for exemption;

''(B) has obtained or attempted to obtain an exemption under this part through misrepresentation or fraud;

''(C) has misappropriated or converted to such person's own use, or improperly withheld, money held under a plan or any multiple employer welfare arrangement;

''(D) is prohibited (or would be prohibited if the arrangement were a plan) from serving in any capacity in connection with the arrangement under section 411,

''(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order lawfully issued by the Secretary compelling such response,

"(F) has previously been subject to a determination under this part resulting in the denial, suspension, or revocation of an exemption under this part on similar grounds, or

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

"(d) FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting of its franchisees, such franchisor shall be treated as the sponsor referred to in the preceding provisions of this section, such network shall be treated as an association referred to in such provisions, and each franchisee shall be treated as a member (of the association and the sponsor) referred to in such provisions, if all participating employers are such franchisees and the requirements of subsection (b)(1) with respect to a sponsor are met with respect to the network.

"(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this section in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but

for the failure to meet any requirement of section 3(40)(C)—

"(1) paragraphs (1) and (2) of subsection (b) and subparagraphs (A), (B), and (D) of paragraph (3) of subsection (b) shall be disregarded, and

"(2) the joint board of trustees shall be considered the operating committee of the arrangement.

"(f) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

"(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer, subsection (b)(3)(D) shall be disregarded.

"(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO EXEMPTED ARRANGEMENTS.

''(a) NOTICE OF MATERIAL CHANGES.—In the case of any multiple employer welfare arrangement with respect to which there is in effect an exemption granted under this part, descriptions of material changes in any information which was required to be submitted with the application for the exemption shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the exemption.

''(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, not-

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

''(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The operating committee of each multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the arrangement.

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

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

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

"SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY ARRANGEMENTS PROVIDING MEDICAL CARE.

''(a) IN GENERAL.—A multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) shall issue to each participating employer—

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

''(2) information describing the contribution rates applicable to participating employers, and

''(3) a statement indicating—

''(A) whether or not the arrangement is fully insured,

''(B) whether or not there is in effect with respect to the arrangement an exemption granted under this part and, if there is in effect such

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

''(C) that the arrangement is not a licensed insurer under the laws of any State.

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

"SEC. 707. MAINTENANCE OF RESERVES.

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

''(1) a reserve for unearned contributions,

''(2) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims, and

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

''(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2)

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

''(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

''(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

''(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

''(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement (including a prepaid health care arrangement) to substitute, for all or part of the reserves required under subsection (a), such secu-

rity, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall continue to meet the requirements of section 707, irrespective of whether such exemption continues in effect. The operating committee of such arrangement shall determine semiannually whether the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as

the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

''(b) TERMINATION.—

''(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part determines that there is reason to believe that the arrangement will terminate, the committee shall so inform the Secretary, shall develop a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and shall submit such plan in writing to the Secretary. Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

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

''(A) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part to meet the requirements of section 707 and has not been notified by the operating committee of the arrangement that corrective action has restored compliance with such requirements, and

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

the operating committee of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the arrangement is obligated.

"SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF EXEMPTION.

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

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

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

''(2) if the Secretary finds that—

''(A) the arrangement, or the sponsor thereof, in the transaction of business while under the exemption, has used fraudulent, coercive, or dishonest practices, or has demonstrated incompetence, untrustworthiness, or financial irresponsibility,

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

injurious to participating employers, or covered individuals,

''(C) the arrangement, or the sponsor thereof, has refused to be examined in accordance with this part or to produce its accounts, records, and files for examination in accordance with this part, or

''(D) any of the officers of the arrangement, or the sponsor thereof, has refused to give information with respect to the affairs of the arrangement or the sponsor or to perform any other legal obligation relating to such an examination when required by the Secretary in accordance with this part.

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

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

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

''(d) NOTIFICATION OF PARTICIPATING EMPLOYERS.—All participating employers in a multiple employer welfare arrangement shall be notified of the expiration, suspension, or revocation of an exemption granted to such arrangement under this part, by such persons and in such form and manner as shall be prescribed in regulations of the Secretary, not later than 20 days after such expiration or after receipt of notice of a final decision requiring such suspension or revocation.

''(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS, AND REVOCATIONS.—The Secretary shall publish all expirations of, and all final decisions to suspend or revoke, exemptions granted under this part.

"SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.

''(a) IN GENERAL.—Any decision by the Secretary which involves the denial of an application by a multiple employer welfare arrangement for an exemption under this part or the suspension or revocation of such an exemption shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the exemption and the statutory provision or provisions relevant to the determination.

"(b) DENIALS OF APPLICATIONS.—In the case of the denial of an application for an exemption under this part, the Secretary shall send a copy of the decision to the applicant by certified or registered mail at the address specified in the records of the Secretary. Such decision shall constitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the decision, files a written appeal of the denial within 30 days after the mailing of such decision. The Secretary may affirm, modify, or reverse the initial decision. The decision on appeal shall become final upon the mailing of a copy by certified or registered mail to the arrangement or party that filed the appeal.

"(c) SUSPENSIONS OR REVOCATIONS OF EXEMPTION.—In the case of the suspension or revocation of an exemption granted under this part, the Secretary shall send a copy of the decision to the arrangement by certified or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrangement, or any party that would be prejudiced by the suspension or revocation, filed within 15 days of the mailing of the Secretary's decision, the Secretary shall schedule a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party requesting such hearing. Such notice shall set forth—

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

''(2) a specific place for the hearing, which shall be in the District of Columbia or in the State and county thereof (or parish or other similar political subdivision thereof) in which is located the arrangement's principal place of business.

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

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

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

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

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating 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 employee welfare benefit plans and exempt from certain restrictions 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.".

SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

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

which an exemption under part 7 is not in effect,'' before ''to the extent not inconsistent with the preceding sections of this title''.

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

''(E) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer welfare arrangements providing medical care, see part 7.''.

SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''common control'';

(2) in clause (iii), by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum inter-

est necessary for common control'', and by striking ''and'' at the end,

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

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

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.''.

SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

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

''(i) under or pursuant to one or more collective bargaining agreements,''.

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

''(C) Clause (i) of subparagraph (A) shall apply only if—

''(i) the plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

''(II) pay a commission or any other type of compensation to a person that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size

of the contributions made by participating employers or covered individuals to the plan or other arrangement,

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

''(I) are employed within a bargaining unit covered by at least one of the collective bargaining agreements with a participating employer (or are covered on the basis of an individual's employment in such a bargaining unit), or

''(II) are present or former employees of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (or are covered on the basis of such present or former employment),

''(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause

(ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan statistical area, this clause shall be applied by reference to the State in which the sponsoring organization represents employees,

''(iv) the employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary—

''(I) that the plan or other arrangement meets the requirements of clauses (i), (ii), and (iii), and

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

scribed in subclause (I) or (II) of clause (ii), the total number of covered individuals and the total number of covered individuals not so described.

''(D)(i) Clause (i) of subparagraph (A) shall not apply to a plan or other arrangement that is established or maintained pursuant to one or more collective bargaining agreements which the National Labor Relations Board determines to have been negotiated or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

''(ii)(I) Whenever a State insurance commissioner has reason to believe that this subparagraph is applicable to part or all of a plan or other arrangement, the State insurance commissioner may file a petition with the National Labor Relations Board for a determination under clause (i), along with sworn written testimony supporting the petition.

''(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I)

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

''(III) The Board shall determine, upon the petition and any response, whether, on the facts before it, the plan or other arrangement was negotiated, created, or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)). Such determination shall constitute a final determination for purposes of this subparagraph and shall be binding in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

''(IV) A person aggrieved by the determination of the Board under subclause (III) may obtain review of the determination in any United States court of appeals in the circuit in which the collective bargaining at issue occurred. Commencement of proceedings under this subclause shall not, unless specifically ordered by the court, operate as a stay of any State administrative or judicial action or proceeding related to the status of the plan or other arrangement, except that in no case may

the court stay, before the completion of the review, an order which prohibits the enrollment of new individuals into coverage under a plan or arrangement.''.

SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

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

''(43) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'employee leasing healthcare arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which—

''(i) one business or other entity (hereinafter in this paragraph referred to as the 'lessee'), under a lease or other arrangement entered into with any other business or other entity (hereinafter in this paragraph referred to as the 'lessor'), receives from the lessor the

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

''(ii) benefits consisting of medical care described in section 607(1) are provided to such individuals or such individuals and their dependents as participants and beneficiaries.

''(B) EXCEPTION.—Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the individuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.''.

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

''(E) The term 'multiple employer welfare arrangement' includes any employee leasing healthcare arrangement, except that such term does not include any employee

leasing healthcare arrangement which is a multiple employer health plan (as defined in section 701(10)).''.

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

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

''SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

''(a) IN GENERAL.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrangement that is an employee leasing healthcare arrangement if the application for exemption includes information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

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

''(2) SOLICITATION RESTRICTIONS.—Employee leasing services provided under the arrangement are not solicited, advertised, or marketed through licensed insurance agents or brokers acting in such capacity.

"(3) CREATION OF EMPLOYMENT RELATIONSHIP.—

"(A) DISCLOSURE STATEMENT.—Written notice is provided to each applicant for employment subject to coverage under the arrangement, at the time of application for employment and before commencing coverage under the arrangement, stating that the employer is the lessor under the arrangement.

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

"(C) INFORMED RECRUITMENT OF LESSEE'S EMPLOYEES.—In any case in which the lessor offers employment to an employee of a lessee under the arrangement, the lessor informs each employee in writing that his or her acceptance of employment with the lessor is voluntary and that refusal of such offer will not be deemed to be resignation from or abandonment of current employment.

"(4) REQUISITE EMPLOYER-EMPLOYEE RELATIONSHIP UNDER ARRANGEMENT.—Under the employer-employee relationship with the employees of the lessor—

''(A) the lessor retains the ultimate authority to hire, terminate, and reassign such employees,

''(B) the lessor is responsible for the payment of wages, payroll-related taxes, and employee benefits, without regard to payment by the lessee to the lessor for its services,

''(C) the lessor maintains the right of direction and control over its employees, except to the extent that the lessee is responsible for supervision of the work performed consistent with the lessee's responsibility for its product or service, and

''(D) in accordance with section 301(a) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(a)), the lessor retains in the absence of an applicable collective bargaining agreement, the right to enter into arbitration and to decide employee grievances, and

''(E) no owner, officer, or director of, or partner in, a lessee is an employee of the lessor, and not more than 10 percent of the individuals covered under the arrangement consist of owners, officers, or directors of, or partners in, such a lessee (or any combination thereof).

''(b) DEFINITIONS.—For purposes of this section—

''(1) LESSOR.—The term 'lessor' means the business or other entity from which services of individuals are obtained under an employee leasing healthcare arrangement.

''(2) LESSEE.—The term 'lessee' means a business or other entity which receives the services of individuals provided under an employee leasing healthcare arrangement.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 710 the following new item:

''Sec. 711. Employee leasing healthcare arrangements.''.

SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

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

(1) in subsection (a)(6), by striking ''subsection (c)(2) or (i) or (l)'' and inserting ''paragraph (2) or (4) of subsection (c) or subsection (i) or (l)''; and

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

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

(b) ACTIONS BY STATES IN FEDERAL COURT.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (5), by striking ''or'' at the end;

(2) in paragraph (6), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

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

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

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as being a multiple employer welfare arrangement granted an exemption under part 7, as being an employee leasing healthcare arrangement under such an exemption, or as having been established or maintained under or pursuant to a collective bargaining agreement shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

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

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

''(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, or

''(B) is not operating in accordance with the terms of an exemption granted by the Secretary under part 7,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

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

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

''(B) is licensed, registered, or otherwise approved in each State in which it offers or provides benefits, except to the extent that such State does not require licensing, registration, or approval of fully insured multiple employer welfare arrangements, and

''(C) with respect to each such State, is operating in accordance with applicable State insurance laws that are not superseded under section 514.

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

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: ''The terms of each multiple employer welfare arrangement to which this section applies and which provides benefits consisting of medical care described in section 607(1) shall require the operating committee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the arrangement.''.

SEC. 1217. FILING REQUIREMENTS FOR HEALTH BENEFIT MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

''(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1994) and no later than February 15 of each year (in the case of an arrangement

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

''(2) Each registration statement—

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

''(B) if the arrangement is not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

''(i) in the case of an arrangement with respect to which an exemption under part 7 is in effect, the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not so exempt, the State insurance commissioner of each State in which the arrangement is located.

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

''(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

''(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

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

SEC. 1218. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements with respect to which an exemption under part 7 is or has been in effect. The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent

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

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

''(2) ASSISTANCE TO STATES.—The Secretary shall—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through

the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

''(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

''(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

''(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''.

SEC. 1219. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this part shall take effect January 1, 1994, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1994, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

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.

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

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

(2) by adding at the end the following:

''(B) Any determination of whether a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) or an insured multiple employer health plan (as defined in section 701(11) of such Act) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

''(i) such plan provides at least standard coverage (consistent with section 102(c) of the Affordable Health Care Now Act of 1993), and

''(ii) in the case of an insured multiple employer health plan, it meets the requirements enforcible under section 514(b)(6)(B)(i) of the

Employee Retirement Income Security Act of 1974 to the extent not preempted by section 1202 of the Affordable Health Care Now Act of 1993.''.

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

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.

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

''(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are covered under the same insured multiple employer health plan (as defined in section 701(11)).''

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

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

PART 5—COMPLIANCE WITH COVERAGE OPTION REQUIREMENTS

SEC. 1241. COMPLIANCE WITH COVERAGE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

(a) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIEMPLOYER PLANS.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 1001(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (c) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(b) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH OTHER MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.—

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

(as defined in paragraph (3)) in an exempted multiple employer health plan or an insured multiple employer health plan, the requirements of section 1001(a) shall be deemed to be met (and the ERISA requirements of paragraph (2) shall be deemed to be met by the employer) with respect to an eligible employee of the employer if—

(A) the employer requirements of subsection (c) are met with respect to the eligible employee, and

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

irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

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

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

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

(C) part 6 of subtitle B of such title I (relating to group health plans),

to the extent that such requirements relate to employers as plan sponsors or plan administrators.

(3) PARTICIPATING EMPLOYER.—In this subsection, the term ''participating employer'' means, in connection with an exempted multiple employer health plan or an insured multiple employer health plan, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such plan in connection with the employment of the employees.

(c) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a plan with respect to an eligible employee if—

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

(2) subject to section 1001(c), such coverage includes at least the standard coverage (consistent with section 1102(c)),

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

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

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

Subtitle D—Health Deduction Fairness

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

(a) PERMANENT EXTENSION OF DEDUCTION.—

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

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1993.

