

103^D CONGRESS
1ST SESSION

S. 223

To contain health care costs and increase access to affordable health care,
and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 27 (legislative day, JANUARY 5), 1993

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

A BILL

To contain health care costs and increase access to affordable
health care, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Access to Affordable Health Care Act”.

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

Sec. 2. Definitions.

TITLE I—MANAGED COMPETITION IN HEALTH CARE PLANS

Sec. 100. Block grant program.

Subtitle A—Health Plan Purchasing Cooperatives

- Sec. 101. Establishment and organization; HPPC areas.
- Sec. 102. Agreements with accountable health plans (AHPs).
- Sec. 103. Agreements with employers.
- Sec. 104. Enrolling individuals in accountable health plans through a HPPC.
- Sec. 105. Receipt of premiums.
- Sec. 106. Coordination among HPPCs.

Subtitle B—Accountable Health Plans (AHPs)

PART 1—REQUIREMENTS FOR ACCOUNTABLE HEALTH PLANS

- Sec. 111. Registration process; qualifications.
- Sec. 112. Specified uniform set of effective benefits.
- Sec. 113. Collection and provision of standardized information.
- Sec. 114. Prohibition of discrimination based on health status for certain conditions; limitation on pre-existing condition exclusions.
- Sec. 115. Use of standard premiums.
- Sec. 116. Financial solvency requirements.
- Sec. 117. Grievance mechanisms; enrollee protections; written policies and procedures respecting advance directives; agent commissions.
- Sec. 118. Additional requirements of open AHPs.
- Sec. 119. Additional requirement of certain AHPs.

PART 2—PREEMPTION OF STATE LAWS FOR ACCOUNTABLE HEALTH PLANS

- Sec. 120. Preemption from State benefit mandates.
- Sec. 121. Preemption of State law restrictions on network plans.
- Sec. 122. Preemption of State laws restricting utilization review programs.

Subtitle C—Federal Health Board

- Sec. 131. Establishment of Federal Health Board.
- Sec. 132. Specification of uniform set of effective benefits.
- Sec. 133. Health benefits and data standards board.
- Sec. 134. Health plan standards board.
- Sec. 135. Registration of accountable health plans.
- Sec. 136. Specification of risk-adjustment factors.
- Sec. 137. National health data system.
- Sec. 138. Measures of quality of care of specialized centers of care.
- Sec. 139. Report on impact of adverse selection; recommendations on mandated purchase of coverage.

TITLE II—TAX INCENTIVES TO INCREASE HEALTH CARE ACCESS

- Sec. 201. Credit for accountable health plan costs.
- Sec. 202. No deduction for employer health plan expenses in excess of accountable health plan costs.
- Sec. 203. Increase in deduction for health plan premium expenses of self-employed individuals.
- Sec. 204. Deduction for health plan premium expenses of individuals.
- Sec. 205. Exclusion from gross income for employer contributions to accountable health plans.

TITLE III—OUTCOMES RESEARCH AND PRACTICE GUIDELINE DEVELOPMENT; APPLICATION OF GUIDELINES AS LEGAL STANDARD

- Sec. 301. Authorization for expansion of health services research.

Sec. 302. Treatment practice guidelines as a legal standard.

TITLE IV—COOPERATIVE AGREEMENTS BETWEEN HOSPITALS

Sec. 401. Purpose.

Sec. 402. Hospital technology and services sharing program.

TITLE V—IMPROVED ACCESS TO HEALTH CARE FOR RURAL AND UNDERSERVED AREAS

Subtitle A—Revenue Incentives for Practice in Rural Areas

Sec. 501. Revenue incentives for practice in rural areas.

Subtitle B—Public Health Service Act Provisions

Sec. 511. National health service corps.

Sec. 512. Establishment of grant program.

Sec. 513. Establishment of new program to provide funds to allow federally qualified health centers and other entities or organizations to provide expanded services to medically underserved individuals.

Sec. 514. Rural mental health outreach grants.

Sec. 515. Health professions training.

Sec. 516. Rural health extension networks.

Sec. 517. Rural managed care cooperatives.

TITLE VI—MALPRACTICE REFORM

Sec. 601. Prelitigation screening panel grants.

TITLE VII—HEALTH PROMOTION AND DISEASE PREVENTION

Sec. 701. Disease prevention and health promotion programs treated as medical care.

Sec. 702. Worksite wellness grant program.

Sec. 703. Expanding and improving school health education.

TITLE VIII—PRESCRIPTION DRUG COST CONTAINMENT

Sec. 801. Reduction in possessions tax credit for excessive pharmaceutical inflation.

TITLE IX—FINANCING

Sec. 901. Repeal of dollar limitation on amount of wages subject to hospital insurance tax.

1 **SEC. 2. DEFINITIONS.**

2 (a) ELIGIBILITY.—As used in this Act:

3 (1) ELIGIBLE INDIVIDUAL.—The term “eligible
4 individual” means, with respect to a HPPC area, an
5 individual who—

6 (A) is an eligible employee;

1 (B) is an eligible resident; or

2 (C) an eligible family member of an eligible
3 employee or eligible resident.

4 (2) ELIGIBLE EMPLOYEE.—The term “eligible
5 employee” means, with respect to a HPPC area, an
6 individual residing in the area who is the employee
7 of a small employer.

8 (3) ELIGIBLE FAMILY MEMBER.—The term “el-
9 igible family member” means, with respect to an eli-
10 gible employee or other principal enrollee, an individ-
11 ual who—

12 (A)(i) is the spouse of the employee or
13 principal enrollee; or

14 (ii) is an unmarried dependent child under
15 22 years of age; including—

16 (I) an adopted child or recognized
17 natural child; and

18 (II) a stepchild or foster child but
19 only if the child lives with the employee or
20 principal enrollee in a regular parent-child
21 relationship;

22 or such an unmarried dependent child regard-
23 less of age who is incapable of self-support be-
24 cause of mental or physical disability which ex-
25 isted before age 22;

1 (B) is a citizen or national of the United
2 States, an alien lawfully admitted to the United
3 States for permanent residence, or an alien oth-
4 erwise lawfully residing permanently in the
5 United States under color of law; and

6 (C) with respect to an eligible resident, is
7 not a medicare-eligible individual.

8 (4) ELIGIBLE RESIDENT.—

9 (A) IN GENERAL.—The term “eligible resi-
10 dent” means, with respect to a HPPC area, an
11 individual who is not an eligible employee, is re-
12 siding in the area, and is a citizen or national
13 of the United States, an alien lawfully admitted
14 for permanent residence, and an alien otherwise
15 permanently residing in the United States
16 under color of law.

17 (B) EXCLUSION OF CERTAIN INDIVIDUALS
18 OFFERED COVERAGE THROUGH A LARGE EM-
19 PLOYER.—The term “eligible resident” does not
20 include an individual who—

21 (i) is covered under an AHP pursuant
22 to an offer made under section
23 105(b)(1)(A); or

1 (ii) could be covered under an AHP as
 2 the principal enrollee pursuant to such an
 3 offer if such offer had been accepted.

4 (C) TREATMENT OF MEDICARE BENE-
 5 FICIARIES.—The term “eligible resident” does
 6 not include a medicare-eligible beneficiary.

7 (5) ENROLLEE UNIT.—The term “enrollee
 8 unit” means one unit in the case of coverage on an
 9 individual basis or in the case of coverage on a fam-
 10 ily basis.

11 (6) MEDICARE BENEFICIARY.—The term “med-
 12 icare beneficiary” means an individual who is enti-
 13 tled to benefits under part A of title XVIII of the
 14 Social Security Act, including an individual who is
 15 entitled to such benefits pursuant to an enrollment
 16 under section 1818 or 1818A of such Act.

17 (7) MEDICARE-ELIGIBLE INDIVIDUAL.—The
 18 term “medicare-eligible individual” means an indi-
 19 vidual who—

20 (A) is a medicare beneficiary; or

21 (B) is not a medicare beneficiary but is eli-
 22 gible to enroll under part A or part B of title
 23 XVIII of the Social Security Act.

24 (b) ABBREVIATIONS.—As used in this Act:

1 (1) AHP; ACCOUNTABLE HEALTH PLAN.—The
2 terms “accountable health plan” and “AHP” mean
3 a health plan registered with the Board under sec-
4 tion 111(a).

5 (2) BOARD.—The term “Board” means the
6 Federal Health Board established under subtitle C
7 of title I.

8 (3) HPPC; HEALTH PLAN PURCHASING COOP-
9 ERATIVE.—The terms “health plan purchasing coop-
10 erative” and “HPPC” mean a health plan purchas-
11 ing cooperative established under subtitle A of title
12 I.

13 (4) CLOSED AND OPEN PLANS.—

14 (A) CLOSED.—A plan is ‘closed’ if the plan
15 is limited by structure or law to a particular
16 employer or industry or is organized on behalf
17 of a particular group. A plan maintained pursu-
18 ant to one or more collective bargaining agree-
19 ments between one or more employee organiza-
20 tions and one or more employers shall be con-
21 sidered to be a closed plan.

22 (B) OPEN.—A plan is “open” if the plan
23 is not closed (within the meaning of subpara-
24 graph (A)).

25 (c) OTHER TERMS.—As used in this Act:

1 (1) HEALTH PLAN.—The term “health plan”
2 means a plan that provides health benefits, whether
3 directly, through insurance, or otherwise, and in-
4 cludes a policy of health insurance, a contract of a
5 service benefit organization, or a membership agree-
6 ment with a health maintenance organization or
7 other prepaid health plan, and also includes an em-
8 ployee welfare benefit plan or a multiple employer
9 welfare plan (as such terms are defined in section 3
10 of the Employee Retirement Income Security Act of
11 1974).

12 (2) SMALL EMPLOYER.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (B), the term “small employer” means
15 an employer that normally employed fewer than
16 100 employees during a typical business day in
17 the previous year.

18 (B) SPECIAL RULE FOR LARGE EMPLOY-
19 ERS.—Subject to subparagraph (C), the Board
20 shall provide a procedure by which, in the case
21 of an employer that is not a small employer but
22 normally employs fewer than 100 employees in
23 a HPPC area (or other locality identified by the
24 Board) during a typical business day, the em-
25 ployer, upon application, would be considered to

1 be a small employer with respect to such em-
2 ployees in the HPPC area (or other locality).
3 Such procedure shall be designed so as to pre-
4 vent the adverse selection of employees with re-
5 spect to which the previous sentence is applied.

6 (C) STATE ELECTION.—Subject to section
7 101(a)(3), a State may by law, with respect to
8 employers in the State, substitute for “100” in
9 subparagraphs (A) and (B) any greater number
10 (not to exceed 10,001), so long as such number
11 is applied uniformly to all employers in a
12 HPPC area.

13 (3) HPPC STANDARD PREMIUM AMOUNT.—The
14 term “HPPC standard premium amount” means,
15 with respect to an AHP offered by a HPPC, the
16 sum of—

17 (A) the standard premium amount estab-
18 lished by the AHP under section 115, and

19 (B) the HPPC overhead amount estab-
20 lished under section 104(a)(3).

21 (4) PREMIUM CLASS.—The term “premium
22 class” means a class established under section
23 115(a)(2).

24 (5) STATE.—The term “State” includes the
25 District of Columbia, Puerto Rico, the Virgin Is-

1 lands, Guam, American Samoa, and the Northern
2 Mariana Islands.

3 (6) TYPE OF ENROLLMENT.—There are 4
4 “types of enrollment”:

5 (A) Coverage only of an individual (re-
6 ferred to in this Act as enrollment “on an indi-
7 vidual basis”).

8 (B) Coverage of an individual and the indi-
9 vidual’s spouse.

10 (C) Coverage of an individual and one
11 child.

12 (D) Coverage of an individual and more
13 than one eligible family member.

14 The types of coverage described in subparagraphs
15 (B) through (D) are collectively referred to in this
16 Act as enrollment “on a family basis”.

17 (7) UNIFORM SET OF EFFECTIVE BENEFITS.—
18 The term “uniform set of effective benefits” means,
19 for a year, such set of benefits as specified by the
20 Board under section 132(a).

21 **TITLE I—MANAGED COMPETI-**
22 **TION IN HEALTH CARE PLANS**

23 **SEC. 100. BLOCK GRANT PROGRAM.**

24 (a) IN GENERAL.—The Secretary shall award grants
25 to States to enable such State to defray the costs associ-

1 ated with the implementation and administration of the
2 requirements of this title in such States.

3 (b) AMOUNT OF GRANTS.—The amount of a grant
4 awarded to a State under this section shall be determined
5 by the Secretary according to a formula developed by the
6 Secretary to take into consideration the population, health
7 care availability, and geographic make-up of the State as
8 compared to other States.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to enable the Secretary
11 to award grants under subsection (a), such sums as may
12 be necessary for each fiscal year.

13 **Subtitle A—Health Plan** 14 **Purchasing Cooperatives**

15 **SEC. 101. ESTABLISHMENT AND ORGANIZATION; HPPC** 16 **AREAS.**

17 (a) HPPC AREAS.—

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

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

1 (A) all portions of each metropolitan sta-
2 tistical area in a State are within the same
3 HPPC area; and

4 (B) the number of individuals residing
5 within a HPPC area is not less than 100,000.

6 (3) ALTERNATIVE, INTERSTATE AREAS.—In ac-
7 cordance with rules established by the Board, one or
8 more contiguous States may provide for the estab-
9 lishment of a HPPC area that includes adjoining
10 portions of the States so long as such area, if it in-
11 cludes any part of a metropolitan statistical area, in-
12 cludes all of such area. In the case of a HPPC serv-
13 ing a multi-state area, section 2(c)(2)(C) shall only
14 apply to the area if all the States encompassed in
15 the area agree to the number to be substituted.

16 (b) ESTABLISHMENT OF HPPCS.—

17 (1) IN GENERAL.—Each State shall provide, by
18 legislation or otherwise, for the establishment by not
19 later than July 1, 1994, as a not-for-profit corpora-
20 tion, with respect to each HPPC area (specified
21 under subsection (a)) of a health plan purchasing
22 cooperative (each in this subtitle referred to as a
23 “HPPC”).

1 (2) SINGLE ORGANIZATION SERVING MULTIPLE
2 HPPC AREAS.—Nothing in this subsection shall be
3 construed as preventing—

4 (A) a single corporation from being the
5 HPPC for more than one HPPC area; or

6 (B) a State from coordinating, through a
7 single entity, the activities of one or more
8 HPPCs in the State.

9 (3) INTERSTATE HPPC AREAS.—HPPCs with
10 respect to interstate areas specified under subsection
11 (a)(3) shall be established in accordance with rules
12 of the Board.

13 (c) BOARD OF DIRECTORS.—Each HPPC shall be
14 governed by a Board of Directors appointed by the Gov-
15 ernor or other chief executive officer of the State (or as
16 otherwise provided under State law or by the Board in
17 the case of a HPPC described in subsection (b)(3)).

18 (d) DUTIES OF HPPCs.—Each HPPC shall—

19 (1) enter into agreements with accountable
20 health plans under section 102;

21 (2) enter into agreements with small employers
22 under section 103;

23 (3) enroll individuals under accountable health
24 plans, in accordance with section 104;

1 (4) receive and forward adjusted premiums, in
2 accordance with section 105, including the reconcili-
3 ation of low-income assistance among accountable
4 health plans;

5 (5) provide for coordination with other HPPCs,
6 in accordance with section 106; and

7 (6) carry out other functions provided for under
8 this title.

9 **SEC. 102. AGREEMENTS WITH ACCOUNTABLE HEALTH**
10 **PLANS (AHPS).**

11 (a) AGREEMENTS.—

12 (1) OPEN AHPS.—Each HPPC for a HPPC
13 area shall enter into an agreement under this section
14 with each open accountable health plan registered
15 with the Board under subtitle B, that serves resi-
16 dents of the area. Each such agreement under this
17 section, between an open AHP and a HPPC shall
18 include (as specified by the Board) provisions con-
19 sistent with the requirements of the succeeding sub-
20 sections of this section. Except as provided in para-
21 graph (3)(A), a HPPC may not refuse to enter into
22 such an agreement with an open AHP which is reg-
23 istered with the Board under subtitle B.