(b) INCREASE IN AMOUNT OF DEDUCTION; INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(1) INCREASE IN AMOUNT OF DEDUCTION.—Paragraph (1) of section 162(l) of such Code is amended by striking ''25 percent of'' and inserting ''100 percent (50 percent in the case of taxable years beginning in 1996 or 1997) of''.

(2) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) of such Code is amended by adding at the end thereof the following new subparagraph:

''(C) INSURANCE MUST MEET CERTAIN STANDARDS.—Paragraph (1) shall apply only to insurance which is—

''(i) a MedAccess plan (as defined in section 1102(a)(2) of such Act), or

''(ii) a health plan which provides at least the standard coverage (consistent with section 1102(c) of the Affordable Health Care Now Act of 1993) with substantial cost-sharing (as defined for purposes of section 1102(a)(1)(A)(i) of such Act).

''(D) TREATMENT OF GROUP HEALTH PLANS.—For purposes of this subsection, an

amount paid into a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) shall be deemed to be an amount paid for insurance which constitutes medical care.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1993.

SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

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

''(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

''(1) IN GENERAL.—Subsection (a) shall be applied without regard to the limitation based on adjusted gross income in the case of the applicable percentage of the amounts paid for insurance referred to in section 162(l)(2)(C) (and including payments referred to in section 162(l)(2)(D)).

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

"(A) 25 percent for taxable years beginning in 1994 or 1995,

"(B) 50 percent for taxable years beginning in 1996 or 1997, and

"(C) 100 percent for taxable years beginning after 1997.

"(3) DEDUCTION NOT ALLOWED TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any individual—

"(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

"(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

"(B) SUBSIDIZED CLASS.—For purposes of subparagraph (A), an individual is a member of a subsidized class of employees of an employer if, at any time during the 3 calendar years end-

ing with or within the taxable year, any member of such class was eligible to participate in any subsidized health plan maintained by such employer.

''(C) SPECIAL RULES.—

''(i) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of subparagraph (B).

''(ii) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

''(4) COORDINATION WITH DEDUCTION FOR OTHER AMOUNTS.—Amounts allowable as a deduction under subsection (a) by reason of this subsection shall not be taken into account in determining the deduction under subsection (a) for other amounts.

''(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection

shall not apply to amount paid for insurance covering an individual who is eligible for benefits under title XVIII of the Social Security Act.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

''(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the extent allowable by reason of section 213(f).''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

Subtitle E—Improved Access to Community Health Services

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS

SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY HEALTH CARE SERVICES FOR UNDERSERVED POPULATIONS.

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall provide for a program of grants to migrant and community health centers (receiving grants or contracts under section 329, 330, or 340 of the Public

Health Service Act) in order to promote the provision of primary health care services for underserved individuals. Such grants may be used—

(1) to promote the provision of off-site services (through means such as mobile medical clinics);

(2) to improve birth outcomes in areas with high infant mortality and morbidity;

(3) to establish primary care clinics in areas identified as in need of such clinics; and

(4) for recruitment and training costs of necessary providers and operating costs for unreimbursed services.

(b) CONDITIONS.—(1) Grants under this subsection shall only be made upon application, approved by the Secretary.

(2) The amount of grants made under this section shall be determined by the Secretary.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) in fiscal year 1994, $100,000,000,

(2) in fiscal year 1995, $200,000,000,

(3) in fiscal year 1996, $300,000,000,

(4) in fiscal year 1997, $400,000,000, and

(5) in fiscal year 1998, $500,000,000,

to carry out this section. Of the amounts appropriated each fiscal year under this section, at least 10 percent shall be used for grants described in subsection (a)(1) and at least 10 percent shall be used for grants described in subsection (a)(2). The Secretary may use not to exceed 50 percent of the amounts appropriated to carry out this section for the purpose of making new grants or contracts under sections 329, 330, and 340 of the Public Health Service Act.

(d) STUDY AND REPORT.—The Secretary shall conduct a study of the impact of the grants made under this section to migrant and community health centers on access to health care, birth outcomes, and the use of emergency room services. Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and on recommendations for changes in the programs under this section in order to promote the appropriate use of cost-effective outpatient services.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF OUTPATIENT PRIMARY HEALTH SERVICES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

''Subpart VII—Delivery of Services

''PROJECTS FOR COORDINATING DELIVERY OF SERVICES

''SEC. 340E. (a) AUTHORITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities to carry out demonstration projects for the purpose of increasing access to outpatient primary health services in geographic areas described in subsection (b) through coordinating the delivery of such services under Federal, State, local, and private programs.

''(2) REQUIREMENT REGARDING PLAN.—The Secretary may make a grant under paragraph (1) only if—

''(A) the applicant involved has received a grant under subsection (l) and the Secretary has approved the plan developed with such grant; and

''(B) the applicant agrees to carry out the project under paragraph (1) in accordance with the plan.

''(b) QUALIFIED HEALTH SERVICE AREAS.—

''(1) IN GENERAL.—A geographic area described in this subsection is a geographic area that—

''(A) is a rational area for the delivery of health services;

''(B) has a population of not more than 500,000 individuals; and

''(C)(i) has been designated by the Secretary as an area with a shortage of personal health services; or

''(ii) has a significant number of individuals who have low incomes or who have insufficient insurance regarding health care.

''(2) AUTHORITY REGARDING MULTIPLE POLITICAL SUBDIVISIONS.—The Secretary shall make a determination of whether a geographic area is a geographic area described in paragraph (1) without regard to whether the area is a political subdivision, without regard to whether the area is located in 2 or more political subdivisions or States, and without

regard to whether the area encompasses 2 or more political subdivisions.

''(c) PREFERENCES IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to applicants demonstrating that, with respect to the outpatient primary health services that will be the subject of the project conducted by the applicant under such subsection—

''(1)(A) the project will result in the reduction of administrative expenses associated with such services by increasing the efficiency of the administrative processes of the providers participating in the project, and (B) the resulting savings will be expended for the direct provision of such services for the designated population; or

''(2) the services that will be the subject of the project will be provided in facilities that are underutilized.

''(d) ACTIVITIES OF PROJECT MUST SERVE DESIGNATED POPULATION.—The Secretary may make a grant under subsection (a) to an applicant only if the applicant demonstrates that carrying out the project under such subsection will increase access to outpatient primary health services for a significant segment of the designated population.

"(e) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of the project to be carried out under subsection (a) by an applicant, the Secretary may make a grant under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

"(1) PROVISION OF HEALTH SERVICES; CONSTRUCTION OF FACILITIES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the grant will not be expended for the direct provision of any health service or for the construction or renovation of facilities.

"(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made for a project under subsection (a) may not exceed 4 years, and the aggregate amount of such payments for the period may not exceed $200,000. The provision of such payments shall be subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments.

"(3) FINANCIAL CAPACITY FOR CONTINUATION OF PROJECT AFTER TERMINATION OF GRANT.—The Secretary may make a grant under subsection (a) only if the Secretary determines that there is a reasonable basis for believing that, after termination of payments under such subsection pursuant to paragraph (2), the project under such subsection will have the financial capacity to continue operating.

"(g) AGREEMENTS AMONG PARTICIPANTS IN PROJECTS.—

"(1) REQUIRED PARTICIPANTS.—The Secretary may make a grant under subsection (a) only if the applicant for the grant has, for purposes of carrying out a project under such subsection, entered into agreements with—

''(A) the chief public health officers, and the chief health officers for the elementary and secondary schools, of each of the political subdivisions of the qualified health service area in which the project under such subsection is to be carried out (or, in the case of a political subdivision that does not have such an official, with another appropriate official of such subdivision);

''(B) each hospital in the qualified health service area;

''(C) representatives of entities in such area that provide outpatient primary health services under Federal, State, local, or private programs;

''(D) representatives of businesses in such area, including small businesses; and

''(E) representatives of nonprofit private entities in such area.

''(2) OPTIONAL PARTICIPANTS.—With respect to compliance with this section, a grantee under subsection (a) may, for purposes of carrying out a project under such subsection, enter into such agreements with public and private entities in the qualified health service area involved (in addition to the

entities specified in paragraph (1)) as the grantee may elect.

''(h) EXPENDITURES OF GRANT.—With respect to a project under subsection (a), the purposes for which a grant under such subsection may be expended include (but are not limited to) expenditures to increase the efficiency of the administrative processes of providers participating in the project, paying the costs of hiring and compensating staff, obtaining computers and other equipment (including vehicles to transport individuals to programs providing outpatient primary health services), and developing and operating provider networks.

''(i) MAINTENANCE OF EFFORT.—In the case of services and populations that are the subject of a project under subsection (a), the Secretary may make such a grant for a fiscal year only if the applicant involved agrees that the applicant, and each entity making an agreement under subsection (g), will maintain expenditures of non-Federal amounts for such services and populations at a level that is not less than the level of such expenditures maintained by the applicant and the entity, respectively, for the fiscal year preceding the first fiscal year for which the applicant receives such a grant.

''(j) REPORTS TO SECRETARY.—The Secretary may make a grant under subsection (a) only if the applicant

involved agrees to submit to the Secretary such reports on the project carried out under such subsection as the Secretary may require.

''(k) EVALUATIONS AND DISSEMINATION OF INFORMATION.—The Secretary shall provide for evaluations of projects carried out under subsection (a), and for the collection and dissemination of information developed as a result of such projects and as a result of similar projects.

''(l) PLANNING GRANTS.—

''(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of developing plans to carry out projects under subsection (a). Such a grant may be made only if the applicant involved submits to the Secretary information—

''(A) providing a detailed statement of the proposal of the applicant for carrying out the project;

''(B) identifying the geographic area in which the project is to be carried out; and

''(C) demonstrating that the area is a qualified health service area and that the proposal otherwise is in accordance with the requirements established in this section for the receipt of a grant under subsection (a).

"(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made under paragraph (1) for the development of a plan under such paragraph may not exceed 1 year, and the amount of such payments may not exceed $100,000.

"(m) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) or (l) only if the applicant for the grant submits an application to the Secretary that—

"(1) contains any agreements, assurances, and information required in this section with respect to the grant; and

"(2) is in such form, is made in such manner, and contains such other agreements, assurances, and information as the Secretary determines to be necessary to carry out the purpose for which the grant is to be provided.

"(n) DEFINITIONS.—For purposes of this section:

"(1) The term 'designated population' means individuals described in subsection (b)(1)(C)(ii).

"(2) The term 'primary health services' includes preventive health services.

"(3) The term 'qualified health service area' means a geographic area described in subsection (b).

"(o) AUTHORIZATION OF APPROPRIATIONS.—

"(1) PLANNING FOR PROJECTS.—For the purpose of grants under subsection (l), there is authorized to be appropriated $5,000,000 for fiscal year 1994, to remain available until expended.

"(2) OPERATION OF PROJECTS.—For the purpose of grants under subsection (a), there is authorized to be appropriated an aggregate $10,000,000 for the fiscal years 1995 through 1998.".

Subtitle F—Improved Access to Rural Health Services

PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE

SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

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

"Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 1503. EFFECTIVE DATE.

The amendments made by sections 1501 and 1502 shall apply to fiscal years beginning on or after October 1, 1993.

PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT

SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

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

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

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

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

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

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

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

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement

to existing ground-based or air emergency medical service systems;

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

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

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

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

''(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level

at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

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

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

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

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

''(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

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

''(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless

the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

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

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

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

''(f) REPORTS.—

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

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

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

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

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

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

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1994, and such

sums as may be necessary for each of the fiscal years 1995 and 1996.''.

PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS

SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

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

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

(2) in the heading for part A, by striking ''GENERAL'' and all that follows and inserting ''GENERAL AUTHORITIES AND DUTIES''; and

(3) by amending section 1201 to read as follows:

''SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

''(a) IN GENERAL.—The Secretary shall establish an office to be known as the Office of Emergency Medical Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

"(b) GENERAL AUTHORITIES AND DUTIES.—With respect to emergency medical services (including trauma care), the Secretary shall—

"(1) conduct and support research, training, evaluations, and demonstration projects;

"(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

"(3) sponsor workshops and conferences;

"(4) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

"(5) provide technical assistance to State and local agencies;

"(6) coordinate activities of the Department of Health and Human Services; and

"(7) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

"(c) CERTAIN REQUIREMENTS.—With respect to emergency medical services (including trauma care), the Secretary shall ensure that activities under subsection (b) are carried out regarding—

''(1) maintaining an adequate number of health professionals with expertise in the provision of the services, including hospital-based professionals and prehospital-based professionals;

''(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appropriate public and private entities, guidelines for the provision of such services (including, for various typical circumstances, guidelines on the number and variety of professionals, on equipment, and on training);

''(3) the appropriate use of available technologies, including communications technologies; and

''(4) the unique needs of underserved inner-city areas and underserved rural areas.

''(d) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

''(e) DEFINITIONS.—For purposes of this part:

''(1) The term 'hospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at a medical facility.

''(2) The term 'prehospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the medical emergency or during transport to a medical facility.''.

SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

(a) TECHNICAL AMENDMENTS TO FACILITATE ESTABLISHMENT OF PROGRAM.—

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

(A) by redesignating section 1239 as section 1235;

(B) by redesignating sections 1231 and 1233 as sections 1236 and 1237, respectively; and

(C) by redesignating sections 1211 through 1222 as sections 1221 through 1232, respectively.

(2) MODIFICATIONS IN FORMAT OF TITLE XII.—Title XII of the Public Health Service Act, as

amended by paragraph (1) of this subsection, is amended—

(A) by striking ''PART B'' and all that follow through ''STATE PLANS'' and inserting the following:

''Subpart II—Formula Grants With Respect to Modifications of State Plans'';

(B) by striking ''PART C—GENERAL PROVISIONS'' and inserting the following:

''Subpart III—General Provisions'';

(C) by redesignating sections 1202 and 1203 as sections 1211 and 1212, respectively; and

(D) by inserting before section 1211 (as so redesignated) the following:

''PART B—TRAUMA CARE

''Subpart I—Advisory Council; Clearinghouse''.

(b) STATE OFFICES.—Title XII of the Public Health Service Act, as amended by subsection (a) of this section, is amended by inserting after section 1201 the following new section:

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

''(a) PROGRAM OF GRANTS.—The Secretary may make grants to States for the purpose of improving the

availability and quality of emergency medical services through the operation of State offices of emergency medical services.

''(b) REQUIREMENT OF MATCHING FUNDS.—

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

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

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

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

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

''(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts

provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

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

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

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

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

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

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

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

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

''(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will be provided with an annual budget of not less than $50,000.

''(e) CERTAIN USES OF FUNDS.—

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

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

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

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

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

''(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''.

SEC. 1523. PROGRAMS FOR RURAL AREAS.