24 (2) CLOSED AHPS.—Each HPPC for a HPPC
25 area shall enter into a special agreement under this

1 paragraph with each closed AHP that serves resi-
2 dents of the area, in order to carry out subsection
3 (e). Except as otherwise specifically provided, any
4 reference in this Act to an agreement under this sec-
5 tion shall not be considered to be a reference to an
6 agreement under this paragraph.

7 (3) TERMINATION OF AGREEMENT.—In accord-
8 ance with regulations of the Board—

9 (A) the HPPC may terminate an agree-
10 ment under paragraph (1) if the AHP's reg-
11 istration under subtitle B is terminated or for
12 other good cause shown; and

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

17 The Board shall establish a process for the termi-
18 nation of agreements under this paragraph.

19 (b) OFFER OF ENROLLMENT OF INDIVIDUALS.—

20 (1) IN GENERAL.—Under an agreement under
21 this section between an AHP and a HPPC, the
22 HPPC shall offer, on behalf of the AHP, enrollment
23 in the AHP to eligible individuals (as defined in sec-
24 tion 2(a)(1)) at the applicable monthly premium
25 rates (specified under section 105(a)).

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

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

7 (B) to other eligible individuals, at such
8 time (including an annual open enrollment pe-
9 riod specified by the Board) as the HPPC shall
10 specify, consistent with section 104(b).

11 (c) RECEIPT OF GROSS PREMIUMS.—

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

17 (2) TIMING OF PAYMENT OF PREMIUMS.—Pre-
18 miums shall be payable on a monthly basis (or, at
19 the option of an eligible individual described in sec-
20 tion 2(a)(2)(B), on a quarterly basis). The HPPC
21 may provide for penalties and grace periods for late
22 payment.

23 (3) AHPs RETAIN RISK OF NONPAYMENT.—
24 Nothing in this subsection shall be construed as
25 placing upon a HPPC any risk associated with fail-

1 ure to make prompt payment of premiums (other
2 than the portion of the premium representing the
3 HPPC overhead amount). Each eligible individual
4 who enrolls with an AHP through the HPPC is lia-
5 ble to the AHP for premiums.

6 (d) FORWARDING OF ADJUSTED PREMIUMS.—

7 (1) IN GENERAL.—Under an agreement under
8 this section between an AHP and a HPPC, subject
9 to section 115(b), the HPPC shall forward to each
10 AHP in which an eligible individual has been en-
11 rolled an amount equal to the sum of—

12 (A) the standard premium rate (estab-
13 lished under section 115) received for type of
14 enrollment, and

15 (B) the product of—

16 (i) the lowest standard premium rate
17 offered by an open AHP for the type of en-
18 rollment; and

19 (ii) a risk-adjustment factor (deter-
20 mined and adjusted in accordance with
21 section 136(b)).

22 (2) PAYMENTS.—Payments shall be made by
23 the HPPC under this subsection within a period
24 (specified by the Board and not to exceed 7 days)
25 after receipt of the premium from the employer of

1 the eligible individual or the eligible individual, as
2 the case may be.

3 (3) ADJUSTMENTS FOR DIFFERENCES IN
4 NONPAYMENT RATES.—In accordance with rules es-
5 tablished by the Board, each agreement between an
6 AHP and a HPPC under this section shall provide
7 that, if a HPPC determines that the rates of
8 nonpayment of premiums during grace periods es-
9 tablished under subsection (c)(2) vary appreciably
10 among AHPs, the HPPC shall provide for such ad-
11 justments in the payments made under this sub-
12 section as will place each AHP in the same position
13 as if the rates of nonpayment were the same.

14 **SEC. 103. AGREEMENTS WITH EMPLOYERS.**

15 (a) IN GENERAL.—Each HPPC for a HPPC area
16 shall offer each small employer that employs individuals
17 in the area the opportunity to enter into an agreement
18 under this section. Each agreement under this section, be-
19 tween an employer and a HPPC shall include (as specified
20 by the Board) provisions consistent with the requirements
21 specified in the succeeding subsections of this section.

22 (b) FORWARDING INFORMATION ON ELIGIBLE EM-
23 PLOYEES.—

24 (1) IN GENERAL.—Under an agreement under
25 this section between a small employer and a HPPC,

1 the employer must forward to the appropriate
2 HPPC the name and address (and other identifying
3 information required by the HPPC) of each em-
4 ployee (including part-time and seasonal employees).

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

10 (c) PAYROLL DEDUCTION.—

11 (1) IN GENERAL.—Under an agreement under
12 this section between a small employer and a HPPC,
13 if the HPPC indicates to the employer that an eligi-
14 ble employee is enrolled in an AHP through the
15 HPPC, the employer shall provide for the deduction,
16 from the employee’s wages or other compensation, of
17 the amount of the premium due (less any employer
18 contribution). In the case of an employee who is paid
19 wages or other compensation on a monthly or more
20 frequent basis, an employer shall not be required to
21 provide for payment of amounts to a HPPC other
22 than at the same time at which the amounts are de-
23 ducted from wages or other compensation. In the
24 case of an employee who is paid wages or other com-
25 pensation less frequently than monthly, an employer

1 may be required to provide for payment of amounts
2 to a HPPC on a monthly basis.

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

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

11 (1) requiring an employer to provide directly for
12 enrollment of eligible employees under an account-
13 able health plan or other health plan;

14 (2) requiring the employer to make, or prevent-
15 ing the employer from making, information about
16 such plans available to such employees; or

17 (3) requiring the employer to make, or prevent-
18 ing the employer from making, an employer con-
19 tribution for coverage of such individuals under such
20 a plan.

21 **SEC. 104. ENROLLING INDIVIDUALS IN ACCOUNTABLE**
22 **HEALTH PLANS THROUGH A HPPC.**

23 (a) IN GENERAL.—Each HPPC shall offer in accord-
24 ance with this section eligible individuals the opportunity

1 to enroll in an AHP for the HPPC area in which the indi-
2 vidual resides.

3 (b) ENROLLMENT PROCESS.—

4 (1) IN GENERAL.—Each HPPC shall establish
5 an enrollment process in accordance with rules es-
6 tablished by the Board consistent with this sub-
7 section.

8 (2) INITIAL ENROLLMENT PERIOD.—Each eligi-
9 ble individual, at the time the individual first be-
10 comes an eligible individual in a HPPC area of a
11 HPPC, have an initial enrollment period (of not less
12 than 30 days) in which to enroll in an AHP.

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

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

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

23 (B) experience a change in employment
24 status (including a significant change in the
25 terms and conditions of employment);

1 each HPPC shall provide for a special enrollment
2 period in which the individual is permitted to change
3 the individual or family basis of coverage or the
4 AHP in which the individual is enrolled. The cir-
5 cumstances under which such special enrollment pe-
6 riods are required and the duration of such periods
7 shall be specified by the Board.

8 (5) TRANSITIONAL ENROLLMENT PERIOD.—
9 Each HPPC shall provide for a special transitional
10 enrollment period (during a period beginning in the
11 months of October through December of 1994 as
12 specified by the Board) during which eligible individ-
13 uals may first enroll.

14 (c) DISTRIBUTION OF COMPARATIVE INFORMA-
15 TION.—Each HPPC shall distribute, to eligible individuals
16 and employers, information, in comparative form, on the
17 prices, outcomes, enrollee satisfaction, and other informa-
18 tion pertaining to the quality of the different AHPs for
19 which it is offering enrollment. Each HPPC also shall
20 make such information available to other interested per-
21 sons.

22 (d) PERIOD OF COVERAGE.—

23 (1) INITIAL ENROLLMENT PERIOD.—In the case
24 of an eligible individual who enrolls with an AHP
25 through a HPPC during an initial enrollment period,

1 coverage under the plan shall begin on such date
2 (not later than the first day of the first month that
3 begins at least 15 days after the date of enrollment)
4 as the Board shall specify.

5 (2) GENERAL ENROLLMENT PERIODS.—In the
6 case of an eligible individual who enrolls with an
7 AHP through a HPPC during a general enrollment
8 period, coverage under the plan shall begin on the
9 1st day of the 1st month beginning at least 15 days
10 after the end of such period.

11 (3) SPECIAL ENROLLMENT PERIODS.—

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

23 (B) TRANSITIONAL SPECIAL ENROLLMENT
24 PERIOD.—In the case of an eligible individual
25 who enrolls with an AHP during the transi-

1 tional special enrollment period described in
2 subsection (b)(5), coverage under the plan shall
3 begin on January 1, 1995.

4 (4) MINIMUM PERIOD OF ENROLLMENT.—In
5 order to avoid adverse selection, each HPPC may re-
6 quire, consistent with rules of the National Board,
7 that enrollments with AHPs be for not less than a
8 specified minimum enrollment period (with excep-
9 tions permitted for such exceptional circumstances
10 as the Board may recognize).

11 **SEC. 105. RECEIPT OF PREMIUMS.**

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

15 (1) the standard premium rate established by
16 the AHP under section 115 for such coverage; and

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

20 (b) HPPC OVERHEAD AMOUNT.—

21 (1) HPPC BUDGET.—Each HPPC shall estab-
22 lish a budget for each year for each HPPC area in
23 accordance with regulations established by the
24 Board.

1 (2) HPPC OVERHEAD PERCENTAGE.—The
2 HPPC shall compute for each HPPC area an over-
3 head percentage which, when applied to the standard
4 premium amount for individual coverage for each en-
5 rollee unit, will provide for revenues equal to the
6 budget for the HPPC area for the year. Such per-
7 centage may in no case exceed 5 percentage points.

8 (3) HPPC OVERHEAD AMOUNT.—The HPPC
9 overhead amount for enrollment, whether on an indi-
10 vidual or family basis, in an AHP for a HPPC area
11 for a month is equal to the applicable HPPC over-
12 head percentage (computed under paragraph (2))
13 multiplied by the standard premium amount for in-
14 dividual coverage under the AHP for the month.

15 **SEC. 106. COORDINATION AMONG HPPCS.**

16 (a) IN GENERAL.—The Board shall establish rules
17 consistent with this section for coordination among
18 HPPCs in cases where small employers are located in one
19 HPPC area and their employees reside in a different
20 HPPC area (and are eligible for enrollment with AHPs
21 located in the other area).

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

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

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

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

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

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

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

3 PART 1—REQUIREMENTS FOR ACCOUNTABLE HEALTH
4 PLANS

5 **SEC. 111. REGISTRATION PROCESS; QUALIFICATIONS.**

6 (a) IN GENERAL.—The Board shall provide a process
7 whereby a health plan (as defined in section 2(c)(1)) may
8 be registered with the Board by its sponsor as an account-
9 able health plan.

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

12 (1) provide, in accordance with section 112, for
13 coverage of the uniform set of effective benefits spec-
14 ified by the Board;

15 (2) provide, in accordance with section 113, for
16 the collection and reporting to the Board of certain
17 information regarding its enrollees and provision of
18 services;

19 (3) not discriminate in enrollment or benefits,
20 as required under section 114;

21 (4) establish standard premiums for the uni-
22 form set of effective benefits, in accordance with sec-
23 tion 115;

24 (5) meet financial solvency requirements, in ac-
25 cordance with section 116;

1 (6) provide for effective grievance procedures
2 and restrict certain physician incentive plans, in ac-
3 cordance with section 117; and

4 (7) in the case of an open plan (as defined in
5 section 2(b)(4)(B)), meet certain additional require-
6 ments under section 118 (relating to acceptance of
7 enrollees and participation as a plan under the medi-
8 care program under the Social Security Act and
9 under the Federal employees health benefits pro-
10 gram).

11 (c) MINIMUM SIZE FOR CLOSED PLANS.—No plan
12 may be registered as a closed AHP under this section un-
13 less the plan covers at least a number of employees greater
14 than the applicable number of employees specified in sec-
15 tion 2(c)(2).

16 (d) MEDICARE REQUIREMENT.—No plan may be reg-
17 istered as an AHP under this section unless the plan—

18 (1) meets the requirement of section 118(c); or

19 (2) provides for payment of the medicare ad-
20 justment amount under section 119.

21 **SEC. 112. SPECIFIED UNIFORM SET OF EFFECTIVE BENE-**

22 **FITS.**

23 (a) BENEFITS.—The Board shall not accept the reg-
24 istration of a health plan as an accountable health plan
25 unless, subject to subsection (b), the plan—

1 (1) offers only the uniform set of effective bene-
2 fits, specified by Board under section 132(a);

3 (2) has entered into arrangements with a suffi-
4 cient number and variety of providers to provide for
5 its enrollees the uniform set of effective benefits
6 without imposing cost-sharing in excess of the cost-
7 sharing described in paragraph (3);

8 (3)(A) provides, subject to subsection (c), for
9 imposition of uniform cost-sharing (such as
10 deductibles and copayments), specified under such
11 subsection as part of such set of benefits; and

12 (B) does not permit providers participating in
13 the plan under paragraph (2) to charge for covered
14 services amounts in excess of such cost-sharing; and

15 (4) provides, in the case of individuals covered
16 under more than one accountable health plan, for
17 coordination of coverage under such plans in an eq-
18 uitable manner.

19 (b) TREATMENT OF ADDITIONAL BENEFITS.—

20 (1) IN GENERAL.—Subject to paragraph (2),
21 subsection (a) shall not be construed as preventing
22 an AHP from offering benefits in addition to the
23 uniform set of effective benefits or for reducing the
24 cost-sharing below the uniform cost-sharing, if such
25 additional benefits or reductions in cost-sharing are

1 offered, and priced, separately from the benefits de-
2 scribed in subsection (a).

3 (2) NO DUPLICATIVE BENEFITS.—An AHP
4 may not offer under paragraph (1) any additional
5 benefits that have the effect of duplicating the bene-
6 fits required under subsection (a).

7 **SEC. 113. COLLECTION AND PROVISION OF STANDARDIZED**
8 **INFORMATION.**

9 (a) PROVISION OF INFORMATION.—

10 (1) IN GENERAL.—Each AHP must provide the
11 Board (at a time, not less frequently than annually,
12 and in an electronic, standardized form and manner
13 specified by the Board) such information as the
14 Board determines to be necessary, consistent with
15 this subsection and section 137, to evaluate the per-
16 formance of the AHP in providing the uniform set
17 of effective benefits to enrollees.

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

21 (A) Information on the characteristics of
22 enrollees that may affect their need for or use
23 of health services.

24 (B) Information on the types of treatments
25 and outcomes of treatments with respect to the

1 clinical health, functional status, and well-being
2 of enrollees.

3 (C) Information on enrollee satisfaction,
4 based on standard surveys prescribed by the
5 Board.

6 (D) Information on health care expendi-
7 tures, volume and prices of procedures, and use
8 of specialized centers of care (for which infor-
9 mation is submitted under section 138).

10 (E) Information on the flexibility permitted
11 by plans to enrollees in their selection of provid-
12 ers.

13 (3) SPECIAL TREATMENT.—The Board may
14 waive the provision of such information under para-
15 graph (2), or require such other information, as the
16 Board finds appropriate in the case of newly estab-
17 lished AHP for which such information is not avail-
18 able.

19 (b) CONDITIONING CERTAIN PROVIDER PAY-
20 MENTS.—

21 (1) IN GENERAL.—In order to assure the collec-
22 tion of all information required from the direct pro-
23 viders of services for which benefits are available
24 through an AHP, each AHP may not provide pay-
25 ment for services (other than emergency services)

1 furnished by a provider to meet the uniform set of
 2 effective benefits unless the provider has given the
 3 AHP (or has given directly to the National Board)
 4 standard information (specified by the Board) re-
 5 specting the services.

6 (2) FORWARDING INFORMATION.—If informa-
 7 tion under paragraph (1) is given to the AHP, the
 8 AHP is responsible for forwarding the information
 9 to the Board.

10 **SEC. 114. PROHIBITION OF DISCRIMINATION BASED ON**
 11 **HEALTH STATUS FOR CERTAIN CONDITIONS;**
 12 **LIMITATION ON PRE-EXISTING CONDITION**
 13 **EXCLUSIONS.**

14 (a) IN GENERAL.—Except as provided under sub-
 15 section (b), an AHP may not deny, limit, or condition the
 16 coverage under (or benefits of) the plan based on the
 17 health status, claims experience, receipt of health care,
 18 medical history, or lack of evidence of insurability, of an
 19 individual.

20 (b) TREATMENT OF PREEXISTING CONDITION EX-
 21 CLUSIONS FOR SERVICES.—

22 (1) IN GENERAL.—Subject to the succeeding
 23 provisions of this subsection, an AHP may exclude
 24 coverage with respect to services related to treat-
 25 ment of a preexisting condition, but the period of

1 such exclusion may not exceed 6 months beginning
2 on the date of coverage under the plan. The exclu-
3 sion of coverage shall not apply to services furnished
4 to newborns and to pregnant women.

5 (2) CREDITING OF PREVIOUS COVERAGE.—

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

15 (B) DEFINITIONS.—As used in this para-
16 graph:

17 (i) PERIOD OF CONTINUOUS COV-
18 ERAGE.—The term “period of continuous
19 coverage” means the period beginning on
20 the date an individual is enrolled under an
21 AHP (or, before July 1, 1994, under any
22 health plan that provides benefits with re-
23 spect to such services) and ends on the
24 date the individual is not so enrolled for a
25 continuous period of more than 3 months.

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

8 (3) LIMITATION.—This subsection shall not
9 apply to treatment which is not within the uniform
10 set of effective benefits.

11 **SEC. 115. USE OF STANDARD PREMIUMS.**

12 (a) STANDARD PREMIUMS FOR OPEN AHPs.—

13 (1) IN GENERAL.—Subject to subsection (b),
14 each open AHP shall establish a standard premium
15 for the uniform set of effective benefits within each
16 HPPC area in which the plan is offered. The
17 amount of premium applicable for all individuals
18 within a premium class (established under para-
19 graph (2)) is the standard premium amount multi-
20 plied by the premium class factor specified by the
21 Board for that class under paragraph (2)(B). Within
22 a HPPC area for individuals within a premium
23 class, the standard premium for all individuals in
24 the class shall be the same.

25 (2) PREMIUM CLASSES.—

1 (A) IN GENERAL.—The Board shall estab-
2 lish premium classes—

3 (i) based on types of enrollment (de-
4 scribed in section 2(c)(6)); and

5 (ii) within each type of enrollment,
6 based on age of principal enrollee.

7 In carrying out clause (ii), the Board shall es-
8 tablish reasonable age bands within which pre-
9 mium amounts will not vary for a type of en-
10 rollment.

11 (B) PREMIUM CLASS FACTORS.—

12 (i) IN GENERAL.—For each premium
13 class established under subparagraph (A),
14 the Board shall establish a premium class
15 factor that reflects, subject to clause (ii),
16 the relative actuarial value of benefits for
17 that class compared to the actuarial value
18 of benefits for an average class.

19 (ii) LIMIT ON VARIATION IN PREMIUM
20 CLASS FACTORS.—The highest premium
21 class factor may not exceed twice the low-
22 est premium class factor and the weighted
23 average of the premium class factors shall
24 be 1.

1 (3) **METHODOLOGY.**—Standard premiums are
2 subject to adjustment in accordance with section
3 102(d)(1).

4 (b) **LIMITATION ON PREMIUM INCREASES.**—

5 (1) **BOARD ACTION.**—The Board shall establish
6 annual limits on the permissible percentage rate of
7 increase for premiums with respect to AHP’s provid-
8 ing the uniform set of effective benefits.

9 (2) **INCREASES.**—Annual increases in premiums
10 for an AHP may not exceed the percentage limit es-
11 tablished by the Board under paragraph (1).

12 **SEC. 116. FINANCIAL SOLVENCY REQUIREMENTS.**

13 (a) **SOLVENCY PROTECTION.**—

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

21 (2) **FOR OTHER PLANS.**—In the case of an
22 AHP that is not an insured plan, the Board may re-
23 quire the plan to provide for such bond or provide
24 other satisfactory assurances that enrollees under

1 the plan are protected with respect to potential in-
2 solvency of the plan.

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

13 **SEC. 117. GRIEVANCE MECHANISMS; ENROLLEE PROTEC-**
14 **TIONS; WRITTEN POLICIES AND PROCE-**
15 **DURES RESPECTING ADVANCE DIRECTIVES;**
16 **AGENT COMMISSIONS.**

17 (a) EFFECTIVE GRIEVANCE PROCEDURES.—Each
18 AHP shall provide for effective procedures for hearing and
19 resolving grievances between the plan and individuals en-
20 rolled under the plan, which procedures meet standards
21 specified by the Board.

22 (b) RESTRICTION ON CERTAIN PHYSICIAN INCEN-
23 TIVE PLANS.—

24 (1) IN GENERAL.—A health plan may not be
25 registered as an AHP if it operates a physician in-

1 centive plan (as defined in paragraph (2)) unless the
2 requirements specified in clauses (i) through (iii) of
3 section 1876(i)(8)(A) of the Social Security Act are
4 met (in the same manner as they apply to eligible
5 organizations under section 1876 of such Act).

6 (2) PHYSICIAN INCENTIVE PLAN DEFINED.—In
7 this subsection, the term “physician incentive plan”
8 means any compensation or other financial arrange-
9 ment between the AHP and a physician or physician
10 group that may directly or indirectly have the effect
11 of reducing or limiting services provided with respect
12 to individuals enrolled under the plan.

13 (c) WRITTEN POLICIES AND PROCEDURES RESPECT-
14 ING ADVANCE DIRECTIVES.—A health plan may not be
15 registered as an AHP unless the plan meets the require-
16 ments of section 1866(f) of the Social Security Act (relat-
17 ing to maintaining written policies and procedures respect-
18 ing advance directives), insofar as such requirements
19 would apply to the plan if the plan were an eligible organi-
20 zation.

21 (d) PAYMENT OF AGENT COMMISSIONS.—An AHP—
22 (1) may pay a commission or other remunera-
23 tion to an agent or broker in marketing the plan to
24 individuals or groups; but

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

5 **SEC. 118. ADDITIONAL REQUIREMENTS OF OPEN AHPS.**

6 (a) REQUIREMENT OF AGREEMENT WITH HPPC.—
7 In the case of a health plan which is an open plan (as
8 defined in section 191(b)(4)(B)), in order to be registered
9 as an AHP the plan must have in effect an agreement
10 (described in section 102) with each HPPC for each
11 HPPC area in which it is offered.

12 (b) REQUIREMENT OF OPEN ENROLLMENT.—

13 (1) IN GENERAL.—In the case of a health plan
14 which is an open health plan, in order to be reg-
15 istered as an AHP the plan must, subject to para-
16 graph (3), not reject the enrollment of any eligible
17 individual whom a HPPC is authorized to enroll
18 under an agreement referred to in subsection (a) if
19 the individual applies for enrollment during an en-
20 rollment period.

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

25 (A) nonpayment of premiums;

1 (B) fraud or misrepresentation; or

2 (C) termination of the plan at the end of
3 a year (after notice and in accordance with
4 standards established by the Board).

5 (3) TREATMENT OF NETWORK PLANS.—

6 (A) GEOGRAPHIC LIMITATIONS.—

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

15 (ii) SERVICE AREAS.—The Board
16 shall establish standards for the designa-
17 tion by network plans of service areas in
18 order to prevent discrimination based on
19 health status of individuals or their need
20 for health services.

21 (B) SIZE LIMITS.—Subject to subpara-
22 graph (C), an AHP which is a network plan
23 may apply to the Board to cease enrolling eligi-
24 ble individuals under the AHP (or in a service
25 area of the plan) if—

1 (i) it ceases to enroll any new eligible
2 individuals; and

3 (ii) it can demonstrate that its finan-
4 cial or administrative capacity to serve pre-
5 viously covered groups or individuals (and
6 additional individuals who will be expected
7 to enroll because of affiliation with such
8 previously covered groups or individuals)
9 will be impaired if it is required to enroll
10 other eligible individuals.

11 (C) FIRST-COME-FIRST-SERVED.—A net-
12 work plan is only eligible to exercise the limita-
13 tions provided for in subparagraphs (A) and
14 (B) if it provides for enrollment of eligible indi-
15 viduals on a first-come-first-served basis.

16 (D) NETWORK PLAN.—In this paragraph,
17 the term “network plan” means an eligible or-
18 ganization (as defined in section 1876(b) of the
19 Social Security Act) and includes a similar or-
20 ganization, specified in regulations of the
21 Board, as requiring a limitation on enrollment
22 of employer groups or individuals due to the
23 manner in which the organization provides
24 health care services.

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

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

11 (2) EXPANSION OF MEDICARE SELECT PRO-
12 GRAM.—Subsection (c) of section 4358 of the Omni-
13 bus Budget Reconciliation Act of 1990 (104 Stat.
14 1388–137) is amended by striking “only apply in 15
15 States” and all that follows through the end and in-
16 sserting “on and after January 1, 1992.”.

17 (d) PARTICIPATION IN FEHBP.—

18 (1) IN GENERAL.—In the case of a health
19 plan which is an open health plan, in order to
20 be registered as an AHP the plan must have
21 entered into an agreement with the Office of
22 Personnel Management to offer a health plan to
23 Federal employees and annuitants, and family
24 members, under the Federal Employees Health
25 Benefits Program under chapter 89 of title 5,

1 United States Code, under the same terms and
 2 conditions offered by the AHP for enrollment of
 3 individuals and small employers through
 4 HPPCs.

5 (2) CHANGE IN CONTRIBUTION AND OTHER
 6 FEHBP RULES.—Notwithstanding any other provi-
 7 sion of law, effective January 1, 1994—

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

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

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

16 (ii) for any premium class shall not
 17 exceed the base individual premium (as de-
 18 fined in section 209(c)(3)), and

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

23 **SEC. 119. ADDITIONAL REQUIREMENT OF CERTAIN AHPS.**

24 (a) MEDICARE ADJUSTMENT PAYMENT RE-
 25 QUIRED.—Each AHP which does not meet the require-

1 ment of section 148(c) shall provide for payment to the
 2 Board of such amounts as may be required as to put the
 3 plan in the same financial position as the AHP would be
 4 in if it met such requirement.

5 (b) REDISTRIBUTION OF PAYMENTS TO PLANS.—
 6 The Board shall provide for the distribution among AHPs
 7 meeting the requirement of section 148(c) of amounts paid
 8 under subsection (a) in such manner as reflects the rel-
 9 ative financial impact of such requirement among such
 10 plans.

11 PART 2—PREEMPTION OF STATE LAWS FOR
 12 ACCOUNTABLE HEALTH PLANS

13 **SEC. 120. PREEMPTION FROM STATE BENEFIT MANDATES.**

14 Effective as of January 1, 1994, no State shall estab-
 15 lish or enforce any law or regulation that—

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

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

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

1 **SEC. 121. PREEMPTION OF STATE LAW RESTRICTIONS ON**
2 **NETWORK PLANS.**

3 (a) LIMITATION ON RESTRICTIONS ON NETWORK
4 PLANS.—Effective as of January 1, 1994—

5 (1) A State may not by law or regulation pro-
6 hibit or unreasonably limit a network plan from in-
7 cluding incentives for enrollees to use the services of
8 participating providers.

9 (2) A State may not prohibit or unreasonably
10 limit a network plan from limiting coverage of serv-
11 ices to those provided by a participating provider.

12 (3)(A) Subject to subparagraph (B), a State
13 may not prohibit or unreasonably limit the negotia-
14 tion of rates and forms of payments for providers
15 under a network plan.

16 (B) Subparagraph (A) shall not apply where
17 the amount of payments with respect to a category
18 of services or providers is established under a State-
19 wide system applicable to all non-Federal payors
20 with respect to such services or providers.

21 (4) A State may not prohibit or unreasonably
22 limit a network plan from limiting the number of
23 participating providers.

24 (5) A State may not prohibit or unreasonably
25 limit a network plan from requiring that services be
26 provided (or authorized) by a practitioner selected

1 by the enrollee from a list of available participating
2 providers.

3 (b) DEFINITIONS.—As used in this section:

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

6 (A) which—

7 (i) limits coverage of the uniform set
8 of basic benefits to those provided by par-
9 ticipating providers; or

10 (ii) provides, with respect to such
11 services provided by persons who are not
12 participating providers, for deductibles or
13 other cost-sharing which are in excess of
14 those permitted under the uniform set of
15 basic benefits for participating providers;

16 (B) which has a sufficient number and dis-
17 tribution of participating providers to assure
18 that the uniform set of basic benefits is—

19 (i) available and accessible to each en-
20 rollee, within the area served by the plan,
21 with reasonable promptness and in a man-
22 ner which assures continuity; and

23 (ii) when medically necessary, avail-
24 able and accessible 24 hours a day and
25 seven days a week; and

1 (C) which provides benefits for the uniform
 2 set of basic benefits not furnished by participat-
 3 ing providers if the services are medically nec-
 4 essary and immediately required because of an
 5 unforeseen illness, injury, or condition.

6 (2) PARTICIPATING PROVIDER.—The term
 7 “participating provider” means an entity or individ-
 8 ual which provides, sells, or leases health care serv-
 9 ices under a contract with a network plan, which
 10 contract does not permit—

11 (A) cost-sharing in excess of the cost-shar-
 12 ing permitted under the uniform set of basic
 13 benefits with respect to basic benefits; and

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

17 **SEC. 122. PREEMPTION OF STATE LAWS RESTRICTING UTI-**
 18 **LIZATION REVIEW PROGRAMS.**

19 (a) IN GENERAL.—Effective January 1, 1994, no
 20 State law or regulation shall prohibit or regulate activities
 21 under a utilization review program (as defined in sub-
 22 section (b)).

23 (b) UTILIZATION REVIEW PROGRAM DEFINED.—In
 24 this section, the term “utilization review program” means
 25 a system of reviewing the medical necessity and appro-

1 priateness of patient services (which may include inpatient
2 and outpatient services) using specified guidelines. Such
3 a system may include preadmission certification, the appli-
4 cation of practice guidelines, continued stay review, dis-
5 charge planning, preauthorization of ambulatory proce-
6 dures, and retrospective review.

7 **Subtitle C—Federal Health Board**

8 **SEC. 131. ESTABLISHMENT OF FEDERAL HEALTH BOARD.**

9 (a) IN GENERAL.—There is hereby established a
10 Federal Health Board.

11 (b) COMPOSITION AND TERMS.—

12 (1) APPOINTMENT.—The Board shall be com-
13 posed of 5 members appointed by the President by
14 and with the advice and consent of the Senate. In
15 appointing members to the Board, the President
16 shall provide that all members shall demonstrate ex-
17 perience with and knowledge of the health care sys-
18 tem.

19 (2) CHAIRPERSON.—The President shall des-
20 ignate one of the members to be Chairperson of the
21 Board.

22 (3) TERMS.—Each member of the Board shall
23 be appointed for a term of 7 years, except that, of
24 the members first appointed, 1 shall each be ap-
25 pointed for terms of 3, 4, 5, 6, and 7 years, as des-

1 ignated by the President at the time of appointment.
2 Members appointed to fill vacancies shall serve for
3 the remainder of the terms of the vacating members.

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

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

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

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

16 (8) COMPENSATION.—Each member of the
17 Board shall be entitled to compensation at the rate
18 provided for level II of the Executive Schedule, sub-
19 ject to such amounts as are provided in advance in
20 appropriation Acts.

21 (c) PERSONNEL.—

22 (1) IN GENERAL.—The Board shall appoint an
23 Executive Director and such additional officers and
24 employees as it considers necessary to carry out its
25 functions under this Act. Except as otherwise pro-

1 vided in any other provision of law, such officers and
2 employees shall be appointed, and their compensa-
3 tion shall be fixed, in accordance with title 5, United
4 States Code.

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

9 (d) MISCELLANEOUS PROVISIONS.—

10 (1) GIFTS, BEQUESTS, AND DEVICES.—The
11 Board may accept, use, and dispose of gifts, be-
12 quests, or devises of services or property for the pur-
13 pose of aiding or facilitating its work.