(a) IN GENERAL.—Title XII of the Public Health Service Act, as amended by section 1522, is amended—

(1) by transferring section 1204 to part A;

(2) by redesignating such section as section 1203;

(3) by inserting such section after section 1202; and

(4) in section 1203 (as so redesignated)—

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

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

''(c) DEMONSTRATION PROGRAM REGARDING TELECOMMUNICATIONS.—

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

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

(b) CONFORMING AMENDMENT.—Section 1203 of the Public Health Service Act, as redesignated by subsection (a)(2) of this section, is amended in the heading for the section by striking ''**ESTABLISHMENT**'' and all that follows and inserting ''**PROGRAMS FOR RURAL AREAS**.''.

SEC. 1524. FUNDING.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) by redesignating parts C through F as parts D through G, respectively;

(2) by inserting after subpart III of part B the following:

''PART C—FUNDING'';

(3) by transferring section 1239 to part C (as so added); and

(4) in such section, by striking subsections (a) and (b) and inserting the following:

''(a) EMERGENCY MEDICAL SERVICES GENERALLY.—

''(1) IN GENERAL.—For the purpose of carrying out section 1201 other than with respect to trauma care, there are authorized to be appropriated $2,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996.

"(2) STATE OFFICES.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996.

"(3) CERTAIN TELECOMMUNICATIONS DEMONSTRATIONS.—For the purpose of carrying out section 1203(c), there are authorized to be appropriated $10,000,000 for fiscal year 1994 and such sums as may be necessary for each of the fiscal years 1995 and 1996.

"(b) TRAUMA CARE AND CERTAIN OTHER ACTIVITIES.—

"(1) IN GENERAL.—For the purpose of carrying out part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), there are authorized to be appropriated $60,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996.

"(2) ALLOCATION OF FUNDS BY SECRETARY.—

"(A) For the purpose of carrying out subpart I of part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), the Secretary shall

make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(B) For the purpose of carrying out section 1203 (other than subsection (c) of such section), the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(C)(i) For the purpose of making allotments under section 1221(a), the Secretary shall, subject to subsection (c), make available 80 percent of the amounts appropriated for a fiscal year under paragraph (1).

''(ii) Amounts paid to a State under section 1221(a) for a fiscal year shall, for the purposes for which the amounts were paid, remain available for obligation until the end of the fiscal year immediately following the fiscal year for which the amounts were paid.''.

SEC. 1525. CONFORMING AMENDMENTS.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) in section 1203(b), by striking ''1214(c)(1)'' and inserting ''1224(c)(1)'';

(2) in section 1211(b)(3), by striking ''1213(c)'' and inserting ''1223(c)'';

(3) in section 1221—

(A) in subsection (a)—

(i) by striking ''1218'' and inserting ''1228''; and

(ii) by striking ''1217'' and inserting ''1227''; and

(B) in subsection (b)—

(i) by striking ''1233'' and inserting ''1237''; and

(ii) by striking ''1213'' and inserting ''1223'';

(4) in section 1222—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) in paragraph (2)(A), by striking ''1211(c)'' and inserting ''1221(c)''; and

(B) in subsection (b), by striking ''1211(a)'' and inserting ''1221(a)'';

(5) in section 1223—

(A) in subsection (a), by striking ''1211(b)'' and inserting ''1221(b)'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) in paragraph (3), by striking ''1211(a)'' and inserting ''1221(a)''; and

(C) in subsection (d), by striking ''1211(a)'' and inserting ''1221(a)'';

(6) in section 1224—

(A) in each of subsections (a) through (c), by striking ''1211(a)'' and inserting ''1221(a)''; and

(B) in subsection (b), by striking ''1213(a)(7)'' and inserting ''1223(a)(7)'';

(7) in section 1225—

(A) in subsection (a)—

(i) by striking ''1211(a)'' and inserting ''1221(a)''; and

(ii) by striking ''1233'' and inserting ''1237''; and

(B) in subsection (b), by striking ''1211(b)'' and inserting ''1221(b)'';

(8) in section 1226, in each of subsections (a) through (c), by striking ''1211(a)'' and inserting ''1221(a)'';

(9) in section 1227—

(A) by striking ''1211(a)'' and inserting ''1221(a)''; and

(B) by striking ''1214'' and inserting ''1224'';

(10) in section 1228—

(A) in each of subsections (a) through (c), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(B) in subsection (b), in each of paragraphs (2)(A) and (3)(A), by striking ''1232(a)'' and inserting ''1239(a)''; and

(C) in subsection (c)(2)—

(i) by striking ''1232(b)(3)'' and inserting ''1239(b)(3)''; and

(ii) by striking ''1217'' and inserting ''1227'';

(11) in section 1229(a), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(12) in section 1230(a), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)'';

(13) in section 1231—

(A) in each of subsections (a) and (b), by striking ''1211(a)'' each place such term appears and inserting ''1221(a)''; and

(B) in each of subsections (a) and (b), by striking ''1211(b)'' and inserting ''1221(b)'';

(14) in section 1232, by striking ''1211'' and inserting ''1221'';

(15) in section 1236—

(A) in the matter preceding paragraph (1), by striking ''this title'' and inserting ''this part''; and

(B) in paragraph (1), by striking ''1213'' and inserting ''1223'';

(16) in section 1237—

(A) in each of subsections (a) and (b), by striking ''1211'' each place such term appears and inserting ''1221'';

(B) in subsection (b)—

(i) by striking ''part B'' and inserting ''subpart II''; and

(ii) by striking ''1214(c)(1)'' and inserting ''1224(c)(1)''; and

(C) in subsection (c), by striking ''1213'' and inserting ''1223''; and

(17) in section 1239(c)(1)—

(A) by striking ''1211(a)'' and inserting ''1221(a)'';

(B) by striking ''1218(a)(2)'' and inserting ''1228(a)(2)''; and

(C) by striking ''part B'' and inserting ''subpart II''.

SEC. 1526. EFFECTIVE DATE.

The amendments made by this part shall take effect October 1, 1993, or upon the date of the enactment of this Act, whichever occurs later.

Subtitle G—State Flexibility in the Medicaid Program: The Medical Health Allowance Program

SEC. 1601. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 13631(b) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) by redesignating section 1931 as section 1932; and

(2) by inserting after section 1930 the following new section:

''STATE HEALTH ALLOWANCE PROGRAMS

''SEC. 1931. (a) TREATMENT OF EXPENDITURES UNDER HEALTH ALLOWANCE PROGRAMS AS MEDICAL ASSISTANCE UNDER STATE PLAN.—

"(1) IN GENERAL.—Notwithstanding any other provision of this title, for purposes of determining the amount to be paid to a State under section 1903(a)(1) for quarters in any fiscal year, amounts expended by an eligible State (as described in subsection (b)) during the fiscal year under a State health allowance program (as described in subsection (c)) shall be included in the total amount expended during the fiscal year as medical assistance under the State plan (except as provided under paragraphs (2) and (3) and under subsection (d)(1)(C)).

"(2) FEDERAL PAYMENT RESTRICTED TO ACUTE CARE SERVICES.—No amounts expended under a State health allowance program that are attributable to medical assistance described in paragraphs (4), (14), (15), (23), or (24) of section 1905(a) shall be included in the total amount expended as medical assistance under the State plan.

"(3) LIMITATION.—In no case shall this subsection result in (A) the total Federal payments to the State for the quarter under this title (including payments attributable to this section and section 1923), exceeding (B) the total Federal payments that the Secretary estimates would have been paid

under this title to the State for the quarter if the State did not have a program under this section.

''(b) ELIGIBILITY OF STATE.—A State is eligible for purposes of subsection (a) if the State submits (at such time and in such form as the Secretary may require) an application to the Secretary containing such information and assurances as the Secretary may require, including assurances that the State has adopted and is enforcing standards regarding quality assurance for group health plans participating in the State health allowance program, including standards regarding—

''(1) uniform reporting requirements for such plans relating to a minimum set of clinical data, patient satisfaction data, and other information that may be used by individuals to compare the quality of various plans; and

''(2) the establishment or designation of an entity of the State government to collect the data described in subparagraph (A) and to regularly report such data to the Secretary.

''(c) STATE HEALTH ALLOWANCE PROGRAM DESCRIBED.—

''(1) ENROLLMENT OF PARTICIPATING INDIVIDUALS IN APPROVED GROUP HEALTH PLANS.—In this section, a State health allowance program is a pro-

gram in effect in all the political subdivisions of the State (except as provided in (c)) under which the State makes payments to a group health plan (approved under paragraph (2)) which provides coverage to the individual as an allowance towards the costs of providing the individual with benefits under the plan.

''(2) APPROVED PLANS DESCRIBED.—For purposes of paragraph (1), a State shall approve group health plans in accordance with such standards as the State may establish, except that—

''(A) the State may not approve a plan for a year unless the actuarial value of the benefits provided by the plan (taking into account the cost-sharing associated with the plan) for the year—

''(i) with respect to the first year for which the plan is approved for purposes of this subsection, is not less than the actuarial value of the medical assistance provided under the State plan under this title for the year (as determined by the Secretary without regard to medical assistance described in paragraphs (4), (14), (15), (23), or (24) of section 1905(a)); and

''(ii) with respect to any subsequent year, is not greater than the amount determined under this subparagraph for the preceding year, increased or decreased by the amount (expressed as a percentage) by which the actuarial value of the medical assistance described in clause (i) for the year exceeds or is less than the actuarial value of such medical assistance for the preceding year;

''(B) at least one of the plans approved by the State shall be a health maintenance organization or other plan under which payments are otherwise made on a capitated basis for providing medical assistance to individuals enrolled in the State plan under this title; and

''(C) in the case of an individual who is entitled to benefits under the State plan under this title as of the first month during which the State health allowance program is in effect, an approved plan may not require the individual to contribute a greater amount of cost-sharing than the individual would have been required to contribute under the State plan (except as may be imposed on an individual described in sub-

paragraph (B) or subparagraph (C) of subsection (d)(1)).

''(3) WAIVER OF STATEWIDENESS REQUIREMENT.—At the request of a State, the Secretary may waive for a period not to exceed 3 years (subject to one 3-year extension) the requirement under paragraph (1) that the State health allowance program be in effect in all political subdivisions of the State.

''(d) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE IN ALLOWANCE PROGRAM.—

''(1) AUTOMATIC ELIGIBILITY OF MEDICAID CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject to subsection (e), any individual to whom the State makes medical assistance available under the State plan under this title pursuant to clause (i) of section 1902(a)(10)(A) shall be eligible to participate in the State health allowance program.

''(2) MANDATORY ELIGIBILITY OF INDIVIDUALS WITH INCOME UNDER THE POVERTY LEVEL.—

''(A) IN GENERAL.—Subject to subsection (e) and subparagraph (B), an individual lawfully residing in the State shall be eligible to participate in the program if the income of the individual's family is equal to or less than 100

percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1991) applicable to a family of the size involved.

''(B) EXCEPTION.—If the application of subparagraph (A) would result in—

''(i) the total State expenditures for a quarter under this title (including expenditures attributable to this section and section 1923), exceeding

''(ii) the total State expenditures that the Secretary estimates would have been made under this title for the quarter if the State did not have a program under this section,

then there shall be substituted for 100 percent in subparagraph (A) such percent as would result in the amount described in clause (i) equaling the amount described in clause (ii).

''(3) OPTIONAL ELIGIBILITY OF INDIVIDUALS WITH INCOME UP TO 200 PERCENT OF POVERTY LEVEL.—

"(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make an individual lawfully residing in the State eligible to participate in the program if the income of the individual's family is greater than 100 percent (but less than such percentage, not to exceed 200 percent, as the State may specify) of such official poverty line.

"(B) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph, the program may require such an individual to contribute all (or a portion) of the premiums and cost-sharing of such a group health plan if the amount of such contribution is determined in accordance with a sliding scale based on the individual's family income.

"(e) EXCLUSION AND USE OF RESOURCE STANDARD.—

"(1) EXCLUSION OF ELDERLY MEDICARE-ELIGIBLE INDIVIDUALS.—No individual shall be eligible to participate in the program if the individual is entitled to benefits under title XVIII of the Social Security Act pursuant to section 226 of such Act.

"(2) USE OF RESOURCE STANDARD.—A State may require an individual to meet a resource standard as a condition of eligibility to participate in the program only if the Secretary approves the State's use of such a standard.

"(f) CONSTRUCTION.—No provision of any Federal law shall prevent a State from enrolling any employee or other individual in accordance with this section. The previous sentence shall not be construed as permitting a State to require the employer of an individual participating in the program to contribute toward the individual's premium required for such participation.

"(g) EVALUATIONS AND REPORTS.—

"(1) EVALUATIONS.—Not later than 3 years after the date of the enactment of this section (and at such subsequent intervals as the Secretary considers appropriate), the Secretary shall evaluate the effectiveness of the State health allowance programs for which Federal financial participation is provided under this section, and the impact of such programs on increasing the number of individuals with health insurance coverage in participating States and in controlling the costs of health care in such States.

"(2) REPORTS.—Not later than 3 years after the date of the enactment of this section (and at

such subsequent intervals as the Secretary considers appropriate), the Secretary shall submit a report on the program to Congress.''.

(b) ENSURING BUDGET NEUTRALITY THROUGH REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR PARTICIPATING STATES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4), as amended by section 13621(b)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by adding at the end the following new subsection:

''(h) REDUCTION IN PAYMENT ADJUSTMENTS FOR STATES WITH HEALTH ALLOWANCE PROGRAMS.—In the case of a State operating a State health allowance program under section 1931 in a fiscal year, the Secretary shall reduce the total payment adjustments made under this section for hospitals in the State for quarters in the year by such amount as the Secretary determines to be necessary to ensure that the total amount paid to the State under section 1903(a)(1) for the year does not exceed the amount that would have been paid to the State under such section for the year if the State did not operate such a program.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1994.

SEC. 1602. OPTIONAL USE OF PROGRAM TO OFFER COVERAGE TO SOME OR ALL STATE RESIDENTS.

Section 1931 of the Social Security Act, as inserted by section 1601(a)(2), is amended—

(1) in subsection (c)(2)(A), in the matter before clause (i), by inserting ‘‘, except as provided in subsection (d)(4)(B)(iii),’’ after ‘‘unless’’, and

(2) by adding at the end of subsection (d) the following new paragraphs:

‘‘(4) OPTIONAL ENROLLMENT OF OTHER INDIVIDUALS.—

‘‘(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make any individual (or class of individuals) who is not described in paragraph (1), (2), or (3) and who is not offered coverage under an employer group health plan eligible to participate in the program.

‘‘(B) SPECIAL RULES.—

‘‘(i) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph, the program may require such an individual to contribute all (or a por-

tion) of the premiums and cost-sharing of such a group health plan.

''(ii) NO FEDERAL MATCHING PAYMENTS.—For purposes of payment to States under section 1903(a), no amounts expended by the State under the program during a fiscal year on behalf of an individual enrolled under subparagraph (A) may be included in the total amount expended during the fiscal year as medical assistance under the State plan.

''(iii) OPTIONAL USE OF STANDARD COVERAGE.—Notwithstanding subsection (c)(2)(A), with respect to individuals enrolled under subparagraph (A), such program may provide standard coverage (consistent with section 1102(c) of the Affordable Health Care Now Act of 1993) rather than the benefits of an actuarial value otherwise required under such subsection.

''(5) OFFERING OF COVERAGE THROUGH OTHER PROGRAMS.—Nothing in this section shall be construed as preventing a State which—

''(A) does not operate a State health allowance program under this section from assuring

that individuals in the State who are not offered coverage under an employer group health plan are offered coverage under a health plan, or

''(B) does operate such a program from assuring that individuals in the State who are not described in paragraph (1), (2), or (3) and who are not offered coverage under an employer group health plan are offered coverage under a health plan other than through such program.''.

Subtitle H—Medicaid Program Flexibility

SEC. 1701. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(1) by striking all that precedes paragraph (4) and inserting the following:

''(m) COORDINATED CARE.—

''(1) PAYMENT CONDITIONED ON COMPLIANCE.—

''(A) GENERAL RULE.—No payment shall be made under this title to a State with respect

to expenditures incurred by it for payment to a risk contracting entity or primary care case management entity (as defined in subparagraph (B)), or with respect to an undertaking described in paragraph (6), unless the State and the entity or undertaking meet the applicable requirements of this subsection. For purposes of determining whether payment may be made under this section, the Secretary may reject a State's determination of compliance with any provision of this subsection.

''(B) GENERAL DEFINITIONS.—For purposes of this title—

''(i) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity that has a contract with the State agency under which the entity—

''(I) provides or arranges for the provision of health care items or services to individuals eligible for medical assistance under the State plan under this title, and

''(II) is at risk (as defined in clause (iv)) for part or all of the cost

of such items or services furnished to such individuals.

''(ii) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a State program under which individuals eligible for medical assistance under the State plan under this title are enrolled with primary care case management entities, and are entitled to receive specified health care items and services covered under such plan only as arranged for and approved by such entities.

''(iii) AT RISK.—An entity is 'at risk', for purposes of this subparagraph, if it has a contract with the State agency under which it is paid a fixed amount for providing or arranging for the provision of specified health care items or services to an individual eligible for medical assistance and enrolled with the entity, regardless of whether such items or services are furnished to such individual, and is liable for all or part of the cost of furnishing such items or services, regardless of whether or

the extent to which such cost exceeds such fixed payment.

"(iv) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider (whether an individual or an entity) that, under a State primary care case management program meeting the requirements of paragraph (7), has a contract with the State agency under which the entity arranges for or authorizes the provision of health care items and services to individuals eligible for medical assistance under the State plan under this title, but is not at risk (as defined in clause (iv)) for the cost of such items or services provided to such individuals.

"(2) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

"(A) FEDERAL OR STATE QUALIFICATION.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it either—

"(i) is a qualified health maintenance organization as defined in section 1310(d)

of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of that Act, or

''(ii) is an entity which the State agency has determined—

''(I) affords, to individuals eligible for medical assistance under the State plan and enrolled with the entity, access to health care items and services furnished by the entity, within the area served by the entity, at least equivalent to the access such individuals would have to such health care items and services in such area if not enrolled with the entity, and

''(II) has made adequate provision against the risk of insolvency, and assures that individuals eligible for medical assistance under this title are not held liable for the entity's debts in case of the entity's insolvency.

''(B) INTERNAL QUALITY ASSURANCE.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection

only if it has in effect an internal quality assurance program that meets the requirements of paragraph (9).

''(C) CONTRACT WITH STATE AGENCY.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if the entity has a written contract with the State agency that provides—

''(i) that the entity will comply with all applicable provisions of this subsection;

''(ii) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that payments to the entity under the contract shall not exceed 100 percent of expenditures that would have been made by the State agency in the absence of the contract;

''(iii) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

''(I) to the ability of the entity to bear the risk of potential financial losses, or

''(II) to services performed or determinations of amounts payable under the contract;

''(iv) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

''(v)(I) that individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination (or at such times as required pursuant to paragraph (8)), and

''(II) for notification of each such individual, at the time of the individual's enrollment, of the right to terminate enrollment;

''(vi) for reimbursement, either by the entity or by the State agency, for medically necessary services provided—

''(I) to an individual eligible for medical assistance under the State plan and enrolled with the entity, and

''(II) other than through the entity because the services were immediately required due to an unforeseen illness, injury, or condition;

''(vii) for disclosure of information in accordance with paragraph (4) and section 1124;

''(viii) in the case of an entity that has entered into a contract with a Federally-qualified health center for the provision of services of such center—

''(I) that rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and

''(II) that, at the election of such center, payments made by the entity to such center for services described in section 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);

''(ix) that any physician incentive plan that the entity operates meets the requirements of section 1876(i)(8);

''(x) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients; and

''(xi) that the entity complies with the requirement of section 1902(w) with respect to each enrollee.

''(3) EXCEPTIONS TO REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—The requirements of paragraph (2) (other than subparagraph (C)(viii)) do not apply to an entity that—

''(A)(i) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments

are to be made under this title, has been the recipient of a grant under either such section; and

''(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under the State plan, the services described in section 1905(a)(7);

''(B) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

''(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965), and

''(ii) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into dur-

ing a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation or other risk basis; or

''(C) which has contracted with the State agency for the provision of services (but not including inpatient hospital services) to persons eligible for medical assistance under this title on a prepaid risk basis prior to 1970.''; and

(2) by adding after paragraph (6) the following new paragraphs:

''(7) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT.—A State that elects in its State plan under this title to implement a primary care case management program under this subsection shall include in the plan methods for the selection and monitoring of participating primary care case management entities to ensure that—

''(A) the numbers, geographic locations, hours of operation, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance reasonable access to and choice among such entities;

"(B) such entities and their professional personnel are qualified to provide health care case management services, through methods including ongoing monitoring of compliance with applicable requirements for licensing of health care providers, providing training and certification of primary care case managers, and providing information and technical assistance; and

"(C) such entities are making timely and appropriate decisions with respect to enrollees' need for health care items and services, and are giving timely approval and referral to providers of adequate quality where such items and services are determined to be medically necessary.

"(8) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

"(A) MANDATORY ENROLLMENT OPTION.—A State plan may require an individual eligible for medical assistance under the State plan (other than a medicare qualified beneficiary) to enroll with a risk contracting entity or primary care case management entity, without regard to the requirement of section 1902(a)(1) (concerning Statewideness), the requirements of section 1902(a)(10)(B) (concern-

ing comparability of benefits), or the requirements of section 1902(a)(23) (concerning freedom of choice of provider), if the individual is permitted a choice—

''(i) between or among two or more risk contracting entities,

''(ii) between a risk contracting entity and a primary care case management entity, or

''(iii) between or among two or more primary care case management entities.

''(B)(i) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—A State plan may restrict the period in which individuals enrolled with a qualifying risk contracting entity (as defined in clause (ii)) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in clause (iii)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to

requests for termination of enrollment for cause.

''(ii) For purposes of this subparagraph, the term 'qualifying risk contracting entity' means a risk contracting entity that is—

''(I) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act;

''(II) an eligible organization with a contract under section 1876;

''(III) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act;

''(IV) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965;

''(V) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under

part B of title XVIII or eligible for medical assistance under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity; or

''(VI) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this subsection to permit disenrollment without cause.

''(iii) For purposes of this subparagraph, the term 'period of enrollment' means—

''(I) a period not to exceed 6 months in duration, or

''(II) a period not to exceed one year in duration, in the case of a State that, on the effective date of this subparagraph, had in effect a waiver under section 1115 of requirements under this title under

which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

''(C) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

''(i) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this subsection,

''(ii) in the next month (or next 2 months) is not eligible for such medical assistance, but

''(iii) in the succeeding month is again eligible for such benefits,

the State plan may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

''(9) REQUIREMENTS FOR INTERNAL QUALITY ASSURANCE PROGRAMS.—The requirements for an internal quality assurance program of a risk contracting entity are that program is written and the program—

''(A) specifies a systematic process including ongoing monitoring, corrective action, and other appropriate activities to achieve specified and measurable goals and objectives for quality of care, and including annual evaluation of the program;

''(B) identifies the organizational units responsible for performing specific quality assurance functions, and ensure that they are accountable to the governing body of the entity and that they have adequate supervision, staff, and other necessary resources to perform these functions effectively;

''(C) if any quality assistance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions, and has mechanisms to ensure that all quality assurance activities are carried out;

''(D) includes methods to ensure that physicians and other health care professionals under contract with the entity are qualified to perform the services they provide, and that these qualifications are ensured through appro-

priate credentialing and recredentialing procedures;

''(E) includes policies addressing enrollee rights and responsibilities, including grievance mechanisms and mechanisms to inform enrollees about access to and use of services provided by the entity;

''(F) provides for continuous monitoring of the delivery of health care, including—

''(i) identification of clinical areas to be monitored,

''(ii) use of quality indicators and standards for assessing care delivered, including availability and accessibility of care,

''(iii) monitoring, through use of epidemiological data or chart review, the care of individuals, as appropriate, and patterns of care overall, and

''(iv) implementation of corrective actions; and

''(G) meets any other requirements prescribed by the Secretary after consultation with States.

"(10) INDEPENDENT REVIEW AND QUALITY ASSURANCE.—

"(A) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or primary care case management entity under this subsection shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

"(i) A toll-free telephone number for enrollee questions and grievances.

"(ii) A State-operated enrollee grievance procedure.

"(iii) Periodic notification of enrollees of their rights with respect to such entity or program.

"(iv) Periodic sample reviews of grievances registered with such entity or program or with the State.

"(v) Periodic survey and analysis of enrollee satisfaction with such entity or program.

"(B) STATE MONITORING OF RISK CONTRACTING ENTITIES' QUALITY ASSURANCE PROGRAMS.—A State contracting with a risk contracting entity under this subsection shall peri-

odically review such entity's quality assurance program to ensure that it meets the requirements of paragraph (9).

''(C) EXTERNAL INDEPENDENT REVIEW OF INTERNAL QUALITY ASSURANCE.—A State contracting with a risk contracting entity under this subsection shall provide for annual external independent review (by a utilization control and peer review organization with a contract under section 1153, or another organization unaffiliated with the State government approved by the Secretary) of such entity's internal quality assurance activities. Such independent review shall include—

''(i) review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of inappropriate utilization and treatment,

''(ii) review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine quality trends,

''(iii) review of the entity's internal quality assurance activities, and

''(iv) notification of the entity and the State, and appropriate followup activities, when the review under this subparagraph indicates inappropriate care or treatment.''.

(b) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(A) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a risk contracting entity (as defined in section 1903(m)(1)(B)(i)) responsible for the provision of inpatient hospital services and any other service described in paragraphs (2), (3), (4), (5), and (7) of section 1905(a),

''(ii) with any risk contracting entity (as so defined) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876 and who would'', and

(B) in subparagraph (B), by striking ''organization or'' each place it appears.

(c) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organizations'' and inserting ''risk contracting entities''.

(3) Section 1902(a)(25)(H) of such Act (42 U.S.C. 1396a(a)(25)(H)), as added by section 13622(b)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(4) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking all that precedes ''with the results'' and inserting ''pro-

vide for independent review and quality assurance of entities with contracts under section 1903(m), in accordance with paragraph (10) of such section,''.

(5) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization'' and inserting ''or risk contracting entity''.

(6) Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by sections 13623(a), 13625(a), and 13631(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

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

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

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

''(63) at State option, provide for a primary care case management program in accordance with section 1903(m)(7).''.

(7) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(8) Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(2)(C)(xi)'', and

(B) in paragraph (2)(E), by striking ''health maintenance organization'' and ''the organization'' and inserting ''risk contracting entity'' and ''the entity'', respectively.

(9) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(10) Section 1903(m)(4)(A) of such Act (42 U.S.C. 1396b(m)(4)(A)) is amended—

(A) in the first sentence, by striking ''Each health maintenance organization'' and inserting ''Each risk contracting entity'',

(B) in the first sentence, by striking ''the organization'' each place it appears and inserting ''the entity'', and

(C) in the second sentence, by striking ''an organization'' and ''the organization'' and inserting ''a risk contracting entity'' and ''the risk contracting entity'', respectively.

(11) Section 1903(m)(4)(B) of such Act (42 U.S.C. 1396b(m)(4)(B)) is amended by striking ''organization'' and inserting ''risk contracting entity''.

(12) Section 1903(m)(5) of such Act (42 U.S.C. 1396b(m)(5)) is amended in paragraphs (A)(iii) and (B)(ii) by striking ''organization'' and inserting ''entity''.

(13) Section 1903(o) (42 U.S.C. 1396b(o)), as amended by section 13622(a)(2) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(14) Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking ''health maintenance organizations (and other organizations with contracts under section 1903(m))'' and inserting ''risk contracting entities with contracts under section 1903(m)''.

(15) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting ''(which may be on a prepaid capitation or other risk basis)'' after ''payment'' the first place it appears.

(16) Section 1908(b) of such Act, as added by section 13623(b) of the Omnibus Budget Reconcili-

ation Act of 1993, is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(17) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking ''health maintenance organization'' and inserting ''risk contracting entity''.

(18) Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking ''HMO'' and inserting ''RISK CONTRACTING ENTITY'',

(B) by striking ''health maintenance organization'' and inserting ''risk contracting entity'' each place it appears, and

(C) by striking ''section 1903(m)(1)(A)'' and inserting ''section 1903(m)(1)(B)(i)''.

(19) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations'' and inserting ''risk contracting entities''.

(20) Section 1927 of such Act (42 U.S.C. 1396s) is amended—

(A) in subsection (c)(1)(C)(i), as amended by section 13602(a)(1) of the Omnibus Budget Reconciliation Act of 1993, by striking ''health

maintenance organization'' and inserting ''risk contracting entity'' , and

(B) in subsection (j)(1), by striking ''*** Health Maintenance Organizations, including those organizations'' and inserting ''risk contracting entities''.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1994.

SEC. 1702. PERIOD OF CERTAIN WAIVERS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended by striking ''No waiver'' and all that follows through ''unless the Secretary'' and inserting ''A waiver under this section (other than under subsection (c), (d), or (e)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5 year periods unless the Secretary''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to waivers pursuant to applications which are approved, and with respect to continuations of waivers for which requests are made, later than 30 days after the date of the enactment of this Act.

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 2002. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under this subtitle that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(4) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an in-

dividual for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(6) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a civil action brought in a State or Federal court against a health care provider or health care professional in which the plaintiff alleges a medical malpractice liability claim, but does not in-

clude any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term ''medical malpractice liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services or the use of a medical product.