14 (2) MAILS.—The Board may use the United
15 States mails in the same manner and under the
16 same conditions as other departments and agencies
17 of the United States.

18 **SEC. 132. SPECIFICATION OF UNIFORM SET OF EFFECTIVE**
19 **BENEFITS.**

20 (a) SPECIFICATION OF UNIFORM SET OF EFFECTIVE
21 BENEFITS.—

22 (1) IN GENERAL.—The Board shall specify, by
23 not later than October 1 of each year (beginning
24 with 1993), the uniform set of effective benefits to
25 apply under this title for the following year.

1 (2) SPECIFICATION OF HEALTH CARE CONDI-
2 TIONS.—

3 (A) IN GENERAL.—Such benefits shall in-
4 clude the full range of legally authorized treat-
5 ment for any health condition for which the
6 Board determines a treatment has been shown
7 to reasonably improve or significantly amelio-
8 rate the condition. The Board may exclude
9 health conditions the treatment of which do not
10 impact on clinical health or functional status of
11 individuals.

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

19 (C) COVERAGE FOR PERSONS WITH SE-
20 VERE MENTAL ILLNESS.—The Board shall es-
21 tablish guidelines concerning nondiscrimination
22 towards individuals with severe mental illnesses
23 and coverage for the treatment of severe mental
24 illnesses. Such guidelines shall ensure that cov-
25 erage of such individuals is equitable and com-

1 mensurate with the coverage provided to other
2 individuals.

3 (D) EXCLUSION FOR INEFFECTIVE TREAT-
4 MENTS.—The Board may exclude from the ben-
5 efits such treatments as the Board determines,
6 based on clinical information, have not been
7 reasonably shown to improve a health condition
8 or significantly ameliorate a health condition.
9 Except as specifically excluded, the actual spe-
10 cific treatments, procedures, and care (such as
11 the use of particular providers or services)
12 which may be used under a plan or be used
13 with respect to health conditions shall be left up
14 to the plan.

15 (E) NONDISCRIMINATION.—In determining
16 the uniform set of effective benefits, the Board
17 shall not discriminate against individuals with
18 serious mental illnesses.

19 (3) DEDUCTIBLES AND COST-SHARING.—

20 (A) IN GENERAL.—Subject to subpara-
21 graph (B), such set shall include uniform
22 deductibles and cost-sharing associated with
23 such benefits.

24 (B) TREATMENT OF NETWORK PLANS.—In
25 the case of a network plan (as defined in sec-

1 tion 121(b)), the plan may provide for charging
2 deductibles and cost-sharing in excess of the
3 uniform deductibles and cost-sharing under
4 subparagraph (A) in the case of services pro-
5 vided by providers that are not participating
6 providers (as defined in such section).

7 (b) BASIS FOR BENEFITS.—In establishing such set,
8 the Board shall judge medical treatments, procedures, and
9 related health services based on—

10 (1) their effectiveness in improving the health
11 status of individuals; and

12 (2) their long-term impact on maintaining and
13 improving health and productivity and on reducing
14 the consumption of health care services.

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

18 (1) include only such cost-sharing as will re-
19 strain consumers from seeking unnecessary services;

20 (2) not impose cost-sharing for covered clinical
21 preventive services;

22 (3) balance the effect of the cost-sharing in re-
23 ducing premiums and in affecting utilization of ap-
24 propriate services; and

1 (4) limit the total cost-sharing that may be in-
2 curred by an individual (or enrollee unit) in a year.

3 **SEC. 133. HEALTH BENEFITS AND DATA STANDARDS**
4 **BOARD.**

5 (a) ESTABLISHMENT.—The Board shall provide for
6 the initial organization, as a nonprofit corporation in the
7 District of Columbia, of the Health Benefits and Data
8 Standards Board (in this section referred to as the “Bene-
9 fits and Data Board”), under the direction of a board of
10 directors consisting of 5 directors.

11 (b) APPOINTMENT OF DIRECTORS.—

12 (1) SOLICITATION.—The Board shall solicit
13 nominations for the initial board of directors of the
14 Benefits and Data Board from organizations that
15 represent the various groups with an interest in the
16 health care system and the functions of the Board.

17 (2) CONTINUATION.—The by-laws of the Bene-
18 fits and Data Board shall provide for the board of
19 directors subsequently to be appointed by the board
20 in a manner that ensures a broad range of represen-
21 tation of through groups with an interest in provid-
22 ing and purchasing health care.

23 (3) TERMS OF DIRECTORS.—The term of each
24 member of the board of directors shall be for 7
25 years, except that in order to provide for staggered

1 terms, the terms of the members initially appointed
2 shall be for 3, 4, 5, 6, and 7 years. In the case of
3 a vacancy by death or resignation, the replacement
4 shall be appointed for the remainder of the term. No
5 individual may serve as a director of the board for
6 more than 14 years.

7 (c) FUNCTIONS.—

8 (1) IN GENERAL.—The Benefits and Data
9 Board shall make recommendations to the Board
10 concerning each of the following:

11 (A) The uniform set of effective benefits.

12 (B) The standards for information collec-
13 tion from AHPs.

14 (C) Auditing standards to ensure the accu-
15 racy of such information.

16 Before making recommendations concerning the
17 standards described in subparagraph (B), the Bene-
18 fits and Data Board shall consult with the Agency
19 for Health Care Policy and Research regarding the
20 Agency's need for information in performing its ac-
21 tivities.

22 (2) ASSESSMENTS.—The Benefits and Data
23 Board shall provide the Board with its assessment
24 of—

25 (A) medical technology;

1 (B) practice variations;

2 (C) the effectiveness of medical practices
3 and drug therapies based on research per-
4 formed by the Agency for Health Care Policy
5 and Research;

6 (D) information from clinical and epi-
7 demologic studies; and

8 (E) information provided by AHPs, includ-
9 ing AHP-specific information on clinical health,
10 functional status, well-being, and plan satisfac-
11 tion of enrolled individuals.

12 (3) NATIONAL HEALTH DATA SYSTEM.—The
13 Benefits and Data Board shall provide the Board
14 with its assistance in the development of the stand-
15 ards for the national data reporting system under
16 section 137.

17 (d) FUNDING.—

18 (1) IN GENERAL.—In order to provide funding
19 for the Benefits and Data Board, the National
20 Health Board shall establish an annual registration
21 fee for AHPs which is imposed on a per-covered-in-
22 dividual-basis and is sufficient, in the aggregate, to
23 provide each year for not more than the amount
24 specified in paragraph (2) for the operation of the
25 Benefits and Data Board.

1 (2) AMOUNT OF FUNDS.—The amount specified
2 in this paragraph for each of fiscal years 1994 and
3 1995, is \$50,000,000, and, for each succeeding fis-
4 cal year, is \$25,000,000.

5 **SEC. 134. HEALTH PLAN STANDARDS BOARD.**

6 (a) ESTABLISHMENT.—The Board shall provide for
7 the initial organization, as a nonprofit corporation in the
8 District of Columbia, of the Health Plan Standards Board
9 (in this section referred to as the “Plan Standards
10 Board”), under the direction of a board of directors con-
11 sisting of 5 directors.

12 (b) APPOINTMENT OF DIRECTORS.—

13 (1) SOLICITATION.—The Board shall solicit
14 nominations for the initial board of directors of the
15 Plan Standards Board from organizations that rep-
16 resent the various groups with an interest in the
17 health care system and the functions of the Board.

18 (2) CONTINUATION.—The by-laws of the Plan
19 Standards Board shall provide for the board of di-
20 rectors subsequently to be appointed by the board in
21 a manner that ensures a broad range of representa-
22 tion of through groups with an interest in providing
23 and purchasing health care.

24 (3) TERMS OF DIRECTORS.—The term of each
25 member of the board of directors shall be for 7

1 years, except that in order to provide for staggered
2 terms, the terms of the members initially appointed
3 shall be for 3, 4, 5, 6, and 7 years. In the case of
4 a vacancy by death or resignation, the replacement
5 shall be appointed for the remainder of the term. No
6 individual may serve as a director of the board for
7 more than 12 years.

8 (c) FUNCTIONS.—

9 (1) IN GENERAL.—The Plan Standards Board
10 shall make recommendations to the Board concern-
11 ing the standards for AHPs (other than standards
12 relating to the uniform set of effective benefits and
13 the national health data system) and for HPPCs.

14 (2) ASSESSMENT OF RISK-ADJUSTMENT FAC-
15 TORS.—The Plan Standards Board shall provide the
16 Board with its assessment of the risk-adjustment
17 factors under section 136.

18 (d) FUNDING.—In order to provide funding for the
19 Plan Standards Board, the National Health Board shall
20 establish an annual registration fee for AHPs which is im-
21 posed on a per-covered-individual-basis and is sufficient,
22 in the aggregate, to provide each year for not more than
23 60 percent of the amount specified in section 133(d)(2)
24 for the operation of the Plan Standards Board.

1 **SEC. 135. REGISTRATION OF ACCOUNTABLE HEALTH**
2 **PLANS.**

3 (a) IN GENERAL.—The Board shall register those
4 health plans that meet the standards under subtitle B.

5 (b) TREATMENT OF STATE CERTIFICATION.—If the
6 Board determines that a State superintendent of insur-
7 ance, State insurance commissioner, or other State official
8 provides for the imposition of standards that the Board
9 finds are equivalent to the standards established under
10 subtitle B for registration of a health benefit plan as an
11 AHP, the Board may provide for registration as AHPs
12 of health plans that such official certifies as meeting the
13 standards for registration. Nothing in this subsection shall
14 require a health plan to be certified by such an official
15 in order to be registered by the Board.

16 (c) MEDICAID WAIVER.—The Board shall develop
17 criteria and procedures under which the Secretary may
18 grant a waiver to a State to permit that State to enroll
19 individuals, otherwise eligible for enrollment under title
20 XIX of the Social Security Act, under ACP's through a
21 HPPC. The waiver shall permit the State to use funds
22 made available under such title XIX for the enrollment
23 of medicaid eligible individuals through a HPPC. The
24 State shall ensure that individuals enrolled in a AHP
25 under such a waiver are guaranteed at least those mini-

1 mum benefits that such individual would have been enti-
2 tled to under such title XIX.

3 **SEC. 136. SPECIFICATION OF RISK-ADJUSTMENT FACTORS.**

4 (a) IN GENERAL.—The Board shall establish rules
5 for the process of risk-adjustment of premiums among
6 AHPs by HPPCs under section 102(d).

7 (b) PROCESS.—

8 (1) IDENTIFICATION OF RELATIVE RISK.—The
9 Board shall determine risk-adjustment factors that
10 are correlated with increased or diminished risk for
11 consumption of the type of health services included
12 in the uniform set of effective benefits. To the maxi-
13 mum extent practicable, such factors shall be deter-
14 mined without regard to the methodology used by in-
15 dividual AHPs in the provision of such benefits. In
16 determining such factors, with respect to an individ-
17 ual who is identified as having—

18 (A) a lower-than-average risk for consump-
19 tion of the services, the factor shall be a num-
20 ber, less than zero, reflecting the degree of such
21 lower risk;

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

24 (C) a higher-than-average risk for con-
25 sumption of the services, the factor shall be a

1 number, greater than zero, reflecting the degree
2 of such higher risk.

3 (2) ADJUSTMENT OF FACTORS.—In applying
4 under section 102(d)(1)(B) the risk-adjustment fac-
5 tors determined under paragraph (1), each HPPC
6 shall adjust such factors, in accordance with a meth-
7 odology established by the Board, so that the sum
8 of such factors is zero for all enrollee units in each
9 HPPC area for which a premium payment is for-
10 warded under section 102(d) for each premium pay-
11 ment period.

12 **SEC. 137. NATIONAL HEALTH DATA SYSTEM.**

13 (a) STANDARDIZATION OF INFORMATION.—

14 (1) IN GENERAL.—The Board shall establish
15 standards for the periodic reporting by AHPs of in-
16 formation under section 113(a).

17 (2) PATIENT CONFIDENTIALITY.—The stand-
18 ards shall be established in a manner that protects
19 the confidentiality of individual enrollees, but may
20 provide for the disclosure of information which dis-
21 closes particular providers within an AHP.

22 (b) ANALYSIS OF INFORMATION.—The Board shall
23 analyze the information reported in order to distribute it
24 in a form, consistent with subsection (a)(2), that—

1 (1) reports, on a national, State, and commu-
2 nity basis, the levels and trends of health care ex-
3 penditures, the rates and trends in the provision of
4 individual procedures, and the price levels and rates
5 of price change for such procedures; and

6 (2) permits the direct comparison of different
7 AHPs on the basis of the ability of the AHPs to
8 maintain and improve clinical health, functional sta-
9 tus, and well-being and to satisfy enrolled individ-
10 uals.

11 The reports under paragraph (1) shall include both aggre-
12 gate and per capita measures for areas and shall include
13 comparative data of different areas. The comparison
14 under paragraph (2) may also be made to show changes
15 in the performance of AHPs over time.

16 (c) DISTRIBUTION OF INFORMATION.—

17 (1) IN GENERAL.—The Board shall provide,
18 through the HPPCs and directly to AHPs, for the
19 distribution of its analysis on individual AHPs. Such
20 distribution shall occur at least annually before each
21 general enrollment period.

22 (2) ANNUAL REPORT ON EXPENDITURES.—The
23 Board shall publish annually (beginning with 1996)
24 a report on expenditures on, and volumes and prices
25 of, procedures. Such report shall be distributed to

1 each AHP, each HPPC, each Governor, and each
2 State legislature.

3 (3) ANNUAL REPORTS.—The Board shall also
4 publish an annual report, based on analyses under
5 this section, that identifies—

6 (A) procedures for which, as reflected in
7 variations in use or rates of increase, there ap-
8 pear to be the greatest need to develop valid
9 clinical protocols for clinical decision-making
10 and review;

11 (B) procedures for which, as reflected in
12 price variations and price inflation, there ap-
13 pear to be the greatest need for strengthening
14 competitive purchasing; and

15 (C) States and localities for which, as re-
16 flected in expenditure levels and rates of in-
17 crease, there appear to be the greatest need for
18 additional cost control measures.

19 (4) SPECIAL DISTRIBUTIONS.—The Board may,
20 whenever it deems appropriate, provide for the dis-
21 tribution—

22 (A) to an AHP of such information relat-
23 ing to the plan as may be appropriate in order
24 to encourage the plan to improve its delivery of
25 care; and

1 (B) to business, consumer, and other
2 groups and individuals of such information as
3 may improve their ability to effect improve-
4 ments in the outcomes, quality, and efficiency
5 of health services.

6 (5) ACCESS BY AGENCY FOR HEALTH CARE
7 POLICY AND RESEARCH.—The Board shall make
8 available to the Agency for Health Care Policy and
9 Research information obtained under section 113(a)
10 in a manner consistent with subsection (a)(2).

11 (d) STANDARDIZED FORMS.—Not later than October
12 1, 1994, the Board, in consultation with representatives
13 of local governments, insurers, health care providers, and
14 consumers shall develop a plan to accelerate electronic bill-
15 ing and computerization of medical records and shall de-
16 velop standardized claim forms and billing procedures for
17 use by all AHP's under this title.

18 **SEC. 138. MEASURES OF QUALITY OF CARE OF SPECIAL-**
19 **IZED CENTERS OF CARE.**

20 (a) COLLECTION OF INFORMATION.—The Board
21 shall provide a process whereby a specialized center of care
22 (as defined in subsection (c)) may submit to the Board
23 such clinical and other information bearing on the quality
24 of care provided with respect to the uniform set of effective
25 benefits at the center as the Board may specify. Such in-

1 formation shall include sufficient information to take into
2 account outcomes and the risk factors associated with in-
3 dividuals receiving care through the center. Such informa-
4 tion shall be provided at such frequency (not less often
5 than annually) as the Board specifies.

6 (b) MEASURES OF QUALITY.—Using information
7 submitted under subsection (a) and information reported
8 under section 137, the Board shall—

9 (1) analyze the performance of such centers
10 with respect to the quality of care provided;

11 (2) rate the performance of such a center with
12 respect to a class of services relative to the perform-
13 ance of other specialized centers of care and relative
14 to the performance of AHPs generally; and

15 (3) publish such ratings.

16 (c) USE OF SERVICE MARK FOR SPECIALIZED CEN-
17 TERS OF CARE.—The Board may establish a service mark
18 for specialized centers of care the performance of which
19 has been rated under subsection (b). Such service mark
20 shall be registrable under the Trademark Act of 1946, and
21 the Board shall apply for the registration of such service
22 mark under such Act. For purposes of such Act, such serv-
23 ice mark shall be deemed to be used in commerce. For
24 purposes of this subsection, the “Trademark Act of 1946”
25 refers to the Act entitled “An Act to provide for the reg-

1 istration and protection of trademarks used in commerce,
2 to carry out the provisions of international conventions,
3 and for other purposes”, approved July 5, 1946 (15
4 U.S.C. 1051 et seq.).

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

11 **SEC. 139. REPORT ON IMPACT OF ADVERSE SELECTION;**
12 **RECOMMENDATIONS ON MANDATED PUR-**
13 **CHASE OF COVERAGE.**

14 (a) STUDY.—The Board shall study—

15 (1) the extent to which those eligible individuals
16 (as defined in subsection (c)) who enroll with AHPs
17 have significantly greater needs for health care serv-
18 ices than the population of eligible individuals as a
19 whole; and

20 (2) methods for reducing adverse impacts that
21 may result from such adverse selection.

22 (b) REPORT.—By not later than January 1, 1996,
23 the Board shall submit to Congress a report on the study
24 under subsection (a) and on appropriate methods for re-
25 ducing adverse impacts that may result from adverse se-

1 lection in enrollment. The report shall specifically in-
2 clude—

3 (1) an examination of the impact of establishing
4 a requirement that all eligible individuals obtain
5 health coverage through enrollment with an AHP;
6 and

7 (2) a recommendation as to whether (and, if so,
8 how) to impose such a requirement.

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

11 (1) includes individuals who would be eligible
12 individuals but for section 2(a)(4)(B), but

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

16 **TITLE II—TAX INCENTIVES TO**
17 **INCREASE HEALTH CARE AC-**
18 **CESS**

19 **SEC. 201. CREDIT FOR ACCOUNTABLE HEALTH PLAN**
20 **COSTS.**

21 (a) IN GENERAL.—Subpart C of part IV of sub-
22 chapter A of chapter 1 of the Internal Revenue Code of
23 1986 (relating to refundable personal credits) is amended
24 by inserting after section 34 the following new section:

1 **“SEC. 34A. ACCOUNTABLE HEALTH PLAN COSTS.**

2 “(a) ALLOWANCE OF CREDIT.—

3 “(1) IN GENERAL.—In the case of an eligible
4 individual, there shall be allowed as a credit against
5 the tax imposed by this subtitle for the taxable year
6 an amount equal to the applicable percentage of the
7 accountable health plan costs paid by such individual
8 during the taxable year.

9 “(2) APPLICABLE PERCENTAGE.—For purposes
10 of paragraph (1), the term ‘applicable percentage’
11 means 60 percent reduced (but not below zero) by
12 10 percentage points for each \$1,000 (or fraction
13 thereof) by which the taxpayer’s adjusted gross in-
14 come for the taxable year exceeds the applicable dol-
15 lar amount.

16 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
17 poses of this subsection, the term ‘applicable dollar
18 amount’ means—

19 “(A) in the case of a taxpayer filing a joint
20 return, \$28,000,

21 “(B) in the case of any other taxpayer
22 (other than a married individual filing a sepa-
23 rate return), \$18,000, and

24 “(C) in the case of a married individual fil-
25 ing a separate return, zero.

1 For purposes of this subsection, the rule of section
2 219(g)(4) shall apply.

3 “(b) ACCOUNTABLE HEALTH PLAN COSTS.—For
4 purposes of this section—

5 “(1) IN GENERAL.—The term ‘accountable
6 health plan costs’ means amounts paid during the
7 taxable year for insurance which constitutes medical
8 care (within the meaning of section 213(g). For pur-
9 poses of the preceding sentence, the rules of section
10 213(d)(6) shall apply.

11 “(2) DOLLAR LIMIT ON ACCOUNTABLE HEALTH
12 PLAN COSTS.—The amount of the accountable
13 health care costs paid during any taxable year which
14 may be taken into account under subsection (a)(1)
15 shall not exceed the reference premium amount for
16 the taxable year.

17 “(3) ELECTION NOT TO TAKE CREDIT.—A tax-
18 payer may elect for any taxable year to have
19 amounts described in paragraph (1) not treated as
20 accountable health plan costs.

21 “(4) DEFINITION.—As used in paragraph (2),
22 the term ‘reference premium rate amount’ means,
23 with respect to an individual in a HPPC area, the
24 lowest premium established by an open accountable
25 health plan and offered in the area for the premium

1 class applicable to such individual (including, if ap-
2 propriate, the HPPC overhead amount established
3 under section 105(b)(3) of the Access to Affordable
4 Health Care Act) applied for the taxable year period
5 involved.

6 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this
7 section, the term ‘eligible individual’ means, with respect
8 to any period, an individual who is not covered during such
9 period by a health plan maintained by an employer of such
10 individual or such individual’s spouse.

11 “(d) SPECIAL RULES.—For purposes of this sec-
12 tion—

13 “(1) COORDINATION WITH ADVANCE PAYMENT
14 AND MINIMUM TAX.—Rules similar to the rules of
15 subsections (g) and (h) of section 32 shall apply to
16 any credit to which this section applies.

17 “(2) MEDICARE-ELIGIBLE INDIVIDUALS.—No
18 expense shall be treated as an accountable health
19 plan cost if it is an amount paid for insurance for
20 an individual for any period with respect to which
21 such individual is entitled (or, on application without
22 the payment of an additional premium, would be en-
23 titled to) benefits under part A of title XVIII of the
24 Social Security Act.

1 “(3) SUBSIDIZED EXPENSES.—No expense shall
2 be treated as an accountable health plan cost to the
3 extent—

4 “(A) such expense is paid, reimbursed, or
5 subsidized (whether by being disregarded for
6 purposes of another program or otherwise) by
7 the Federal Government, a State or local gov-
8 ernment, or any agency or instrumentality
9 thereof, and

10 “(B) the payment, reimbursement, or sub-
11 sidy of such expense is not includible in the
12 gross income of the recipient.

13 “(e) REGULATIONS.—The Secretary shall prescribe
14 such regulations as may be necessary to carry out the pur-
15 poses of this section.”.

16 (b) ADVANCE PAYMENT OF CREDIT.—

17 (1) IN GENERAL.—Chapter 25 of the Internal
18 Revenue Code of 1986 is amended by inserting after
19 section 3507 the following new section:

20 **“SEC. 3507A. ADVANCE PAYMENT OF ACCOUNTABLE**
21 **HEALTH PLAN COSTS.**

22 “(a) GENERAL RULE.—Except as otherwise provided
23 in this section, every employer making payment of wages
24 with respect to whom an accountable health plan costs eli-
25 gibility certificate is in effect shall, at the time of paying

1 such wages, make an additional payment equal to such
2 employee's accountable health plan costs advance amount.

3 “(b) ACCOUNTABLE HEALTH PLAN COSTS ELIGI-
4 BILITY CERTIFICATE.—For purposes of this title, an ac-
5 countable health plan costs eligibility certificate is a state-
6 ment furnished by an employee to the employer which—

7 “(1) certifies that the employee will be eligible
8 to receive the credit provided by section 34A for the
9 taxable year,

10 “(2) certifies that the employee does not have
11 an accountable health plan costs eligibility certificate
12 in effect for the calendar year with respect to the
13 payment of wages by another employer,

14 “(3) states whether or not the employee's
15 spouse has an accountable health plan costs eligi-
16 bility certificate in effect, and

17 “(4) estimates the amount of accountable
18 health plan costs (as defined in section 34A(b)) for
19 the calendar year.

20 For purposes of this section, a certificate shall be treated
21 as being in effect with respect to a spouse if such a certifi-
22 cate will be in effect on the first status determination date
23 following the date on which the employee furnishes the
24 statement in question.

1 “(c) ACCOUNTABLE HEALTH PLAN COSTS ADVANCE
2 AMOUNT.—

3 “(1) IN GENERAL.—For purposes of this title,
4 the term ‘accountable health plan costs advance
5 amount’ means, with respect to any payroll period,
6 the amount determined—

7 “(A) on the basis of the employee’s wages
8 from the employer for such period,

9 “(B) on the basis of the employee’s esti-
10 mated accountable health plan costs included in
11 the accountable health plan costs eligibility cer-
12 tificate, and

13 “(C) in accordance with tables provided by
14 the Secretary.

15 “(2) ADVANCE AMOUNT TABLES.—The tables
16 referred to in paragraph (1)(D) shall be similar in
17 form to the tables prescribed under section 3402
18 and, to the maximum extent feasible, shall be coordi-
19 nated with such tables and the tables prescribed
20 under section 3507(c).

21 “(d) OTHER RULES.—For purposes of this section,
22 rules similar to the rules of subsections (d) and (e) of sec-
23 tion 3507 shall apply.

1 “(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section.”.

4 (2) CONFORMING AMENDMENT.—The table of
5 sections for chapter 25 of such Code is amended by
6 adding after the item relating to section 3507 the
7 following new item:

 “Sec. 3507A. Advance payment of accountable health plan costs
 credit.”.

8 (c) COORDINATION WITH DEDUCTIONS FOR HEALTH
9 INSURANCE EXPENSES.—

10 (1) SELF-EMPLOYED INDIVIDUALS.—Section
11 162(l) of the Internal Revenue Code of 1986, as
12 amended by section 203, is further amended by add-
13 ing after paragraph (5) the following new para-
14 graph:

15 “(6) COORDINATION WITH HEALTH INSURANCE
16 PREMIUM CREDIT.—Paragraph (1) shall not apply to
17 any amount taken into account in computing the
18 amount of the credit allowed under section 34A.”.

19 (2) MEDICAL, DENTAL, ETC., EXPENSES.—Sub-
20 section (e) of section 213 of such Code is amended
21 by inserting “or section 34A” after “section 21”.

22 (d) TERMINATION OF HEALTH INSURANCE CRED-
23 IT.—Section 32 of the Internal Revenue Code of 1986 (re-

1 lating to earned income credit) is amended by adding at
 2 the end thereof the following new subsection:

3 “(d) TERMINATION OF HEALTH INSURANCE CRED-
 4 IT.—In the case of taxable years beginning after Decem-
 5 ber 31, 1991, the health insurance credit percentage shall
 6 be equal to 0 percent.”

7 (e) CLERICAL AMENDMENT.—The table of sections
 8 for subpart A of part IV of subchapter A of chapter 1
 9 of the Internal Revenue Code of 1986 is amended by in-
 10 serting after the item relating to section 34 the following
 11 new item:

“Sec. 34A. Accountable health plan costs.”.

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

15 **SEC. 202. NO DEDUCTION FOR EMPLOYER HEALTH PLAN**
 16 **EXPENSES IN EXCESS OF ACCOUNTABLE**
 17 **HEALTH PLAN COSTS.**

18 (a) IN GENERAL.—Section 162 of the Internal Reve-
 19 nue Code of 1986 (relating to trade or business expenses)
 20 is amended by redesignating subsection (m) as subsection
 21 (n) and by inserting after subsection (l) the following new
 22 subsection:

23 “(m) GENERAL RULE.—

1 “(1) LIMITATION ON DEDUCTION.—No deduc-
2 tion shall be allowed under this section for the ex-
3 cess health plan expenses of any employer.

4 “(2) EXCESS HEALTH PLAN EXPENSES.—For
5 purposes of this subsection—

6 “(A) IN GENERAL.—The term ‘excess
7 health plan expenses’ means health plan ex-
8 penses paid or incurred by the employer for any
9 month with respect to any covered individual to
10 the extent such expenses do not meet the re-
11 quirements of subparagraphs (B), (C), and (D).

12 “(B) LIMIT TO ACCOUNTABLE HEALTH
13 PLANS.—Health plan expenses meet the re-
14 quirements of this subparagraph only if the ex-
15 penses are attributable to—

16 “(i) coverage of the covered individual
17 under an accountable health plan, or

18 “(ii) in the case of a small employer,
19 payment to a health plan purchasing coop-
20 erative for coverage under an accountable
21 health plan.

22 “(C) LIMIT ON PER EMPLOYEE CONTRIBU-
23 TION.—

24 “(i) IN GENERAL.—Health plan ex-
25 penses with respect to any employee meet

1 the requirements of this subparagraph for
2 any month only to the extent that the
3 amount of such expenses does not exceed
4 the reference premium rate amount for the
5 month.

6 “(ii) TREATMENT OF HEALTH PLANS
7 OUTSIDE THE UNITED STATES.—For pur-
8 poses of clause (i), in the case of an em-
9 ployee residing outside the United States,
10 there shall be substituted for the reference
11 premium rate such reasonable amounts as
12 the Federal Health Board determines to be
13 comparable to the limit imposed under
14 clause (i).

15 “(iii) DEFINITION.—As used in clause
16 (i), the term ‘reference premium rate
17 amount’ means, with respect to an individ-
18 ual in a HPPC area, the lowest premium
19 established by an open accountable health
20 plan and offered in the area for the pre-
21 mium class applicable to such individual
22 (including, if appropriate, the HPPC over-
23 head amount established under section
24 105(b)(3) of the Access to Affordable
25 Health Care Act).

1 “(D) REQUIREMENT OF LEVEL CONTRIBU-
2 TION.—Health plan expenses meet the require-
3 ments of this subparagraph for any month only
4 if the amount of the employer contribution (for
5 a premium class) does not vary based on the
6 accountable health plan selected.

7 “(3) EXCEPTION FOR MEDICARE-ELIGIBLE RE-
8 TIREES.—Paragraphs (1) and (2) shall not apply to
9 health plan expenses with respect to an individual
10 who is eligible for benefits under part A of title
11 XVIII of the Social Security Act if such expenses
12 are for a health plan that is not a primary payor
13 under section 1862(b) of such Act.

14 “(4) SPECIAL RULES.—

15 “(A) TREATMENT OF SELF-INSURED
16 PLANS.—In the case of a self-insured health
17 plan, the amount of contributions per employee
18 shall be determined for purposes of paragraph
19 (2)(C) in accordance with rules established by
20 the Federal Health Board which are based on
21 the principles of section 4980B(f)(4)(B) (as in
22 effect before the date of the enactment of this
23 subsection).

24 “(B) CONTRIBUTIONS TO CAFETERIA
25 PLANS.—Contributions under a cafeteria plan

1 on behalf of an employee that may be used for
2 a group health plan coverage shall be treated
3 for purposes of this section as health plan ex-
4 penses paid or incurred by the employer.

5 “(5) EMPLOYEES HELD HARMLESS.—Nothing
6 in this section shall be construed as affecting the ex-
7 clusion from gross income of an employee under sec-
8 tion 106.

9 “(6) OTHER DEFINITIONS.—For purposes of
10 this subsection—

11 “(A) COVERED INDIVIDUAL.—The term
12 ‘covered individual’ means any beneficiary of a
13 group health plan.

14 “(B) GROUP HEALTH PLAN.—The term
15 ‘group health plan’ has the meaning given such
16 term by section 5000(b)(1).

17 “(C) HEALTH PLAN EXPENSES.—

18 “(i) IN GENERAL.—The term ‘health
19 plan expenses’ means employer expenses
20 for any group health plan, including ex-
21 penses for premiums as well as payment of
22 deductibles and coinsurance that would
23 otherwise be applicable.

24 “(ii) EXCLUSION OF CERTAIN DIRECT
25 EXPENSES.—Such term does not include

1 expenses for direct services which are de-
2 termined by the Federal Health Board to
3 be primarily aimed at workplace health
4 care and health promotion or related popu-
5 lation-based preventive health activities.

6 “(D) ACCOUNTABLE HEALTH PLAN.—The
7 term ‘accountable health plan’ has the meaning
8 given such term by section 2(b)(1) of the Ac-
9 cess to Affordable Health Care Act.