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or de-

vice which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of

life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(12) PUNITIVE DAMAGES; EXEMPLARY DAMAGES.—The terms ''punitive damages'' and ''exemplary damages'' mean compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

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

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

SEC. 2003. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and section 2017(c), this subtitle shall apply with respect to claims accruing or actions brought on or after the expiration of the 3-year period that begins on the date of the enactment of this Act.

(b) EXCEPTION FOR STATES REQUESTING EARLIER IMPLEMENTATION OF REFORMS.—

(1) APPLICATION.—A State may submit an application to the Secretary requesting the early imple-

mentation of this subtitle with respect to claims or actions brought in the State.

(2) DECISION BY SECRETARY.—The Secretary shall issue a response to a State's application under paragraph (1) not later than 90 days after receiving the application. If the Secretary determines that the State meets the requirements of this subtitle at the time of submitting its application, the Secretary shall approve the State's application, and this subtitle shall apply with respect to actions brought in the State on or after the expiration of the 90-day period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical mal-

practice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 2032(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 2032(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the com-

pletion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

(A) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(B) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) BASIS FOR RECOVERY.—Punitive or exemplary damages shall not be awarded in a medical malpractice liability action unless the claimant es-

tablishes by clear and convincing evidence that the injury suffered was the direct result of conduct manifesting a malicious, wanton, willful, or excessively reckless disregard of the safety of others.

(2) NO AWARD AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

(3) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(A) IN GENERAL.—Any punitive or exemplary damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided.

(B) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services pro-

vided in the State, including (but not limited to)—

(i) licensing or certifying health care professionals and health care providers in the State;

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(C) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subparagraph (A) to supplement and not to replace amounts spent by the State for the activities described in subparagraph (B).

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a de-

fendant may not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) WAIVER.—A court may waive the application of paragraph (1) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a medical malpractice liability claim may not charge, demand, receive, or collect for services rendered in connection with such claim in excess of the following amount recovered by judgment or settlement under such claim:

(A) 25 percent of the first $150,000 (or portion thereof) recovered, plus

(B) 10 percent of any amount in excess of $150,000 recovered.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim

under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action does not exceed the amount of damages awarded to the party under the ADR system by at least 10 percent; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not at least 10 percent less than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the ruling was based on an error of law;

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) REQUIREMENT FOR PERFORMANCE BOND.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to post a performance bond (in such

amount and consisting of such funds and assets as the court determines to be appropriate), except that the court may waive the application of such requirement to a party if the court determines that the posting of such a bond is not necessary to ensure that the party shall meet the requirements of this subsection to pay the opposing party the costs incurred by the opposing party under the action.

(4) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(5) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for pro-

fessional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 2014. JOINT AND SEVERAL LIABILITY.

Except as provided in subsection (b), a defendant may be held severally but not jointly liable in a medical malpractice action. A person found liable for damages in any such action may be found liable, if at all, only for those damages directly attributable to the person's proportionate share of fault or responsibility for the injury, and may not be found liable for damages attributable to the proportionate share of fault or responsibility of any other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

SEC. 2015. STATUTE OF LIMITATIONS.

A medical malpractice liability claim may not be brought after the expiration of the 7-year period that begins on the date the alleged injury that is the subject of the claim occurred. If the commencement of such an action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

A defendant in a medical malpractice liability action may not be found to have acted negligently unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

SEC. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, if the health care professional against whom the claim is brought did not previously treat the individual alleged to have been injured for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care professional unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during

labor or the delivery of a baby pursuant to an agreement with another health care professional.

(c) EFFECTIVE DATE.—This section shall apply with respect to claims accruing or actions brought on or after the expiration of the 2-year period that begins on the date of the enactment of this Act.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

SEC. 2031. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the courts of that State;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a

professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 2 shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1994), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution

system meets the requirements of this part for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 2031.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1994, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 2031(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims

brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year—

(A) the State shall reimburse the United States (at such time and in such manner as the Secretary may require) for the costs incurred by the United States during the year as a result of the application of the system with respect to the State; and

(B) notwithstanding any other provision of law, no funds may be paid to the State (or to any unit of local government in the State) or to any entity in the State pursuant to the Public Health Service Act.

SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 2032(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which

medical malpractice liability claims shall be resolved on a no-fault basis.

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 2041. PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.

(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care practitioner may enter into agreements with State or county professional societies of such type of health care practitioner to permit such societies to participate in the licensing of such health care practitioner, and to review any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner. Any such agreement shall comply with subsection (b).

(b) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under subsection (a) for licensing activities or the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall provide that—

(1) the health care professional society conducts such activities or review as expeditiously as possible;

(2) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

(3) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

(4) no individual affiliated with such society is liable for any damages or injury directly caused by the individual's actions in conducting such activities or review.

(c) AGREEMENTS NOT MANDATORY.—Nothing in this section may be construed to require a State to enter into agreements with societies described in subsection (a) to conduct the activities described in such subsection.

(d) EFFECTIVE DATE.—This section shall take effect 2 years after the date of the enactment of this Act.

SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOLUNTARY SERVICE BY PHYSICIANS.

(a) STUDY.—The Secretary shall conduct a study analyzing the existence and effectiveness of incentives adopted by State and local governments, insurers, medical

societies, and other entities to encourage physicians (whether practicing or retired) to volunteer to provide health care services in medically underserved areas.

(b) REPORTS.—(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit an interim report to Congress on the study conducted under subsection (a), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

(2) Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a final report to the Congress on the study conducted under subsection (a) (taking into account the effects of this subtitle on the incidence and costs of medical malpractice), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PROGRAMS.

(a) REQUIREMENTS FOR PROVIDERS.—Each State shall require each health care professional and health care provider providing services in the State to participate in a risk management program to prevent and provide early

warning of practices which may result in injuries to patients or which otherwise may endanger patient safety.

(b) REQUIREMENTS FOR INSURERS.—Each State shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

(1) establish risk management programs based on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other entities; and

(2) require each such professional or provider, as a condition of maintaining insurance, to participate in one program described in paragraph (1) at least once in each 3-year period.

(c) EFFECTIVE DATE.—This section shall take effect 2 years after the date of the enactment of this Act.

SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.

(a) RESEARCH ON MEDICAL INJURY PREVENTION AND COMPENSATION.

(1) IN GENERAL.—The Secretary shall make grants for the conduct of basic research in the prevention of and compensation for injuries resulting from health care professional or health care provider

malpractice, and research of the outcomes of health care procedures.

(2) PREFERENCE FOR RESEARCH ON CERTAIN ACTIVITIES.—In making grants under paragraph (1), the Secretary shall give preference to applications for grants to conduct research on the behavior of health care providers and health care professionals in carrying out their professional duties and of other participants in systems for compensating individuals injured by medical malpractice, the effects of financial and other incentives on such behavior, the determinants of compensation system outcomes, and the costs and benefits of alternative compensation policy options.

(3) APPLICATION.—The Secretary may not make a grant under paragraph (1) unless an applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary may require.

(b) GRANTS FOR LICENSING AND DISCIPLINARY ACTIVITIES.—

(1) IN GENERAL.—The Secretary shall make grants to States to assist States in improving the State's ability to license and discipline health care professionals.

(2) USES FOR GRANTS.—A State may use a grant awarded under subsection (a) to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States receiving grants under paragraph (1) to assist them in evaluating their medical practice acts and procedures and to encourage the use of efficient and effective early warning systems and other mechanisms for detecting practices which endanger patient safety and for disciplining health care professionals.

(4) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

(1) IN GENERAL.—The Secretary shall make grants to States and to local governments, private nonprofit organizations, and health professional schools (as defined in paragraph (3)) for—

(A) educating the general public about the appropriate use of health care and realistic expectations of medical intervention;

(B) educating the public about the resources and role of health care professional licensing and disciplinary boards in investigating claims of incompetence or health care malpractice; and

(C) developing programs of faculty training and curricula for educating health care professionals in quality assurance, risk management, and medical injury prevention.

(2) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(3) HEALTH PROFESSIONAL SCHOOL DEFINED.—In paragraph (1), the term ''health professional school'' means a school of nursing (as defined in section 853(2) of the Public Health Service Act) or a school or program under section 799(1) of such Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated not more than

$15,000,000 for each of the first 5 fiscal years beginning on or after the date of the enactment of this Act for grants under this section.

Subtitle B—Administrative Cost Savings

PART 1—STANDARDIZATION OF CLAIMS PROCESSING

SEC. 2101. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current taskforces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of the enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of the enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of the enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 2102. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 2101 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic trans-

mission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 2101 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 2101(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in

paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 2101, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall per-

mit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 2103. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 2101;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 2101, then, in the case of any claim for benefits submitted under a health benefit plan more than the minimum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 2102 instead of the standards previously promulgated.

SEC. 2104. HEALTH BENEFIT PLAN DEFINED.

In this subtitle, the term ''health benefit plan'' has the meaning given such term in section 112(6) and includes—

(1) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(2) a State medicaid plan (approved under title XIX of such Act).

PART 2—ELECTRONIC MEDICAL DATA STANDARDS

SEC. 2111. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1994, and January 1, 1995, the Secretary shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 2101.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concern-

ing electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 2115, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 2112. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1996, sub-

ject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 2111(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 2111(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to pro-

vide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the Medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 2113. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or transmission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 2111, described in paragraph (4) or (5) of section 2111(b).

SEC. 2114. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 2111 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 2115. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this part, and

(2) operational concerns about the implementation of such standards under this part.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1994 through 1999 to carry out this section.

PART 3—DEVELOPMENT AND DISTRIBUTION OF COMPARATIVE VALUE INFORMATION

SEC. 2121. STATE COMPARATIVE VALUE INFORMATION PROGRAMS FOR HEALTH CARE PURCHASING.

(a) PURPOSE.—In order to assure the availability of comparative value information to purchasers of health care in each State, the Secretary shall determine whether each State is developing and implementing a health care value information program that meets the criteria and schedule set forth in subsection (b).

(b) CRITERIA AND SCHEDULE FOR STATE PROGRAMS.—The criteria and schedule for a State health care value information program in this subsection shall be specified by the Secretary as follows:

(1) The State begins promptly after enactment of this Act to develop (directly or through contractual or other arrangements with one or more States, coalitions of health insurance purchasers, other entities, or any combination of such arrangements) information systems regarding comparative health values.

(2) The information contained in such systems covers at least the average prices of common health care services (as defined in subsection (d)) and

health insurance plans, and, where available, measures of the variability of these prices within a State or other market areas.

(3) The information described in paragraph (2) is made available within the State beginning not later than one year after the date of the enactment of this Act, and is revised as frequently as reasonably necessary, but at intervals of no greater than one year.

(4) Not later than 6 years after the date of the enactment of this Act the State has developed information systems that provide comparative costs, quality, and outcomes data with respect to health insurance plans and hospitals and made the information broadly available within the relevant market areas.

Nothing in this section shall preclude a State from providing additional information, such as information on prices and benefits of different health benefit plans, available.

(c) GRANTS TO STATES FOR THE DEVELOPMENT OF STATE PROGRAMS.—

(1) GRANT AUTHORITY.—The Secretary may make grants to each State to enable such State to plan the development of its health care value information program and, if necessary, to initiate the implementation of such program. Each State seeking

such a grant shall submit an application therefore, containing such information as the Secretary finds necessary to assure that the State is likely to develop and implement a program in accordance with the criteria and schedule in subsection (b).

(2) OFFSET AUTHORITY.—If, at any time within the 3-year period following the receipt by a State of a grant under this subsection, the Secretary is required by section 2122 to implement a health care information program in the State, the Secretary may recover the amount of the grant under this subsection by offset against any other amount payable to the State under the Social Security Act. The amount of the offset shall be made available (from the appropriation account with respect to which the offset was taken) to the Secretary to carry out such section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to make grants under this subsection, to remain available until expended.

(d) COMMON HEALTH CARE SERVICES DEFINED.—In this section, the term ''common health care services'' includes such procedures as the Secretary may specify and

any additional health care services which a State may wish to include in its comparative value information program.

(e) STATE DEFINED.—In this subtitle, the term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 2122. FEDERAL IMPLEMENTATION.

(a) IN GENERAL.—If the Secretary finds, at any time, that a State has failed to develop or to continue to implement a health care value information program in accordance with the criteria and schedule in section 2121(b), the Secretary shall take the actions necessary, directly or through grants or contract, to implement a comparable program in the State.

(b) FEES.—Fees may be charged by the Secretary for the information materials provided pursuant to a program under this section. Any amounts so collected shall be deposited in the appropriation account from which the Secretary's costs of providing such materials were met, and shall remain available for such purposes until expended.

SEC. 2123. COMPARATIVE VALUE INFORMATION CONCERNING FEDERAL PROGRAMS.

(a) DEVELOPMENT.—The head of each Federal agency with responsibility for the provision of health insurance or of health care services to individuals shall promptly de-

velop health care value information relating to each program that such head administers and covering the same types of data that a State program meeting the criteria of section 2121(b) would provide.

(b) DISSEMINATION OF INFORMATION.—Such information shall be made generally available to States and to providers and consumers of health care services.

SEC. 2124. DEVELOPMENT OF MODEL SYSTEMS.

(a) IN GENERAL.—The Secretary shall, directly or through grant or contract, develop model systems to facilitate—

(1) the gathering of data on health care cost, quality, and outcome described in section 2121(b)(4), and

(2) analyzing such data in a manner that will permit the valid comparison of such data among providers and among health plans.

(b) EXPERIMENTATION.—The Secretary shall support experimentation with different approaches to achieve the objectives of subsection (a) in the most cost effective manner (relative to the accuracy and timeliness of the data secured) and shall evaluate the various methods to determine their relative success.

(c) STANDARDS.—When the Secretary considers it appropriate, the Secretary may establish standards for the

collection and reporting of data on health care cost, quality and outcomes in order to facilitate analysis and comparisons among States and nationally.

(d) REPORT.—By not later than 3 years after the date of the enactment of this Act, the Secretary shall report to the Congress and the States on the models developed, and experiments conducted, under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for each fiscal year beginning with fiscal year 1994 to enable the Secretary to carry out this section, including evaluation of the different approaches tested under subsection (b) and their relative cost effectiveness.

PART 4—ADDITIONAL STANDARDS AND REQUIREMENTS; RESEARCH AND DEMONSTRATIONS

SEC. 2131. STANDARDS RELATING TO USE OF MEDICARE AND MEDICAID MAGNETIZED HEALTH BENEFIT CARDS; SECONDARY PAYOR DATA BANK.

(a) MAGNETIZED IDENTIFICATION CARDS UNDER MEDICARE PROGRAM.—The Secretary shall adopt standards relating to the design and use of magnetized medicare identification cards in order to assist health care providers providing medicare covered services to individuals—

(1) in determining whether individuals are eligible for benefits under the medicare program, and

(2) in billing the medicare program for such services provided to eligible individuals.

Such cards shall be designed to be compatible with machines currently employed to transmit information on credit cards. Such cards also shall be designed to be able to be used with respect to the provision of benefits under medicare supplemental policies.

(b) ADOPTION UNDER MEDICAID PLANS.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to encourage and assist States to design and use magnetized medicaid identification cards that meet such standards, for use under their medicaid plans.

(2) LIMITATION ON MMIS FUNDS.—In applying section 1903(a)(3) of the Social Security Act, the Secretary may determine that Federal financial participation is not available under that section to a State which has provided for a magnetized card system that is inconsistent with the standards adopted under subsection (a).

(c) MEDICARE AND MEDICAID SECONDARY PAYOR DATA BANK.—The Secretary shall establish a medicare and medicaid information system which is designed to pro-

vide information on those group health plans and other health benefit plans that are primary payors to the medicare program and medicaid program under section 1862(b) or section 1905(a)(25) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, a total of $25,000,000 to carry out subsections (a) and (c), including the issuance of magnetized cards to medicare beneficiaries.

SEC. 2132. PREEMPTION OF STATE QUILL PEN LAWS.

(a) IN GENERAL.—Effective January 1, 1994, no effect shall be given to any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic form.

(b) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services may issue regulations to carry out subsection (a). Such regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, with respect to controlled substances, and in such other cases as the Secretary deems appropriate.

SEC. 2133. USE OF STANDARD IDENTIFICATION NUMBERS.

(a) IN GENERAL.—Effective January 1, 1995, each health benefit plan shall—

(1) for each of its beneficiaries that has a social security account number, use that number as the personal identifier for claims processing and related purposes, and

(2) for each provider that has a unique identifier for purposes of title XVIII of the Social Security Act and that furnishes health care items or services to a beneficiary under the plan, use that identifier as the identifier of that provider for claims processing and related purposes.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards established under subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 2134. COORDINATION OF BENEFIT STANDARDS.

(a) REVIEW OF COORDINATION OF BENEFIT PROBLEMS.—Between July 1, 1994, and January 1, 1995, the Secretary shall determine whether problems relating to—

(1) the rules for determining the liability of health benefit plans when benefits are payable under two or more such plans, or

(2) the availability of information among such health benefit plans when benefits are so payable,

cause significant administrative costs.

(b) CONTINGENT PROMULGATION OF STANDARDS.—

(1) IN GENERAL.—If the Secretary determines that such problems do cause significant administrative costs that could be significantly reduced through the implementation of standards, the Secretary shall promulgate standards concerning—

(A) the liability of health benefit plans when benefits are payable under two or more such plans, and

(B) the transfer among health benefit plans of appropriate information (which may include standards for the use of unique identifiers, and for the listing of all individuals covered under a health benefit plan) in determining liability in cases when benefits are payable under two or more such plans.

(2) EFFECTIVE DATE.—The standards promulgated under paragraph (1) shall become effective on a date specified by the Secretary, which date shall be not earlier than one year after the date of promulgation of the standards.

(c) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with standards promulgated under subsection (b) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty

under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the standards established under subsection (b), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such standards with respect to such plans.

(d) REVISION OF STANDARDS.—If the Secretary establishes standards under subsection (b), the Secretary may revise such standards from time to time and such revised standards shall be applied under subsection (c) on or after such date (not earlier than 6 months after the date the revision is promulgated) as the Secretary shall specify.

SEC. 2135. RESEARCH AND DEMONSTRATIONS.

(a) DEMONSTRATIONS AND RESEARCH ON MONITORING AND IMPROVING PATIENT CARE.—

(1) The Secretary shall provide grants to qualified entities to demonstrate (and conduct research

concerning) the application of comprehensive information systems—

(A) in continuously monitoring patient care, and

(B) in improving patient care.

(2) To make grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $10,000,000 for each fiscal year (beginning with fiscal year 1994 and ending with fiscal year 1998).

(b) COMMUNICATION LINKS.—

(1) The Secretary may make grants to at least two, but not more than five, community organizations, or coalitions of health care providers, health benefit plans, and purchasers, to establish and document the efficacy of communication links between the information systems of health benefit plans and of health care providers.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(c) REGIONAL OR COMMUNITY BASED CLINICAL INFORMATION SYSTEMS.—

(1) The Secretary may make grants to at least two, but not more than five, public or private non-profit entities for the development of regional or community-based clinical information systems.

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

(d) AMBULATORY CARE DATA SETS.—

(1) The Secretary may make grants to public or private non-profit entities to develop and test, for electronic medical data generated by physicians and other entities (other than hospitals) that provide health care services—

(A) the definition of a comprehensive set of data elements, and

(B) the specification of, and manner of presentation of, the individual data elements of the set under subparagraph (A).

(2) To make grants under this subsection, there are authorized to be appropriated such sums as may be necessary for fiscal year 1994, to remain available until expended.

Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts

SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM GROSS INCOME FOR COST OF CATASTROPHIC HEALTH PLAN.

(a) IN GENERAL.—Subsection (a) of section 62 of the Internal Revenue Code of 1986, as amended by title I, is amended by inserting after paragraph (16) the following new paragraph:

''(17) MEDICAL EXPENSES ATTRIBUTABLE TO CATASTROPHIC HEALTH PLAN COVERAGE.—

''(A) IN GENERAL.—The deduction allowed by section 213 to the extent attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to coverage of an individual who has coverage described in section 220(c)(1)(B)(i).''.

(b) COORDINATION WITH DEDUCTION FOR OTHER MEDICAL EXPENSES.—Subsection (a) of section 213 of such Code is amended to read as follows:

''(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the tax-

able year, not compensated by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152) in an amount equal to the sum of—

''(1) the portion of such expenses attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)), and

''(2) the excess of such expenses (other than expenses described in paragraph (1)) over 7.5 percent of the adjusted gross income of the taxpayer.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 2202. MEDICAL SAVINGS ACCOUNTS.

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

''SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction the applicable percentage of the amounts paid in cash during the taxable year by or on behalf of such indi-

vidual to a medical savings account for the benefit of such individual and (if any) such individual's spouse and dependents if such spouse and dependents are eligible individuals.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

''(A) 25 percent for taxable years beginning in 1994 or 1995,

''(B) 50 percent for taxable years beginning in 1996 or 1997, and

''(C) 100 percent for taxable years beginning after 1997.

''(b) LIMITATIONS.—

''(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by this Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent of such individual or spouse if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

''(2) DOLLAR LIMITATION.—The amount allowable as a deduction under subsection (a) for the taxable year shall not exceed the lesser of—

''(A) the lowest deductible under any catastrophic health plan providing coverage to any beneficiary of the medical savings account, or

''(B)(i) $2,500, or

''(ii) $5,000 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual.

A beneficiary of such account who has attained age 65 before the close of the taxable year shall not be taken into account in determining the limitation under the preceding sentence.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means any individual who is covered under a catastrophic health plan throughout the calendar year in which or with which the taxable year ends.

''(B) LIMITATIONS.—Such term does not include—

''(i) an individual who is 65 years of age or older, unless the individual is covered under a catastrophic health plan that is a primary plan (within the meaning of

section 1862(b)(2)(A) of the Social Security Act); and

''(ii) an individual who has coverage under a group health plan or health insurance plan (other than a plan described in 1107(4)(B) of the Affordable Health Care Now Act of 1993) that has either a deductible that is less than the minimum deductible required under a catastrophic health plan (as defined in paragraph (2)) or has an actuarial value that is greater than the value for MedAccess catastrophic coverage (as provided in section 1102(d) of such Act).

''(C) DEDUCTION NOT ALLOWED BEFORE 1999 TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—In the case of any taxable year beginning before January 1, 1999, such term does not include an individual—

''(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

"(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

The rules of subparagraphs (B) and (C) of section 213(f)(3) shall apply for purposes of this preceding sentence.

"(2) CATASTROPHIC HEALTH PLAN.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The term 'catastrophic health plan' means a health plan covering specified expenses incurred by an individual for medical care for such individual and the spouse and dependents (as defined in section 152) of such individual only to the extent such expenses covered by the plan for any calendar year exceed $1,800 ($3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

"(B) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1994, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(d) MEDICAL SAVINGS ACCOUNTS.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—

"(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the medical expenses of the beneficiaries of such trust, but only if the written governing instrument creating the trust meets the following requirements:

"(i) Except in the case of a rollover contribution described in subsection (e)(4), no contribution will be accepted unless it is in cash, and contributions will not be accepted in excess of the amount allowed as a deduction under this section for the taxable year (or would be allowed as such a deduction but for subsection (c)(1)(C)).

''(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(iii) No part of the trust assets will be invested in life insurance contracts.

''(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(v) The interest of an individual in the balance in his account is nonforfeitable.

''(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

''(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—For purposes of this section, an account held by an insurance company in the United States

shall be treated as a medical savings account (and such company shall be treated as a bank) if—

''(i) such account is part of a health insurance plan that includes a catastrophic health plan (as defined in subsection (c)(2)),

''(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such catastrophic health plan, and

''(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

''(2) MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for—

''(i) medical care (as defined in section 213), or

''(ii) long-term care (as defined in paragraph (3)),

for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan.

''(ii) EXCEPTION.—Clause (i) shall not apply—

''(I) in the case of coverage of an individual under 65 years of age under a catastrophic health plan or under a long-term care insurance plan, or

''(II) in the case of coverage of an individual 65 years of age or older under a medicare supplemental policy or under a long-term care insurance plan or for payment of premiums under part A or part B of title XVIII of the Social Security Act.

''(3) LONG-TERM CARE.—

"(A) IN GENERAL.—The term 'long-term care' means diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services which are required by, and provided to, a chronically ill individual, which have as their primary purpose the direct provision of needed assistance with 1 or more activities of daily living (or the alleviation of the conditions necessitating such assistance) that the individual is certified under subparagraph (B) as being unable to perform, and which are provided in a setting other than an acute care unit of a hospital pursuant to a continuing plan of care prescribed by a physician or registered professional nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the maintenance of a household or participation in community life, such as case management, transportation or legal services, or the performance of home maintenance or household chores.

"(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' means an individual who is certified by a physician or registered professional nurse as being unable to

perform at least 3 activities of daily living without substantial assistance from another individual. For purposes of this paragraph, the term 'activities of daily living' means bathing, dressing, eating, toileting, transferring, and walking.

''(4) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the medical expenses of such individual.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the

amount allowable as a deduction under subsection (a) if—

"(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

"(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used to pay the medical expenses of the individual for whose benefit the account was established shall be increased by 10 percent of the amount of such payment or distribution which is includible in gross income under paragraph (1).

"(B) ACCOUNT BALANCE LIMITATION.—If—

"(i) the tax imposed by this chapter is required to be increased under subparagraph (A) by reason of a distribution, and

"(ii) after such distribution, the aggregate balance of all medical savings accounts established for the benefit of the individual, is less than the amount of the deductible under the catastrophic health plan covering such individual,

subparagraph (A) shall be applied by substituting '50 percent' for '10 percent'.

"(4) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which he received the payment or distribution.

"(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

"(A) IN GENERAL.—If during any taxable year—

"(i) there is a payment of a mandatory distribution expense incurred by a beneficiary of a medical savings account, and

"(ii) the person making such payment is not reimbursed for such payment with a distribution from such account before the 60th day after such payment,

the taxpayer's tax imposed by this chapter for such taxable year shall be increased by 100 percent of the excess of the amount of such payment over the amount of reimbursement made before such 60th day.

"(B) MANDATORY DISTRIBUTION EXPENSE.—For purposes of subparagraph (A), the term 'mandatory distribution expense' means—

"(i) any expense incurred which may be counted towards a deductible, or for a copayment or coinsurance, under the catastrophic health plan covering such beneficiary, and

"(ii) in the case of a beneficiary who has attained age 65, any expense for coverage described in subsection (d)(2)(B)(ii)(II) and any expense incurred which may be counted toward a deductible, or for a copayment or coinsurance, under title XVIII of the Social Security Act.

"(f) TAX TREATMENT OF ACCOUNTS.—

"(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay medical expenses.

"(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer

the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new paragraph:

''(18) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) DISTRIBUTIONS FROM MEDICAL SAVINGS ACCOUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 of such Code is amended by adding at the end thereof the following new subsection:

''(g) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the distributions from any medical savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for medical care.''

(d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT TAXES.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of such Code is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is rea-

sonable to believe that a corresponding deduction is allowable under section 220.''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

''(10) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) con-

tracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)),'',

(3) by striking ''or'' at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross income under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(e)(2) applies shall be treated as an amount not contributed.''

(f) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 220(d)'' in subsection (e)(1) after ''described in section 408(a)''.

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(h) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.
''Sec. 221. Cross reference.''

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting ''or on medical savings accounts'' after ''annuities'' in the item relating to section 6693.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

Subtitle D—Anti-Fraud

PART 1—CRIMINAL PROSECUTION OF HEALTH CARE FRAUD

SEC. 2301. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) OFFENSE.—Whoever, being a health care provider, knowingly engages in any scheme or artifice to defraud any person in connection with the provision of health care shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) DEFINITION.—In this section, the term 'health care provider' means—

''(1) a physician, nurse, dentist, therapist, pharmacist, or other professional provider of health care; and

''(2) a hospital, health maintenance organization, pharmacy, laboratory, clinic, or other health care facility or a provider of medical services, medical devices, medical equipment, or other medical supplies.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States

Code, is amended by adding at the end the following new item:

''1347. Health care fraud.''.

SEC. 2302. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting ''or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier,'' after ''Postal Service,''; and

(2) by inserting ''or such carrier'' after ''causes to be delivered by mail''.

SEC. 2303. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for the purposes of carrying out the purposes of this part and the amendments made by this part—

(1) such sums as may be necessary for the Federal Bureau of Investigation to hire, equip, and train no fewer than 225 special agents and support staff to investigate health-care fraud cases;

(2) such sums as may be necessary to hire, equip, and train no fewer than 50 assistant United States Attorneys and support staff to prosecute health-care fraud cases; and

(3) such sums as may be necessary to hire, equip, and train no fewer than 25 investigators in the Office of Inspector General, Department of Health and Human Services, to be devoted exclusively to health-care fraud cases.

SEC. 2304. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1101.

''(2) A person is not eligible for a payment under paragraph (1) if—

''(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

''(B) the person knowingly participated in the offense;

''(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

''(i) in a criminal, civil, or administrative proceeding;

''(ii) in a congressional, administrative or General Accounting Office report, hearing, audit, or investigation; or

''(iii) by the news media, unless the person is the original source of the information; or

''(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

''(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

''(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.''.