10 “(E) SMALL EMPLOYER.—The term ‘small
11 employer’ means, for a taxable year, an em-
12 ployer that is a small employer (within the
13 meaning of section 2(c)(2) of the Access to Af-
14 fordable Health Care Act) for the most recent
15 calendar year ending before the end of the tax-
16 able year.”.

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Except as otherwise pro-
19 vided in this subsection, the amendments made by
20 this section shall apply to expenses incurred for the
21 provision of health services for periods after Decem-
22 ber 31, 1993.

23 (2) TRANSITION FOR COLLECTIVE BARGAINING
24 AGREEMENTS.—The amendments made by this sec-
25 tion shall not apply to employers with respect to

1 their employees, insofar as such employees are cov-
2 ered under a collective bargaining agreement ratified
3 before the date of the enactment of this Act, earlier
4 than the date of termination of such agreement (de-
5 termined without regard to any extension thereof
6 agreed to after the date of the enactment of this
7 Act), or January 1, 1996, whichever is earlier.

8 **SEC. 203. INCREASE IN DEDUCTION FOR HEALTH PLAN**
9 **PREMIUM EXPENSES OF SELF-EMPLOYED IN-**
10 **DIVIDUALS.**

11 (a) INCREASING DEDUCTION TO 100 PERCENT.—
12 Paragraph (1) of section 162(l) of the Internal Revenue
13 Code of 1986 (relating to special rules for health insur-
14 ance costs of self-employed individuals) is amended by
15 striking “25 percent of”.

16 (b) MAKING PROVISION PERMANENT.—Section
17 162(l) of such Code is amended by striking paragraph (6).

18 (c) LIMITATION TO ACCOUNTABLE HEALTH
19 PLANS.—Paragraph (2) of section 162(l) of such Code is
20 amended by adding at the end thereof the following new
21 subparagraph:

22 “(C) DEDUCTION LIMITED TO ACCOUNT-
23 ABLE HEALTH PLAN COSTS.—No deduction
24 shall be allowed under this section for any
25 amount which would be excess health plan ex-

1 penses (as defined in subsection (m)(2), deter-
2 mined without regard to subparagraph (D)
3 thereof) if the taxpayer were an employer.”.

4 (d) EFFECTIVE DATE.—

5 (1) IN GENERAL.—Except as otherwise pro-
6 vided in this subsection, the amendments made by
7 this section shall apply to taxable years beginning
8 after December 31, 1993.

9 (2) EXCEPTION.—The amendment made by
10 subsection (c) shall apply to expenses for periods of
11 coverage beginning on or after January 1, 1994.

12 **SEC. 204. DEDUCTION FOR HEALTH PLAN PREMIUM EX-**
13 **PENSES OF INDIVIDUALS.**

14 (a) IN GENERAL.—Section 213 of the Internal Reve-
15 nue Code of 1986 (relating to medical, dental, etc., ex-
16 penses) amended by adding at the end the following new
17 subsection:

18 “(g) SPECIAL RULES FOR HEALTH PLAN PREMIUM
19 EXPENSES.—

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

1 “(2) LIMIT.—The amount allowed as a deduc-
2 tion under paragraph (1) with respect to the cost of
3 providing coverage for any individual shall not ex-
4 ceed the applicable limit specified in section
5 162(m)(2)(C) reduced by the aggregate amount paid
6 by all other entities (including any employer or any
7 level of government) for coverage of such individual
8 under any health plan.

9 “(3) DEDUCTION ALLOWED AGAINST GROSS IN-
10 COME.—The deduction under this subsection shall
11 be taken into account in determining adjusted gross
12 income under section 62(a).

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

18 (b) EFFECTIVE DATE.—The amendment made by
19 subsection (a) shall apply to taxable years beginning after
20 December 31, 1993.

21 **SEC. 205. EXCLUSION FROM GROSS INCOME FOR EM-**
22 **EMPLOYER CONTRIBUTIONS TO ACCOUNTABLE**
23 **HEALTH PLANS.**

24 (a) IN GENERAL.—Section 106 of the Internal Reve-
25 nue Code of 1986 (relating to contributions by employers

1 to accident and health plans) is amended to read as fol-
 2 lows:

3 “Gross income of an employee does not include em-
 4 ployer-provided basic coverage under an accountable
 5 health plan (as defined in section 162(m)(2)(B)).”.

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

9 **TITLE III—OUTCOMES RE-**
 10 **SEARCH AND PRACTICE**
 11 **GUIDELINE DEVELOPMENT;**
 12 **APPLICATION OF GUIDE-**
 13 **LINES AS LEGAL STANDARD**

14 **SEC. 301. AUTHORIZATION FOR EXPANSION OF HEALTH**
 15 **SERVICES RESEARCH.**

16 Section 926(a) of the Public Health Service Act (42
 17 U.S.C. 299c-5) is amended to read as follows:

18 (a) GENERAL AUTHORIZATION OF APPROPRIA-
 19 TIONS.—For the purpose of carrying out this title, there
 20 are authorized to be appropriated \$120,000,000 for fiscal
 21 year 1993, \$155,000,000 for fiscal year 1994, and
 22 \$185,000,000 for fiscal year 1995.”.

1 **SEC. 302. TREATMENT PRACTICE GUIDELINES AS A LEGAL**
2 **STANDARD.**

3 Section 912 of the Public Health Service Act (42 U.S.C.
4 299b-1) is amended by adding at the end thereof the fol-
5 lowing new subsection:

6 “(g) TREATMENT PRACTICE GUIDELINES AS A
7 LEGAL STANDARD.—

8 “(1) IN GENERAL.—Except as provided in
9 paragraph (2) and notwithstanding any other provi-
10 sion of law, guidelines established under this section
11 may not be introduced in evidence or used in any ac-
12 tion brought in a Federal or State court arising
13 from the provision of a health care service to an in-
14 dividual.

15 “(2) PROVISION OF HEALTH CARE UNDER
16 GUIDELINES.—Notwithstanding any other provision
17 of law, in any action brought in a Federal or State
18 court arising from the provision of a health care
19 service to an individual, if the service was provided
20 to the individual in accordance with guidelines estab-
21 lished under this section, the guidelines—

22 “(A) may be introduced by a provider who
23 is a party to the action; and

24 “(B) if introduced, shall establish a rebut-
25 table presumption that the service prescribed by

1 “(b) ELIGIBLE APPLICANTS.—

2 “(1) IN GENERAL.—To be eligible to receive a
3 waiver under subsection (a), an entity shall be a hos-
4 pital and shall prepare and submit to the Secretary
5 an application at such time, in such manner, and
6 containing such information as the Secretary may
7 require, including—

8 “(A) a statement that such hospital desires
9 to negotiate and enter into a voluntary coopera-
10 tive agreement with at least one other hospital
11 operating in the State or region of the applicant
12 hospital for the sharing of medical technology
13 or services;

14 “(B) a description of the nature and scope
15 of the activities contemplated under the coopera-
16 tive agreement and any consideration that may
17 pass under such agreement to any other hos-
18 pital that may elect to become a party to the
19 agreement; and

20 “(C) any other information determined ap-
21 propriate by the Secretary.

22 “(2) DEVELOPMENT OF EVALUATION GUIDE-
23 LINES.—Not later than 90 days after the date of en-
24 actment of this section, the Administrator of the
25 Agency for Health Care Policy and Research shall

1 develop evaluation guidelines with respect to applica-
2 tions submitted under paragraph (1).

3 “(3) EVALUATIONS OF APPLICATIONS.—The
4 Secretary, in consultation with the Administrator of
5 the Agency for Health Care Policy and Research,
6 shall evaluate applications submitted under para-
7 graph (1). In determining which applications to ap-
8 prove for purposes of granting waivers under sub-
9 section (a), the Secretary shall consider whether the
10 cooperative agreement described in each such appli-
11 cation is likely to result in—

12 “(A) a reduction of costs and an increase
13 in access to care;

14 “(B) the enhancement of the quality of
15 hospital or hospital-related care;

16 “(C) the preservation of hospital facilities
17 in geographical proximity to the communities
18 traditionally served by such facilities;

19 “(D) improvements in the cost-effective-
20 ness of high-technology services by the hospitals
21 involved;

22 “(E) improvements in the efficient utiliza-
23 tion of hospital resources and capital equip-
24 ment; or

1 “(F) the avoidance of duplication of hos-
2 pital resources.

3 “(c) MEDICAL TECHNOLOGY AND SERVICES.—

4 “(1) IN GENERAL.—Cooperative agreements fa-
5 cilitated under this section shall provide for the
6 sharing of medical or high technology equipment or
7 services among the hospitals which are parties to
8 such agreements.

9 “(2) MEDICAL TECHNOLOGY.—For purposes of
10 this section, the term ‘medical technology’ shall in-
11 clude the drugs, devices, and medical and surgical
12 procedures utilized in medical care, and the organi-
13 zational and support systems within which such care
14 is provided.

15 “(3) ELIGIBLE SERVICES.—With respect to
16 services that may be shared under an agreement en-
17 tered into under this section, such services shall—

18 “(A) either have high capital costs or ex-
19 tremely high annual operating costs; and

20 “(B) be services with respect to which
21 there is a reasonable expectation that shared
22 ownership will avoid a significant degree of the
23 potential excess capacity of such services in the
24 community or region to be served under such
25 agreement.

1 Such services may include mobile clinic services.

2 “(d) REPORT.—Not later than 5 years after the date
3 of enactment of this section, the Secretary shall prepare
4 and submit to the appropriate committees of Congress, a
5 report concerning the potential for cooperative agreements
6 of the type entered into under this section to—

7 “(1) contain health care costs;

8 “(2) increase the access of individuals to medi-
9 cal services; and

10 “(3) improve the quality of health care.

11 Such report shall also contain the recommendations of the
12 Secretary with respect to future programs to facilitate co-
13 operative agreements.

14 “(e) DEFINITION.—For purposes of this section, the
15 term ‘antitrust laws’ means—

16 “(1) the Act entitled ‘An Act to protect trade
17 and commerce against unlawful restraints and mo-
18 nopolies’, approved July 2, 1890, commonly known
19 as the ‘Sherman Act’ (26 Stat. 209; chapter 647; 15
20 U.S.C. 1 et seq.);

21 “(2) the Federal Trade Commission Act, ap-
22 proved September 26, 1914 (38 Stat. 717; chapter
23 311; 15 U.S.C. 41 et seq.);

24 “(3) the Act entitled ‘An Act to supplement ex-
25 isting laws against unlawful restraints and monopo-

1 lies, and for other purposes’, approved October 15,
 2 1914, commonly known as the ‘Clayton Act’ (38
 3 Stat. 730; chapter 323; 15 U.S.C. 12 et seq.; 18
 4 U.S.C. 402, 660, 3285, 3691; 29 U.S.C. 52, 53);
 5 and

6 “(4) any State antitrust laws that would pro-
 7 hibit the activities described in subsection (a).”.

8 **TITLE V—IMPROVED ACCESS TO**
 9 **HEALTH CARE FOR RURAL**
 10 **AND UNDERSERVED AREAS**

11 **Subtitle A—Revenue Incentives for**
 12 **Practice in Rural Areas**

13 **SEC. 501. REVENUE INCENTIVES FOR PRACTICE IN RURAL**
 14 **AREAS.**

15 (a) **NONREFUNDABLE CREDIT FOR CERTAIN PRI-**
 16 **MARY HEALTH SERVICES PROVIDERS.—**

17 (1) **IN GENERAL.—**Subpart A of part IV of sub-
 18 chapter A of chapter 1 of the Internal Revenue Code
 19 of 1986 (relating to nonrefundable personal credits)
 20 is amended by inserting after section 25 the follow-
 21 ing new section:

22 **“SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.**

23 “(a) **ALLOWANCE OF CREDIT.—**In the case of a
 24 qualified primary health services provider, there is allowed
 25 as a credit against the tax imposed by this chapter for

1 any taxable year in a mandatory service period an amount
2 equal to the product of—

3 “(1) the lesser of—

4 “(A) the number of months of such period
5 occurring in such taxable year, or

6 “(B) 36 months, reduced by the number of
7 months taken into account under this para-
8 graph with respect to such provider for all pre-
9 ceding taxable years (whether or not in the
10 same mandatory service period), multiplied by

11 “(2) \$1,000 (\$500 in the case of a qualified
12 health services provider who is a physician assistant
13 or a nurse practitioner).

14 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
15 VIDER.—For purposes of this section, the term ‘qualified
16 primary health services provider’ means any physician,
17 physician assistant, or nurse practitioner who for any
18 month during a mandatory service period is certified by
19 the Bureau to be a primary health services provider who—

20 “(1) is providing primary health services—

21 “(A) full time, and

22 “(B) to individuals at least 80 percent of
23 whom reside in a rural health professional
24 shortage area,

1 “(2) is not receiving during such year a scholar-
2 ship under the National Health Service Corps Schol-
3 arship Program or a loan repayment under the Na-
4 tional Health Service Corps Loan Repayment Pro-
5 gram,

6 “(3) is not fulfilling service obligations under
7 such Programs, and

8 “(4) has not defaulted on such obligations.

9 “(c) MANDATORY SERVICE PERIOD.—For purposes
10 of this section, the term ‘mandatory service period’ means
11 the period of 60 consecutive calendar months beginning
12 with the first month the taxpayer is a qualified primary
13 health services provider.

14 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
15 poses of this section—

16 “(1) BUREAU.—The term ‘Bureau’ means the
17 Bureau of Health Care Delivery and Assistance,
18 Health Resources and Services Administration of the
19 United States Public Health Service.

20 “(2) PHYSICIAN.—The term ‘physician’ has the
21 meaning given to such term by section 1861(r) of
22 the Social Security Act.

23 “(3) PHYSICIAN ASSISTANT; NURSE PRACTI-
24 TIONER.—The terms ‘physician assistant’ and ‘nurse

1 practitioner' have the meanings given to such terms
2 by section 1861(aa)(3) of the Social Security Act.

3 “(4) PRIMARY HEALTH SERVICES PROVIDER.—
4 The term ‘primary health services provider’ means a
5 provider of primary health services (as defined in
6 section 330(b)(1) of the Public Health Service Act).

7 “(5) RURAL HEALTH PROFESSIONAL SHORTAGE
8 AREA.—The term ‘rural health professional shortage
9 area’ means—

10 “(A) a class 1 or class 2 health profes-
11 sional shortage area (as defined in section
12 332(a)(1)(A) of the Public Health Service Act)
13 in a rural area (as determined under section
14 1886(d)(2)(D) of the Social Security Act), or

15 “(B) an area which is determined by the
16 Secretary of Health and Human Services as
17 equivalent to an area described in subparagraph
18 (A) and which is designated by the Bureau of
19 the Census as not urbanized.

20 “(e) RECAPTURE OF CREDIT.—

21 “(1) IN GENERAL.—If, during any taxable year,
22 there is a recapture event, then the tax of the tax-
23 payer under this chapter for such taxable year shall
24 be increased by an amount equal to the product of—

25 “(A) the applicable percentage, and

1 “(B) the aggregate unrecaptured credits
 2 allowed to such taxpayer under this section for
 3 all prior taxable years.

4 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

5 “(A) IN GENERAL.—For purposes of this
 6 subsection, the applicable recapture percentage
 7 shall be determined from the following table:

“If the recapture event occurs during:	The applicable recap- ture percentage is:
Months 1-24	100
Months 25-36	75
Months 37-48	50
Months 49-60	25
Months 61 and thereafter	0.

8 “(B) TIMING.—For purposes of subpara-
 9 graph (A), month 1 shall begin on the first day
 10 of the mandatory service period.

11 “(3) RECAPTURE EVENT DEFINED.—

12 “(A) IN GENERAL.—For purposes of this
 13 subsection, the term ‘recapture event’ means
 14 the failure of the taxpayer to be a qualified pri-
 15 mary health services provider for any month
 16 during any mandatory service period.

17 “(B) CESSATION OF DESIGNATION.—The
 18 cessation of the designation of any area as a
 19 rural health professional shortage area after the
 20 beginning of the mandatory service period for
 21 any taxpayer shall not constitute a recapture
 22 event.