PART 2—COORDINATION OF HEALTH CARE ANTI-FRAUD AND ABUSE ACTIVITIES

SEC. 2311. ESTABLISHMENT OF ALL-PAYER ANTI-FRAUD AND ABUSE PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1995, the Secretary shall establish in the Office of the Inspector General of the Department of Health and Human Services a program—

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

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program established under subsection (a), the Secretary shall consult with, and arrange for the sharing of data and resources with the Attorney General, State law enforcement agencies, State

medicaid fraud and abuse units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Secretary shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

(1) IN GENERAL.—The Secretary shall by regulation establish standards to carry out the program under subsection (a).

(2) INFORMATION STANDARDS.—

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

(B) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner

that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Secretary under the program under this section, with respect to the Secretary's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

(e) ENSURING ACCESS TO DOCUMENTATION.—

(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services is authorized to exercise the authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (relating to subpoenas and administration of oaths) with respect to the activities under the all-payor fraud and abuse control program established under this section to the same extent as such Inspector General may exercise such authorities

to perform the functions assigned to such official by such Act.

(2) FAILURE TO COMPLY AS GROUNDS FOR EXCLUSION FROM MEDICARE AND MEDICAID PROGRAMS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) FAILURE TO SUPPLY REQUESTED INFORMATION TO THE INSPECTOR GENERAL.—Any individual or entity that fails fully and accurately to provide, upon request of the Inspector General of the Department of Health and Human Services, records, documents, and other information necessary for the purposes of carrying out activities under the all-payor fraud and abuse control program established under section 2311 of the Affordable Health Care Now Act of 1993.''.

SEC. 2312. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

(a) IN GENERAL.—In addition to any other amounts authorized to be appropriated to the Secretary of Health and Human Services for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be ap-

propriated additional amounts described in subsection (b) to enable the Secretary to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 2311 in a fiscal year.

(b) AMOUNTS DESCRIBED.—The amounts referred to in subsection (a) are as follows:

(1) For fiscal year 1995, $100,000,000.

(2) For each of the fiscal years 1996 through 1998, such sums as may be necessary to assist the Secretary in carrying out the program established under section 2311 for such a fiscal year.

SEC. 2313. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Anti-Fraud and Abuse Trust Fund'' (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this subtitle and section 1128A(f)(3) of the Social Security Act.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund, or any activity financed through the Trust Fund.

(b) MANAGEMENT.—

(1) IN GENERAL.—The Trust Fund shall be managed by the Secretary through a Managing Trustee designated by the Secretary.

(2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the trustee's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obliga-

tions issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Trustee determines that the purchase of such other obligations is in the public interest.

(3) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt

obligations may be redeemed at par plus accrued interest.

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

(5) The receipts and disbursements of the Secretary in the discharge of the functions of the Secretary shall not be included in the totals of the budget of the United States Government. For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Secretary and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(c) USE OF FUNDS.—Amounts in the Trust Fund shall be used to assist the Inspector General of the Department of Health and Human Services in carrying out the all-payor fraud and abuse control program established under section 2311(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–

7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 2313(a) of the Affordable Health Care Now Act of 1993''.

(e) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a–7a(f)) is amended in the matter preceding paragraph (1) by striking ''Secretary and disposed of as follows:'' and inserting the following: ''Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:''.

SEC. 2314. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH BENEFIT PLAN.

(a) CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In subsection (a)(1), in the matter before subparagraph (A), by inserting ''or of any health benefit plan,'' after ''subsection (i)(1)),''.

(2) In subsection (b)(1)(A), by inserting ''or under a health benefit plan'' after ''title XIX''.

(3) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a health benefit plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan.''.

(4) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health benefit plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health benefit plan'' after ''or XX''.

(b) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by adding at the end the following: ''OR HEALTH BENEFIT PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health benefit plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health benefit plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health benefit plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

(E) In subsection (b)(1), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health benefit plan''.

(F) In subsection (b)(2), by striking ''title XVIII or a State health care program'' each

place it appears and inserting ''title XVIII, a State health care program, or a health benefit plan''.

(G) In subsection (b)(3), by striking ''title XVIII or a State health care program'' each place it appears in subparagraphs (A) and (C) and inserting ''title XVIII, a State health care program, or a health benefit plan''.

(H) In subsection (d)(2)—

(i) by striking ''title XIX,'' and inserting ''title XIX or under a health benefit plan,'', and

(ii) by striking ''State plan,'' and inserting ''State plan or the health benefit plan,''.

(2) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(f) In addition to the fines that may be imposed under subsection (a), (b), or (c), any individual found to have violated the provisions of any of such subsections may be subject to treble damages.''.

(3) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42

U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

''(g) The Secretary shall—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(c) HEALTH BENEFIT PLAN DEFINED.—Section 1128 of such Act (42 U.S.C. 1320a–7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

''(i) HEALTH BENEFIT PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health benefit plan' means a health benefit program other than the medicare program, the medicaid program, or a State health care program.''.

(d) CONFORMING AMENDMENT.—Section 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a–7(b)(8)(B)(ii)) is amended by striking ''1128A'' and in-

serting ''1128A (other than a penalty arising from a health benefit plan, as defined in subsection (i))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1995.

Subtitle E—Medicare Payment Changes; Part B Premium Tax for High-Income Individuals

PART 1—MEDICARE PAYMENT CHANGES

SEC. 2401. ELIMINATION OF MEMBERSHIP LIMITATION FOR MEDICARE HMOS.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by striking subsection (f).

(b) CONFORMING AMENDMENTS.—Such section is further amended—

(1) in subsection (c)(3)(A)(i), by striking ''in failure to meet the requirements of subsection (f) or would result'', and

(2) in subsection (i)(1)(C), by striking ''(e), and (f)'' and inserting ''and (e)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 2402. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as ''OBRA–1990'') is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA–1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition

and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except

in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

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

''(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

''(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such

individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I)'', and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

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

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall

be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1994 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1994 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Janu-

ary 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2403. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) including over a 5-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

PART 2—PART B PREMIUM TAX FOR HIGH-INCOME INDIVIDUALS

SEC. 2411. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

"PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

"SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

''(b) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for any taxable year if—

''(1) such individual is covered under Medicare part B for any month during such year, and

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

"(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

"(1) IN GENERAL.—The Medicare part B premium tax for any month is ⅔ the amount equal to the excess of—

"(A) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

"(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

"(2) PHASEIN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by less than $50,000, the Medicare part B premium tax for any month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to $50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $100,000,

"(B) $125,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married at the close of the taxable year but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for

the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1993 in taxable years ending after December 31, 1993.

Subtitle F—Removing Anti-Trust Impediments

SEC. 2501. ESTABLISHMENT OF LIMITED EXEMPTION PROGRAM FOR HEALTH CARE JOINT VENTURES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Attorney General, after consultation with the Secretary of Health and Human Services and the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care, shall promulgate specific guidelines under which a health care joint venture may submit an application requesting that the At-

torney General provide the entities participating in the joint venture with an exemption under which (notwithstanding any other provision of law)—

(A) monetary recovery on a claim under the antitrust laws shall be limited to actual damages if the claim results from conduct within the scope of the joint venture that occurs while the exemption is in effect; and

(B) the conduct of the entity in making or performing a contract to carry out the joint venture shall not be deemed illegal per se under the antitrust laws but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including (but not limited to) effects on competition in properly defined, relevant research, development, product, process, and service markets (taking into consideration worldwide capacity to the extent that it may be appropriate in the circumstances).

(2) DEADLINE FOR RESPONSE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall approve or disapprove the application of a health care joint venture for an exemption under this subsection not later than 30

days after the Attorney General receives the joint venture's application.

(3) PROVIDING REASONS FOR DISAPPROVAL.—If the Attorney General disapproves the application of a health care joint venture for an exemption under this subsection, the Attorney General shall provide the joint venture with a statement explaining the reasons for the Attorney General's disapproval.

(b) REQUIREMENTS FOR APPROVAL.—For purposes of subsection (a), the Attorney General shall approve the application of a health care joint venture for an exemption under subsection (a) if an entity participating in the joint venture submits to the Attorney General an application not later than 30 days after the entity has entered into a written agreement to participate in the joint venture (or not later than 30 days after the date of the enactment of this Act in the case of a joint venture in effect as of such date) that contains the following information and assurances:

(1) The identities of the parties to the joint venture.

(2) The nature, objectives, and planned activities of the joint venture.

(3) Assurances that the entities participating in the joint venture shall notify the Attorney General

of any changes in the information described in paragraphs (1) and (2) during the period for which the exemption is in effect.

(c) REVOCATION OF EXEMPTION.—

(1) IN GENERAL.—The Attorney General, after consultation with the Secretary, may revoke an exemption provided to a health care joint venture under this section if, at any time during which the exemption is in effect, the Attorney General finds that the joint venture no longer meets the applicable requirements for approval under subsection (b), except that the Attorney General may not revoke such an exemption if the failure of the health care joint venture to meet such requirements is merely technical in nature.

(2) TIMING.—The revocation of an exemption under paragraph (1) shall apply only to conduct of the health care joint venture occurring after the exemption is no longer in effect.

(d) WITHDRAWAL OF APPLICATION.—Any party that submits an application under this section may withdraw such application at any time before the Attorney General's response to the application.

(e) REQUIREMENTS RELATING TO NOTICE AND PUBLICATION OF EXEMPTIONS AND RELATED INFORMATION.—

(1) PUBLICATION OF APPROVED APPLICATIONS FOR EXEMPTIONS IN FEDERAL REGISTER.—

(A) IN GENERAL.—With respect to each exemption for a health care joint venture provided under subsection (a), the Attorney General (acting jointly with the Secretary) shall—

(i) prepare a notice with respect to the joint venture that identifies the parties to the venture and that describes the planned activities of the venture;

(ii) submit the notice to the entities participating in the joint venture; and

(iii) after submitting the notice to such entities (but not later than 30 days after approving the application for the exemption for the joint venture), publish the notice in the Federal Register.

(B) EFFECT OF PUBLICATION.—An exemption provided by the Attorney General under subsection (a) shall take effect as of the date of the publication in the Federal Register

of the notice with respect to the exemption pursuant to subparagraph (A).

(2) WAIVER OF DISCLOSURE REQUIREMENTS FOR INFORMATION RELATING TO APPLICATIONS FOR EXEMPTIONS.—

(A) IN GENERAL.—All information and documentary material submitted as part of an application of a health care joint venture for an exemption under subsection (a), together with any other information obtained by the Attorney General, the Secretary, or the Advisory Committee in the course of any investigation, administrative proceeding, or case with respect to a potential violation of the antitrust laws by the joint venture with respect to which the exemption applies, shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or administrative proceeding in which such information and material is subject to any protective order.

(B) EXCEPTION FOR INFORMATION INCLUDED IN FEDERAL REGISTER NOTICE.—Subparagraph (A) shall not apply with respect to information contained in a notice published in the Federal Register pursuant to paragraph (1).

(3) USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the fact of disclosure of conduct under an application for an exemption under subsection (a) and the fact of publication of a notice in the Federal Register under paragraph (1) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections provided by an exemption granted under subsection (a).

(B) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for an exemption under subsection (a), or revokes an exemption under such section, neither the negative determination nor the statement of reasons therefor shall be admissible into evidence in any admin-

istrative or judicial proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 2502. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall issue in accordance with this section a certificate of public advantage to each eligible health care joint venture that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such venture, and the parties to such venture, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such venture if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

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

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

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

(2) FACTORS TO BE CONSIDERED.—

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

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

(ii) to increase access to health care,

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

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

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

(vi) to reduce inefficient health care resource duplication.

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

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

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

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

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly

by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care joint venture (in the case of a venture in existence as of the time of the application) and implementation plan for the joint venture.

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

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

(2) an agreement that the venture will submit to the Attorney General annually a report that de-

scribes the operations of the venture and information regarding the impact of the venture on health care and on competition in health care, and

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

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

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

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an applica-

tion for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

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

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

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney

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

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

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

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

SEC. 2503. INTERAGENCY ADVISORY COMMITTEE ON COMPETITION, ANTITRUST POLICY, AND HEALTH CARE.

(a) ESTABLISHMENT.—There is hereby established the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. The Advisory Committee shall be composed of—

(1) the Secretary of Health and Human Services (or the designee of the Secretary);

(2) the Attorney General (or the designee of the Attorney General);

(3) the Director of the Office of Management and Budget (or the designee of the Director); and

(4) a representative of the Federal Trade Commission.

(b) DUTIES.—The duties of the Advisory Committee are—

(1) to discuss and evaluate competition and antitrust policy, and their implications with respect to the performance of health care markets;

(2) to analyze the effectiveness of health care joint ventures receiving exemptions under the program established under section 2501(a) or certificates under section 2502 in reducing the costs of and expanding access to the health care services that are the subject of such ventures; and

(3) to make such recommendations to Congress not later than 2 years after the date of the enactment of this Act (and at such subsequent periods as the Advisory Committee considers appropriate) regarding modifications to the program established under section 2501(a) or to section 2502 as the Ad-

visory Committee considers appropriate, including modifications relating to the costs to health care providers of obtaining an exemption for a joint venture under such program.

SEC. 2504. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''Advisory Committee'' means the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care established under section 2503.

(2) The term ''antitrust laws''—

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

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

(3) The term ''certificate'' means a certificate of public advantage authorized to be issued under section 2502(a).

(4) The term ''health care joint venture'' means an agreement (whether existing or proposed) between 2 or more providers of health care services

that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

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

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

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

(8) The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities

PART 1—APPLICATION OF THE CLAYTON ACT TO MEDICAL SELF-REGULATORY ENTITIES

SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES.

(a) IN GENERAL.—(1) Except as provided in paragraph (2), no damages, interest on damages, cost of suit, or attorney's fee may be recovered under section 4, 4A, or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or under any State law similar to such section, from any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in standard setting or enforcement activities that are—

(A) designed to promote the quality of health care provided to patients, and

(B) not conducted for purposes of financial gain.

(2) Paragraph (1) shall not prohibit the recovery of actual damages, interest on damages, the cost of suit, or a reasonable attorney's fee under section 4 or 4A of the Clayton Act (15 U.S.C. 15, 15a), or under any State law

similar to such section, by a State or the United States from a medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) for injury sustained as a result of engaging in the conduct described in such paragraph.

(b) FEES.—In any action under section 4, 4C, or 16 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a similar State law, brought against any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in conduct described in subsection (a)(1), the court shall award the cost of suit, including a reasonable attorney's fee, to a substantially prevailing defendant.

SEC. 2602. DEFINITIONS.

For purposes of this subtitle:

(1) The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff.

(2) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the quality of health care provided by a medical professional.