1 “(C) SECRETARIAL WAIVER.—The Sec-
2 retary may waive any recapture event caused by
3 extraordinary circumstances.

4 “(4) NO CREDITS AGAINST TAX.—Any increase
5 in tax under this subsection shall not be treated as
6 a tax imposed by this chapter for purposes of deter-
7 mining the amount of any credit under subpart A,
8 B, or D of this part.”.

9 (2) CLERICAL AMENDMENT.—The table of sec-
10 tions for subpart A of part IV of subchapter A of
11 chapter 1 of such Code is amended by inserting
12 after the item relating to section 25 the following
13 new item:

 “Sec. 25A. Primary health services providers.”.

14 (3) EFFECTIVE DATE.—The amendments made
15 by this subsection shall apply to taxable years begin-
16 ning after December 31, 1993.

17 (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-
18 PAYMENTS EXCLUDED FROM GROSS INCOME.—

19 (1) IN GENERAL.—Part III of subchapter B of
20 chapter 1 of the Internal Revenue Code of 1986 (re-
21 lating to items specifically excluded from gross in-
22 come) is amended by redesignating section 136 as
23 section 137 and by inserting after section 135 the
24 following new section:

1 **“SEC. 136. NATIONAL HEALTH SERVICE CORPS LOAN RE-**
2 **PAYMENTS.**

3 “(a) GENERAL RULE.—Gross income shall not in-
4 clude any qualified loan repayment.

5 “(b) QUALIFIED LOAN REPAYMENT.—For purposes
6 of this section, the term ‘qualified loan repayment’ means
7 any payment made on behalf of the taxpayer by the Na-
8 tional Health Service Corps Loan Repayment Program
9 under section 338B(g) of the Public Health Service Act.”.

10 (2) CONFORMING AMENDMENT.—Paragraph (3)
11 of section 338B(g) of the Public Health Service Act
12 is amended by striking “Federal, State, or local”
13 and inserting “State or local”.

14 (3) CLERICAL AMENDMENT.—The table of sec-
15 tions for part III of subchapter B of chapter 1 of
16 the Internal Revenue Code of 1986 is amended by
17 striking the item relating to section 136 and insert-
18 ing the following:

“Sec. 136. National Health Service Corps loan repayments.
“Sec. 137. Cross references to other Acts.”.

19 (4) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply to payments made
21 under section 338B(g) of the Public Health Service
22 Act after the date of the enactment of this Act.

23 (c) EXPENSING OF MEDICAL EQUIPMENT.—

1 (1) IN GENERAL.—Section 179 of the Internal
2 Revenue Code of 1986 (relating to election to ex-
3 pense certain depreciable business assets) is amend-
4 ed—

5 (A) by striking paragraph (1) of subsection
6 (b) and inserting the following:

7 “(1) DOLLAR LIMITATION.—

8 “(A) GENERAL RULE.—The aggregate cost
9 which may be taken into account under sub-
10 section (a) for any taxable year shall not exceed
11 \$10,000.

12 “(B) RURAL HEALTH CARE PROPERTY.—

13 In the case of rural health care property, the
14 aggregate cost which may be taken into account
15 under subsection (a) for any taxable year shall
16 not exceed \$25,000, reduced by the amount
17 otherwise taken into account under subsection
18 (a) for such year.”; and

19 (B) by adding at the end of subsection (d)
20 the following new paragraph:

21 “(11) RURAL HEALTH CARE PROPERTY.—For
22 purposes of this section, the term ‘rural health care
23 property’ means section 179 property used by a phy-
24 sician (as defined in section 1861(r) of the Social
25 Security Act) in the active conduct of such physi-

1 cian’s full-time trade or business of providing pri-
2 mary health services (as defined in section 330(b)(1)
3 of the Public Health Service Act) in a rural health
4 professional shortage area (as defined in section
5 25A(d)(5)).”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to property placed in
8 service after December 31, 1993, in taxable years
9 ending after such date.

10 (d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY
11 MEDICAL PROFESSIONALS PRACTICING IN RURAL
12 AREAS.—

13 (1) INTEREST ON STUDENT LOANS NOT TREAT-
14 ED AS PERSONAL INTEREST.—Section 163(h)(2) of
15 the Internal Revenue Code of 1986 (defining per-
16 sonal interest) is amended by striking “and” at the
17 end of subparagraph (D), by striking the period at
18 the end of subparagraph (E) and inserting “, and”,
19 and by adding at the end thereof the following new
20 subparagraph:

21 “(F) any qualified medical education interest
22 (within the meaning of subsection (k)).”.

23 (2) QUALIFIED MEDICAL EDUCATION INTEREST
24 DEFINED.—Section 163 of such Code (relating to in-
25 terest expenses) is amended by redesignating sub-

1 section (k) as subsection (l) and by inserting after
2 subsection (j) the following new subsection:

3 “(k) QUALIFIED MEDICAL EDUCATION INTEREST OF
4 MEDICAL PROFESSIONALS PRACTICING IN RURAL
5 AREAS.—

6 “(1) IN GENERAL.—For purposes of subsection
7 (h)(2)(F), the term ‘qualified medical education in-
8 terest’ means an amount which bears the same ratio
9 to the interest paid on qualified educational loans
10 during the taxable year by an individual performing
11 services under a qualified rural medical practice
12 agreement as—

13 “(A) the number of months during the tax-
14 able year during which such services were per-
15 formed, bears to

16 “(B) the number of months in the taxable
17 year.

18 “(2) DOLLAR LIMITATION.—The aggregate
19 amount which may be treated as qualified medical
20 education interest for any taxable year with respect
21 to any individual shall not exceed \$5,000.

22 “(3) QUALIFIED RURAL MEDICAL PRACTICE
23 AGREEMENT.—For purposes of this subsection—

24 “(A) IN GENERAL.—The term ‘qualified
25 rural medical practice agreement’ means a writ-

1 ten agreement between an individual and an ap-
2 plicable rural community under which the indi-
3 vidual agrees—

4 “(i) in the case of a medical doctor,
5 upon completion of the individual’s resi-
6 dency (or internship if no residency is re-
7 quired), or

8 “(ii) in the case of a registered nurse,
9 nurse practitioner, or physician’s assistant,
10 upon completion of the education to which
11 the qualified education loan relates,

12 to perform full-time services as such a medical
13 professional in the applicable rural community
14 for a period of 24 consecutive months. An indi-
15 vidual and an applicable rural community may
16 elect to have the agreement apply for 36 con-
17 secutive months rather than 24 months.

18 “(B) SPECIAL RULE FOR COMPUTING PE-
19 RIODS.—An individual shall be treated as meet-
20 ing the 24 or 36 consecutive month requirement
21 under subparagraph (A) if, during each 12-con-
22 secutive month period within either such period,
23 the individual performs full-time services as a
24 medical doctor, registered nurse, nurse practi-
25 tioner, or physician’s assistant, whichever ap-

1 plies, in the applicable rural community during
 2 9 of the months in such 12-consecutive month
 3 period. For purposes of this subsection, an indi-
 4 vidual meeting the requirements of the preced-
 5 ing sentence shall be treated as performing
 6 services during the entire 12-month period.

7 “(C) APPLICABLE RURAL COMMUNITY.—
 8 The term ‘applicable rural community’ means—

9 “(i) any political subdivision of a
 10 State which—

11 “(I) has a population of 5,000 or
 12 less, and

13 “(II) has a per capita income of
 14 \$15,000 or less, or

15 “(ii) an Indian reservation which has
 16 a per capita income of \$15,000 or less.

17 “(4) QUALIFIED EDUCATIONAL LOAN.—The
 18 term ‘qualified educational loan’ means any indebt-
 19 edness to pay qualified tuition and related expenses
 20 (within the meaning of section 117(b)) and reason-
 21 able living expenses—

22 “(A) which are paid or incurred—

23 “(i) as a candidate for a degree as a
 24 medical doctor at an educational institu-

1 tion described in section 170(b)(1)(A)(ii),
2 or

3 “(ii) in connection with courses of in-
4 struction at such an institution necessary
5 for certification as a registered nurse,
6 nurse practitioner, or physician’s assistant,
7 and

8 “(B) which are paid or incurred within a
9 reasonable time before or after such indebted-
10 ness is incurred.

11 “(5) RECAPTURE.—If an individual fails to
12 carry out a qualified rural medical practice agree-
13 ment during any taxable year, then—

14 “(A) no deduction with respect to such
15 agreement shall be allowable by reason of sub-
16 section (h)(2)(F) for such taxable year and any
17 subsequent taxable year, and

18 “(B) there shall be included in gross in-
19 come for such taxable year the aggregate
20 amount of the deductions allowable under this
21 section (by reason of subsection (h)(2)(F)) for
22 all preceding taxable years.

23 “(6) DEFINITIONS.—For purposes of this sub-
24 section, the terms ‘registered nurse’, ‘nurse practi-
25 tioner’, and ‘physician’s assistant’ have the meaning

1 given such terms by section 1861 of the Social Secu-
2 rity Act.”.

3 (3) DEDUCTION ALLOWED IN COMPUTING AD-
4 JUSTED GROSS INCOME.—Section 62(a) of such
5 Code is amended by inserting after paragraph (13)
6 the following new paragraph:

7 “(14) INTEREST ON STUDENT LOANS OF RURAL
8 HEALTH PROFESSIONALS.—The deduction allowable
9 by reason of section 163(h)(2)(F) (relating to stu-
10 dent loan payments of medical professionals practic-
11 ing in rural areas).”.

12 (4) EFFECTIVE DATE.—The amendments made
13 by this subsection shall apply to taxable years begin-
14 ning after December 31, 1993.

15 **Subtitle B—Public Health Service** 16 **Act Provisions**

17 **SEC. 511. NATIONAL HEALTH SERVICE CORPS.**

18 Section 338H(b) of the Public Health Service Act (42
19 U.S.C. 254q(b)) is amended—

20 (1) in paragraph (1), by striking “and such
21 sums” and all that follows through the end thereof
22 and inserting “\$118,900,000 for each of the fiscal
23 years 1993 through 1996.”; and

24 (2) in paragraph (2)—

1 (A) by redesignating subparagraphs (A)
2 and (B) as subparagraphs (B) and (C), respec-
3 tively; and

4 (B) by inserting before subparagraph (B)
5 (as so redesignated) the following new subpara-
6 graph:

7 “(A) IN GENERAL.—Of the amount appro-
8 priated under paragraph (1) for each fiscal
9 year, the Secretary shall utilize 25 percent of
10 such amount to carry out section 338A and 75
11 percent of such amount to carry out section
12 338B.”.

13 **SEC. 512. ESTABLISHMENT OF GRANT PROGRAM.**

14 Subpart I of part D of title III of the Public Health
15 Service Act (42 U.S.C. 254b et seq.) is amended by adding
16 at the end thereof the following new section:

17 **“SEC. 330A. COMMUNITY BASED PRIMARY HEALTH CARE**
18 **GRANT PROGRAM.**

19 “(a) ESTABLISHMENT.—The Secretary shall estab-
20 lish and administer a program to provide allotments to
21 States to enable such States to provide grants for the cre-
22 ation or enhancement of community based primary health
23 care entities that provide services to pregnant women and
24 children up to age three.

25 “(b) ALLOTMENTS TO STATES.—

1 “(1) IN GENERAL.—From the amounts avail-
2 able for allotment under subsection (h) for a fiscal
3 year, the Secretary shall allot to each State an
4 amount equal to the product of the grant share of
5 the State (as determined under paragraph (2)) mul-
6 tiplied by the amount available for allotment for
7 such fiscal year.

8 “(2) GRANT SHARE.—

9 “(A) IN GENERAL.—For purposes of para-
10 graph (1), the grant share of a State shall be
11 the product of the need-adjusted population of
12 the State (as determined under subparagraph
13 (B)) multiplied by the Federal matching per-
14 centage of the State (as determined under sub-
15 paragraph (C)), expressed as a percentage of
16 the sum of the products of such factors for all
17 States.

18 “(B) NEED-ADJUSTED POPULATION.—

19 “(i) IN GENERAL.—For purposes of
20 subparagraph (A), the need-adjusted popu-
21 lation of a State shall be the product of
22 the total population of the State (as esti-
23 mated by the Secretary of Commerce) mul-
24 tiplied by the need index of the State (as
25 determined under clause (ii)).

1 “(ii) NEED INDEX.—For purposes of
2 clause (i), the need index of a State shall
3 be the ratio of—

4 “(I) the weighted sum of the geo-
5 graphic percentage of the State (as
6 determined under clause (iii)), the
7 poverty percentage of the State (as
8 determined under clause (iv)), and the
9 multiple grant percentage of the State
10 (as determined under clause (v)); to

11 “(II) the general population per-
12 centage of the State (as determined
13 under clause (vi)).

14 “(iii) GEOGRAPHIC PERCENTAGE.—

15 “(I) IN GENERAL.—For purposes
16 of clause (ii)(I), the geographic per-
17 centage of the State shall be the esti-
18 mated population of the State that is
19 residing in nonurbanized areas (as de-
20 termined under subclause (II)) ex-
21 pressed as a percentage of the total
22 nonurbanized population of all States.

23 “(II) NONURBANIZED POPU-
24 LATION.—For purposes of subclause
25 (I), the estimated population of the

1 State that is residing in non-urban-
2 ized areas shall be one minus the ur-
3 banized population of the State (as
4 determined using the most recent de-
5 cennial census), expressed as a per-
6 centage of the total population of the
7 State (as determined using the most
8 recent decennial census), multiplied by
9 the current estimated population of
10 the State.

11 “(iv) POVERTY PERCENTAGE.—For
12 purposes of clause (ii)(I), the poverty per-
13 centage of the State shall be the estimated
14 number of people residing in the State
15 with incomes below 200 percent of the in-
16 come official poverty line (as determined
17 by the Office of Management and Budget)
18 expressed as a percentage of the total
19 number of such people residing in all
20 States

21 “(v) MULTIPLE GRANT PERCENT-
22 AGE.—For purposes of clause (ii)(I), the
23 multiple grant percentage of the State
24 shall be the amount of Federal funding re-
25 ceived by the State under grants awarded

1 under sections 329, 330 and 340, ex-
2 pressed as a percentage of the total
3 amounts received under such grants by all
4 States. With respect to a State, such
5 amount shall not exceed twice the general
6 population percentage of the State under
7 clause (vi) or be less than one half of the
8 States general population percentage.

9 “(vi) GENERAL POPULATION PER-
10 CENTAGE.—For purposes of clause (ii)(II),
11 the general population percentage of the
12 State shall be the total population of the
13 State (as determined by the Secretary of
14 Commerce) expressed as a percentage of
15 the total population of all States.

16 “(C) FEDERAL MATCHING PERCENTAGE.—

17 “(i) IN GENERAL.—For purposes of
18 subparagraph (A), the Federal matching
19 percentage of the State shall be equal to
20 one less the State matching percentage (as
21 determined under clause (ii)).

22 “(ii) STATE MATCHING PERCENT-
23 AGE.—For purposes of clause (ii), the
24 State matching percentage of the State
25 shall be 0.25 multiplied by the ratio of the

1 total taxable resource percentage (as deter-
2 mined under clause (iii)) to the need-ad-
3 justed population of the State (as deter-
4 mined under subparagraph (B)).

5 “(iii) TOTAL TAXABLE RESOURCE
6 PERCENTAGE.—For purposes of clause (ii),
7 the total taxable resources percentage of
8 the State shall be the total taxable re-
9 sources of a State (as determined by the
10 Secretary of the Treasury) expressed as a
11 percentage of the sum of the total taxable
12 resources of all States.

13 “(3) ANNUAL ESTIMATES.—

14 “(A) IN GENERAL.—If the Secretary of
15 Commerce does not produce the annual esti-
16 mates required under paragraph (2)(B)(iv),
17 such estimates shall be determined by multiply-
18 ing the percentage of the population of the
19 State that is below 200 percent of the income
20 official poverty line as determined using the
21 most recent decennial census by the most recent
22 estimate of the total population of the State.
23 Except as provided in subparagraph (B), the
24 calculations required under this subparagraph
25 shall be made based on the most recent 3 year

1 average of the total taxable resources of individ-
2 uals within the State.