PART 2—CONSULTATION BY FEDERAL AGENCIES

SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGULATORY ENTITIES RESPECTING MEDICAL PROFESSIONAL GUIDELINES AND STANDARDS.

Any Federal agency engaged in the establishment of medical professional standards shall consult with appropriate medical societies or associations, specialty boards, or recognized accrediting agencies, if available, in carrying out medical professional standard setting and guidelines or standards relating to the practice of medicine.

Subtitle H—Prefunding Government Health Benefits for Certain Annuitants

SEC. 2701. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term ''agency'' means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term ''health benefits plan'' means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term ''health-benefits coverage'' means coverage under a health benefits plan'';

(4) an individual shall be considered to be an ''annuitant of an agency'' if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term ''Office'' means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a ''pay-as-you-go'' basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

Subtitle I—Miscellaneous Provisions

SEC. 2801. INCREASE IN MINIMUM AGE REQUIRED IN ORDER TO BE ELIGIBLE FOR AN IMMEDIATE CIVIL SERVICE ANNUITY.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) WITH 30 YEARS OF SERVICE.—Section 8336(a) of title 5, United States Code, is amended to read as follows:

"(a)(1) An employee who is separated from the service after attaining the minimum retirement age under paragraph (2) and completing 30 years of service is entitled to an annuity.

"(2) The minimum retirement age under this paragraph is—

"(A) for an individual whose date of birth is before January 1, 1939, 55 years of age; and

"(B) for an individual whose date of birth is after December 31, 1938, and before January 1, 1942, 58 years of age.

"(3) The preceding provisions of this subsection shall not apply with respect to any individual whose date of birth is after December 31, 1941.".

(2) WITH 20 YEARS OF SERVICE.—Section 8336(b) of title 5, United States Code, is amended to read as follows:

"(b)(1) An employee who is separated from the service after attaining the minimum retirement age under paragraph (2) and completing 20 years of service is entitled to an annuity.

"(2) The minimum retirement age under this paragraph is, for an individual whose date of birth is before January 1, 1935, 60 years of age.

''(3) The preceding provisions of this subsection shall not apply with respect to any individual whose date of birth is after December 31, 1934.''.

(3) MEMBERS OF CONGRESS.—Section 8336(g) of title 5, United States Code, is amended—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and by striking ''(g)'' and inserting ''(g)(1)'';

(B) in the first sentence by striking ''becoming 60 years of age'' and inserting ''satisfying the requirements of paragraph (2)'';

(C) in the second sentence by striking ''becoming 55 years of age (but before becoming 60 years of age)'' and inserting ''satisfying the requirements of paragraph (3)''; and

(D) by adding at the end the following:

''(2) A Member shall be considered to satisfy the requirements of this paragraph if such Member has attained the minimum retirement age which would apply to such Member under section 8336(b), except that such requirements shall not be considered satisfied by any Member described in section 8336(b)(3).

''(3) A Member shall be considered to satisfy the requirements of this paragraph if such Member—

''(A) has attained the minimum retirement age which would apply to such Member under section 8336(a), but

''(B) has not attained the minimum retirement age which would apply to such Member under section 8336(b),

except that such requirements shall not be considered satisfied by any Member described in section 8336(b)(3).''.

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(1) WITH 20 YEARS OF SERVICE.—Section 8412(b) of title 5, United States Code, is amended to read as follows:

''(b)(1) An employee or Member who is separated from the service after attaining the minimum retirement age under paragraph (2) and completing 20 years of service is entitled to an annuity.

''(2) The minimum retirement age under this paragraph is, for an individual whose date of birth is before January 1, 1935, 60 years of age.

''(3) The preceding provisions of this subsection shall not apply with respect to any individual whose date of birth is after December 31, 1934.''.

(2) WITH 30 YEARS OF SERVICE.—Section 8412(h) of title 5, United States Code, is amended to read as follows:

''(h)(1) The applicable minimum retirement age under this subsection is—

''(A) for an individual whose date of birth is before January 1, 1939, 55 years of age; and

''(B) for an individual whose date of birth is after December 31, 1938, and before January 1, 1948, 58 years of age.

''(2) Nothing in paragraph (1) shall be considered to apply with respect to any individual whose date of birth is after December 31, 1947.''.

(c) CONFORMING AMENDMENT.—Section 8442(c)(2)(B)(i)(I) of title 5, United States Code, is amended by striking ''age 60'' and inserting ''the minimum retirement age under section 8412(b)''.

(d) CONFORMANCE OF THE RETIREMENT SYSTEMS RELATING TO THE FOREIGN SERVICE AND THE CENTRAL INTELLIGENCE AGENCY.—

(1) FOREIGN SERVICE.—The President shall, in accordance with applicable provisions of section 827 of the Foreign Service Act of 1980 (22 U.S.C. 4067), provide that the Foreign Service Retirement and Disability System and the Foreign Service Pension System are conformed to reflect the amendments made by this section.

(2) CENTRAL INTELLIGENCE AGENCY.—The President shall, using the authority available to him under section 292 of the Central Intelligence Agency Retirement Act, as set forth in section 802 of the CIARDS Technical Corrections Act of 1992 (Public Law 102–496; 106 Stat. 3241), provide that the Central Intelligence Agency Retirement and Disability System shall be conformed to reflect the amendments made by this section.

(e) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect on January 1, 1994, and shall apply with respect to annuities based on the service of any individual separating on or after that date.

TITLE III—LONG-TERM CARE

Subtitle A—Tax Treatment of Long-term Care Insurance

SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this part, a long-term care insurance contract shall be treated as an accident or health insurance contract.

''(b) LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

''(B) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

''(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(D) such contract is guaranteed renewable,

''(E) such contract does not have any cash surrender value, and

"(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

"(2) SPECIAL RULES.—

"(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

"(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

"(A) are required by a chronically ill individual in a qualified facility, and

"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"(2) CHRONICALLY ILL INDIVIDUAL.—

"(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

"(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

"(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

"(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

"(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

"(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

"(i) which is licensed under State law, or

"(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

"(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

"(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

"(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy continuation coverage requirements of group health plans) applies.

"(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

"(1) IN GENERAL.—In the case of a calendar year after 1994, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost ad-

justment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1993."

(b) CLERICAL AMENDMENT.—The table of sections for such subpart E is amended by inserting after the item relating to section 818 the following new item:

"Sec. 818A. Treatment of long-term care insurance or plans."

SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE; INCLUSION OF EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking "and" at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting ", and", and by inserting after paragraph (4) the following new paragraph:

"(6) benefits under a long-term care insurance contract (as defined in section 818A(b))."

(b) INCLUSION OF EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end thereof the following sentence:

''The preceding sentence shall not apply to any plan providing coverage for long-term care services.''

SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 818A(c)), or''.

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses.''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2)(A) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

''In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	$200
More than 40 but not more than 50	375

More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

"(B) INDEXING.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(II) such component for August of 1991."

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 3004. CERTAIN EXCHANGES OF LIFE INSURANCE CONTRACTS FOR LONG-TERM CARE INSURANCE CONTRACTS NOT TAXABLE.

Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end thereof the following new paragraph:

''(4) a contract of life insurance or an endowment or annuity contract for a long-term care insurance contract (as defined in section 818A).''

SEC. 3005. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS OR 401(k) PLANS FOR LONG-TERM CARE INSURANCE.

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

"SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS AND SECTION 401(k) PLANS FOR LONG-TERM CARE INSURANCE.

''(a) GENERAL RULE.—The amount includible in the gross income of an individual for the taxable year by reason of qualified distributions during such taxable year shall not exceed the excess of—

''(1) the amount which would (but for this section) be so includible by reason of such distributions, over

''(2) the aggregate premiums paid by such individual during such taxable year for any long-term care insurance contract (as defined in section 818A) for the benefit of such individual or the spouse of such individual.

''(b) QUALIFIED DISTRIBUTION.—For purposes of this section, the term 'qualified distribution' means any

distribution to an individual from an individual retirement account or a section 401(k) plan if such individual has attained age 59½ on or before the date of the distribution (and, in the case of a distribution used to pay premiums for the benefit of the spouse of such individual, such spouse has attained age 59½ on or before the date of the distribution).

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIVIDUAL RETIREMENT ACCOUNT.—The term 'individual retirement account' has the meaning given such term by section 408(a).

''(2) SECTION 401(k) PLAN.—The term 'section 401(k) plan' means any employer plan which meets the requirements of section 401(a) and which includes a qualified cash or deferred arrangement (as defined in section 401(k)).

''(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

''(1) WITHDRAWALS CANNOT EXCEED ELECTIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR DEFERRED ARRANGEMENT.—This section shall not apply to any distribution from a section 401(k) plan to the extent the aggregate amount of such distributions for the use described in subsection (a) exceeds the aggregate employer contributions made pursuant to the employee's election under section 401(k)(2).

''(2) WITHDRAWALS NOT TO CAUSE DISQUALIFICATION.—A plan shall not be treated as failing to satisfy the requirements of section 401, and an arrangement shall not be treated as failing to be a qualified cash or deferred arrangement (as defined in section 401(k)(2)), merely because under the plan or arrangement distributions are permitted which are excludable from gross income by reason of this section.''

(b) CONFORMING AMENDMENTS.—

(1) Section 401(k) of such Code is amended by adding at the end the following new paragraph:

''(11) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals for payment of long-term care premiums, see section 137."

(2) Section 408(d) of such Code is amended by adding at the end the following new paragraph:

''(8) CROSS REFERENCE.—

"For provision permitting tax-free withdrawals from individual retirement accounts for payment of long-term care premiums, see section 137."

(3) The table of sections for such part III is amended by striking the last item and inserting the following new items:

''Sec. 137. Distributions from individual retirement accounts and section 401(k) plans for long-term care insurance.
''Sec. 138. Cross references to other Acts.''

SEC. 3006. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

Section 101 of the Internal Revenue Code of 1986 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount paid or advanced to an individual under a life insurance contract on the life of an insured—

''(A) who is a terminally ill individual, or

''(B) who is a chronically ill individual (as defined in section 818A(c)(2)) who is confined to a qualified facility (as defined in section 818A(c)(3)(A)),

shall be treated as an amount paid by reason of the death of such insured.

''(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

"(3) PHYSICIAN.—For purposes of this subsection, the term 'physician' has the meaning given to such term by section 213(d)(4)."

SEC. 3007. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1994.

Subtitle B—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance

SEC. 3101. PROTECTION OF ASSETS THROUGH USE OF QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 1601(a), is amended—

(1) by redesignating section 1932 as section 1933; and

(2) by inserting after section 1931 the following new section:

"SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

"SEC. 1932. (a) IN GENERAL.—Each State plan under this title, as a condition for the receipt of payment under section 1903(a) with respect to long-term care services (as defined in subsection (c)(1)), shall provide that in determining the eligibility of an individual for medical assistance under the plan with respect to such services

there shall be disregarded some or all of the individual's assets which are attributable (as determined under subsection (c)(2)) to coverage under a qualified long-term care insurance contract (as defined in subsection (b)).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—In this section, the term 'qualified long-term care insurance contract' means, with respect to a State, a long-term care insurance contract (as defined in section 818A(b) of the Internal Revenue Code of 1986) which—

''(1) provides such protection against the costs of receiving long-term care services as the State may require by law;

''(2) provides that benefits under the contract shall be paid without regard to eligibility for medical assistance under this title; and

''(3) meets such other requirements (such as requirements relating to premiums, disclosure, minimum benefits, rights of conversion, and standards for claims processing) as the State may determine to be appropriate.

''(c) OTHER DEFINITIONS.—In this section:

''(1) LONG-TERM CARE SERVICES.—The term 'long-term care services' means nursing facility services, home health care services, and home and com-

munity-based services, and includes such other similar items and services described in section 1905(a) as a State may specify.

''(2) ATTRIBUTION RULES.—An individual's assets are considered to be 'attributable' to a qualified long-term care insurance contract to the extent specified under the State plan. Such a plan shall provide for at least one of the following:

''(A) All assets are considered attributable if the insurance contract provides coverage for at least a specified period of coverage (of not less than 3 years and of not more than 6 years) for long-term care services.

''(B) An amount of assets, up to the dollar limitation on benefits for long-term care services under the contract, is considered attributable to the contract.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A)) is amended by inserting ''and section 1932'' after ''objectives of this title''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply (except as provided under paragraph (2)) to payments to States under title

XIX of the Social Security Act for calendar quarters beginning on or after one year after the date of the enactment of this Act, without regard to whether regulations to implement such amendment are promulgated by such date.

(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle C—Studies

SEC. 3201. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOMEBOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 3202. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of adjusted gross income.

SEC. 3203. CASE MANAGEMENT OF CURRENT LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility

of encouraging or requiring the use of a single designated public or nonprofit agency (such as an area agency on aging) to coordinate, through case management, the provision of long-term care benefits under current Federal, State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Congress a report on the study conducted under subsection (a) by not later than 1 year after the date of the enactment of this Act. Such report shall include such recommendations regarding changes in legislation to encourage or require the use (described in subsection (a)) of an agency to coordinate long-term care benefits as may be appropriate.

Subtitle D—Volunteer Service Credit Demonstration Projects

SEC. 3301. AMENDMENT TO THE OLDER AMERICANS ACT OF 1965.

(a) IN GENERAL.—Part B of title IV of the Older Americans Act of 1965 (42 U.S.C. 3034–3035r) is amended by adding at the end the following:

"SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRATION PROJECTS.

''(a) REQUIREMENTS.—The Commissioner shall—

''(1) establish and operate (directly, or through the State agency on aging or one or more area agen-

cies on aging) a volunteer service credit demonstration project in all or part of each State;

''(2) establish criteria for selecting individuals to whom volunteer services will be provided under volunteer service credit demonstration projects operated under paragraph (1);

''(3) recruit and train (directly or through State agencies on aging or area agencies on aging) individuals who volunteer to provide services through such projects;

''(4) establish a minimum standard for each service to be provided by volunteers through such projects;

''(5) monitor services provided by volunteers through such projects to ensure that standards established under paragraph (4) are met; and

''(6) maintain (directly or through State agencies on aging or area agencies on aging) with respect to each individual who provides services through a volunteer service credit demonstration project operated under paragraph (1) a separately identifiable account showing the number of hours such individual provided such services.

''(b) DEFINITION.—For purposes of subsection (a), the term 'volunteer service credit demonstration project'

means a demonstration project through which homemaker services, respite care for families, adult day care, and educational, transportation, and home-delivery services are provided by—

''(1) volunteer older individuals for the benefit of older individuals or low-income children; or

''(2) volunteer individuals of any age for the benefit of older individuals;

in return for the the receipt of similar services under any such demonstration project (that is established under this section) at a time at which such volunteers are older individuals in need of such services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 1994.

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