3 “(B) DISTRICT OF COLUMBIA.—Notwith-
4 standing subparagraph (A), the calculations re-
5 quired under such subparagraph with respect to
6 the District of Columbia shall be based on the
7 most recent 3 year average of the personal in-
8 come of individuals residing within the District
9 as a percentage of the personal income for all
10 individuals residing within the District, as de-
11 termined by the Secretary of Commerce.

12 “(4) MATCHING REQUIREMENT.—A State that
13 receives an allotment under this section shall make
14 available State resources (either directly or indi-
15 rectly) to carry out this section in an amount that
16 shall equal the State matching percentage for the
17 State (as determined under paragraph (2)(C)(II))
18 divided by the Federal matching percentage (as de-
19 termined under paragraph (2)(C)).

20 “(c) APPLICATION.—

21 “(1) IN GENERAL.—To be eligible to receive an
22 allotment under this section, a State shall prepare
23 and submit an application to the Secretary at such
24 time, in such manner, and containing such informa-
25 tion as the Secretary may by regulation require.

1 “(2) ASSURANCES.—A State application sub-
2 mitted under paragraph (1) shall contain an assur-
3 ance that—

4 “(A) the State will use amounts received
5 under it’s allotment consistent with the require-
6 ments of this section; and

7 “(B) the State will provide, from non-Fed-
8 eral sources, the amounts required under sub-
9 section (b)(4).

10 “(d) USE OF FUNDS.—

11 “(1) IN GENERAL.—The State shall use
12 amounts received under this section to award grants
13 to eligible public and nonprofit private entities, or
14 consortia of such entities, within the State to enable
15 such entities or consortia to provide services of the
16 type described in paragraph (2) of section 329(h) to
17 pregnant women and children up to age three.

18 “(2) ELIGIBILITY.—To be eligible to receive a
19 grant under paragraph (1), an entity or consortium
20 shall—

21 “(A) prepare and submit to the admin-
22 istering entity of the State, an application at
23 such time, in such manner and containing such
24 information as such administering entity may

1 require, including a plan for the provision of
2 services;

3 “(B) provide assurances that services will
4 be provided under the grant at fee rates estab-
5 lished or determined in accordance with section
6 330(e)(3)(F); and

7 “(C) provide assurances that in the case of
8 services provided to individuals with health in-
9 surance, such insurance shall be used as the
10 primary source of payment for such services.

11 “(3) TARGET POPULATIONS.—Entities or con-
12 sortia receiving grants under paragraph (1) shall, in
13 providing the services described in paragraph (3),
14 substantially target populations of pregnant women
15 and children within the State who—

16 “(A) lack the health care coverage, or abil-
17 ity to pay, for primary or supplemental health
18 care services; or

19 “(B) reside in medically underserved or
20 health professional shortage areas, areas cer-
21 tified as underserved under the rural health
22 clinic program, or other areas determined ap-
23 propriate by the State, within the State.

24 “(4) PRIORITY.—In awarding grants under
25 paragraph (1), the State shall—

1 “(A) give priority to entities or consortia
2 that can demonstrate through the plan submit-
3 ted under paragraph (2) that—

4 “(i) the services provided under the
5 grant will expand the availability of pri-
6 mary care services to the maximum num-
7 ber of pregnant women and children who
8 have no access to such care on the date of
9 the grant award; and

10 “(ii) the delivery of services under the
11 grant will be cost-effective; and

12 “(B) ensure that an equitable distribution
13 of funds is achieved among urban and rural en-
14 tities or consortia.

15 “(e) REPORTS AND AUDITS.—Each State shall pre-
16 pare and submit to the Secretary annual reports concern-
17 ing the State’s activities under this section which shall be
18 in such form and contain such information as the Sec-
19 retary determines appropriate. Each such State shall es-
20 tablish fiscal control and fund accounting procedures as
21 may be necessary to assure that amounts received under
22 this section are being disbursed properly and are ac-
23 counted for, and include the results of audits conducted
24 under such procedures in the reports submitted under this
25 subsection.

1 “(f) PAYMENTS.—

2 “(1) ENTITLEMENT.—Each State for which an
3 application has been approved by the Secretary
4 under this section shall be entitled to payments
5 under this section for each fiscal year in an amount
6 not to exceed the State’s allotment under subsection
7 (b) to be expended by the State in accordance with
8 the terms of the application for the fiscal year for
9 which the allotment is to be made.

10 “(2) METHOD OF PAYMENTS.—The Secretary
11 may make payments to a State in installments, and
12 in advance or, by way of reimbursement, with nec-
13 essary adjustments on account of overpayments or
14 underpayments, as the Secretary may determine.

15 “(3) STATE SPENDING OF PAYMENTS.—Pay-
16 ments to a State from the allotment under sub-
17 section (b) for any fiscal year must be expended by
18 the State in that fiscal year or in the succeeding fis-
19 cal year.

20 “(g) DEFINITION.—As used in this section, the term
21 ‘administering entity of the State’ means the agency or
22 official designated by the chief executive officer of the
23 State to administer the amounts provided to the State
24 under this section.

1 “(h) FUNDING.—Notwithstanding any other provi-
 2 sion of law, the Secretary shall use 50 percent of the
 3 amounts that the Secretary is required to utilize under
 4 section 330B(h) in each fiscal year to carry out this sec-
 5 tion.”.

6 **SEC. 513. ESTABLISHMENT OF NEW PROGRAM TO PROVIDE**
 7 **FUNDS TO ALLOW FEDERALLY QUALIFIED**
 8 **HEALTH CENTERS AND OTHER ENTITIES OR**
 9 **ORGANIZATIONS TO PROVIDE EXPANDED**
 10 **SERVICES TO MEDICALLY UNDERSERVED IN-**
 11 **DIVIDUALS.**

12 (a) IN GENERAL.—Subpart I of part D of title III
 13 of the Public Health Service Act (42 U.S.C. 254b et seq.)
 14 (as amended by section 512) is further amended by adding
 15 at the end thereof the following new section:

16 **“SEC. 330B. ESTABLISHMENT OF NEW PROGRAM TO PRO-**
 17 **VIDE FUNDS TO ALLOW FEDERALLY QUALI-**
 18 **FIED HEALTH CENTERS AND OTHER ENTI-**
 19 **TIES OR ORGANIZATIONS TO PROVIDE EX-**
 20 **PANDED SERVICES TO MEDICALLY UNDER-**
 21 **SERVED INDIVIDUALS.**

22 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-
 23 CESS PROGRAM.—From amounts appropriated under this
 24 section, the Secretary shall, acting through the Bureau of
 25 Health Care Delivery Assistance, award grants under this

1 section to federally qualified health centers (hereinafter re-
2 ferred to in this section as ‘FQHC’s’) and other entities
3 and organizations submitting applications under this sec-
4 tion (as described in subsection (c)) for the purpose of
5 providing access to services for medically underserved pop-
6 ulations (as defined in section 330(b)(3)) or in high im-
7 pact areas (as defined in section 329(a)(5)) not currently
8 being served by a FQHC.

9 “(b) ELIGIBILITY FOR GRANTS.—

10 “(1) IN GENERAL.—The Secretary shall award
11 grants under this section to entities or organizations
12 described in this paragraph and paragraph (2) which
13 have submitted a proposal to the Secretary to ex-
14 pand such entities or organizations operations (in-
15 cluding expansions to new sites (as determined nec-
16 essary by the Secretary)) to serve medically under-
17 served populations or high impact areas not cur-
18 rently served by a FQHC and which—

19 “(A) have as of January 1, 1992, been cer-
20 tified by the Secretary as a FQHC under sec-
21 tion 1905(l)(2)(B) of the Social Security Act;
22 or

23 “(B) have submitted applications to the
24 Secretary to qualify as FQHC’s under such sec-
25 tion 1905(l)(2)(B); or

1 “(C) have submitted a plan to the Sec-
2 retary which provides that the entity will meet
3 the requirements to qualify as a FQHC when
4 operational.

5 “(2) NON FQHC ENTITIES.—

6 “(A) ELIGIBILITY.—The Secretary shall
7 also make grants under this section to public or
8 private nonprofit agencies, health care entities
9 or organizations which meet the requirements
10 necessary to qualify as a FQHC except, the re-
11 quirement that such entity have a consumer
12 majority governing board and which have sub-
13 mitted a proposal to the Secretary to provide
14 those services provided by a FQHC as defined
15 in section 1905(l)(2)(B) of the Social Security
16 Act and which are designed to promote access
17 to primary care services or to reduce reliance on
18 hospital emergency rooms or other high cost
19 providers of primary health care services, pro-
20 vided such proposal is developed by the entity
21 or organizations (or such entities or organiza-
22 tions acting in a consortium in a community)
23 with the review and approval of the Governor of
24 the State in which such entity or organization
25 is located.

1 “(B) LIMITATION.—The Secretary shall
2 provide in making grants to entities or organi-
3 zations described in this paragraph that no
4 more than 10 percent of the funds provided for
5 grants under this section shall be made avail-
6 able for grants to such entities or organizations.

7 “(c) APPLICATION REQUIREMENTS.—

8 “(1) IN GENERAL.—In order to be eligible to
9 receive a grant under this section, a FQHC or other
10 entity or organization must submit an application in
11 such form and at such time as the Secretary shall
12 prescribe and which meets the requirements of this
13 subsection.

14 “(2) REQUIREMENTS.—An application submit-
15 ted under this section must provide—

16 “(A)(i) for a schedule of fees or payments
17 for the provision of the services provided by the
18 entity designed to cover its reasonable costs of
19 operations; and

20 “(ii) for a corresponding schedule of dis-
21 counts to be applied to such fees or payments,
22 based upon the patient’s ability to pay (deter-
23 mined by using a sliding scale formula based on
24 the income of the patient);

1 “(B) assurances that the entity or organi-
2 zation provides services to persons who are eli-
3 gible for benefits under title XVIII of the Social
4 Security Act, for medical assistance under title
5 XIX of such Act or for assistance for medical
6 expenses under any other public assistance pro-
7 gram or private health insurance program; and

8 “(C) assurances that the entity or organi-
9 zation has made and will continue to make
10 every reasonable effort to collect reimbursement
11 for services—

12 “(i) from persons eligible for assist-
13 ance under any of the programs described
14 in subparagraph (B); and

15 “(ii) from patients not entitled to ben-
16 efits under any such programs.

17 “(d) LIMITATIONS ON USE OF FUNDS.—

18 “(1) IN GENERAL.—From the amounts award-
19 ed to an entity or organization under this section,
20 funds may be used for purposes of planning but may
21 only be expended for the costs of—

22 “(A) assessing the needs of the populations
23 or proposed areas to be served;

24 “(B) preparing a description of how the
25 needs identified will be met;

1 “(C) development of an implementation
2 plan that addresses—

3 “(i) recruitment and training of per-
4 sonnel; and

5 “(ii) activities necessary to achieve
6 operational status in order to meet FQHC
7 requirements under section 1905(l)(2)(B)
8 of the Social Security Act.

9 “(2) RECRUITING, TRAINING AND COMPENSA-
10 TION OF STAFF.—From the amounts awarded to an
11 entity or organization under this section, funds may
12 be used for the purposes of paying for the costs of
13 recruiting, training and compensating staff (clinical
14 and associated administrative personnel (to the ex-
15 tent such costs are not already reimbursed under
16 title XIX of the Social Security Act or any other
17 State or Federal program)) to the extent necessary
18 to allow the entity to operate at new or expanded ex-
19 isting sites.

20 “(3) FACILITIES AND EQUIPMENT.—From the
21 amounts awarded to an entity or organization under
22 this section, funds may be expended for the purposes
23 of acquiring facilities and equipment but only for the
24 costs of—

1 “(A) construction of new buildings (to the
2 extent that new construction is found to be the
3 most cost-efficient approach by the Secretary);

4 “(B) acquiring, expanding, or modernizing
5 of existing facilities;

6 “(C) purchasing essential (as determined
7 by the Secretary) equipment; and

8 “(D) amortization of principal and pay-
9 ment of interest on loans obtained for purposes
10 of site construction, acquisition, modernization,
11 or expansion, as well as necessary equipment.

12 “(4) SERVICES.—From the amounts awarded
13 to an entity or organization under this section, funds
14 may be expended for the payment of services but
15 only for the costs of—

16 “(A) providing or arranging for the provi-
17 sion of all services through the entity necessary
18 to qualify such entity as a FQHC under section
19 1905(l)(2)(B) of the Social Security Act;

20 “(B) providing or arranging for any other
21 service that a FQHC may provide and be reim-
22 bursed for under title XIX of such Act; and

23 “(C) providing any unreimbursed costs of
24 providing services as described in section 330(a)
25 to patients.

1 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

2 “(1) CERTIFIED FQHC’S.—The Secretary shall
3 give priority in awarding grants under this section
4 to entities which have, as of January 1, 1992, been
5 certified as a FQHC under section 1905(l)(2)(B) of
6 the Social Security Act and which have submitted a
7 proposal to the Secretary to expand their operations
8 (including expansion to new sites) to serve medically
9 underserved populations for high impact areas not
10 currently served by a FQHC. The Secretary shall
11 give first priority in awarding grants under this sec-
12 tion to those FQHCs or other entities which propose
13 to serve populations with the highest degree of
14 unmet need, and which can demonstrate the ability
15 to expand their operations in the most efficient man-
16 ner.

17 “(2) QUALIFIED FQHC’S.—The Secretary shall
18 give second priority in awarding grants to entities
19 which have submitted applications to the Secretary
20 which demonstrate that the entity will qualify as a
21 FQHC under section 1905(l)(2)(B) of the Social Se-
22 curity Act before it provides or arranges for the pro-
23 vision of services supported by funds awarded under
24 this section, and which are serving or proposing to
25 serve medically underserved populations or high im-

1 pact areas which are not currently served (or pro-
2 posed to be served) by a FQHC.

3 “(3) EXPANDED SERVICES AND PROJECTS.—

4 The Secretary shall give third priority in awarding
5 grants in subsequent years to those FQHCs or other
6 entities which have provided for expanded services
7 and project and are able to demonstrate that such
8 entity will incur significant unreimbursed costs in
9 providing such expanded services.

10 “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS

11 REIMBURSED FROM OTHER SOURCES.—To the extent
12 that an entity or organization receiving funds under this
13 section is reimbursed from another source for the provi-
14 sion of services to an individual, and does not use such
15 increased reimbursement to expand services furnished,
16 areas served, to compensate for costs of unreimbursed
17 services provided to patients, or to promote recruitment,
18 training, or retention of personnel, such excess revenues
19 shall be returned to the Secretary.

20 “(g) TERMINATION OF GRANTS.—

21 “(1) FAILURE TO MEET FQHC REQUIRE-
22 MENTS.—

23 “(A) IN GENERAL.—With respect to any
24 entity that is receiving funds awarded under
25 this section and which subsequently fails to

1 meet the requirements to qualify as a FQHC
2 under section 1905(l)(2)(B) or is an entity that
3 is not required to meet the requirements to
4 qualify as a FQHC under section 1905(l)(2)(B)
5 of the Social Security Act but fails to meet the
6 requirements of this section, the Secretary shall
7 terminate the award of funds under this section
8 to such entity.

9 “(B) NOTICE.—Prior to any termination
10 of funds under this section to an entity, the en-
11 tities shall be entitled to 60 days prior notice of
12 termination and, as provided by the Secretary
13 in regulations, an opportunity to correct any de-
14 ficiencies in order to allow the entity to con-
15 tinue to receive funds under this section.

16 “(2) REQUIREMENTS.—Upon any termination
17 of funding under this section, the Secretary may (to
18 the extent practicable)—

19 “(A) sell any property (including equip-
20 ment) acquired or constructed by the entity
21 using funds made available under this section
22 or transfer such property to another FQHC,
23 provided, that the Secretary shall reimburse
24 any costs which were incurred by the entity in
25 acquiring or constructing such property (includ-

1 ing equipment) which were not supported by
2 grants under this section; and

3 “(B) recoup any funds provided to an en-
4 tity terminated under this section.

5 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section,
7 \$400,000,000 for fiscal year 1993, \$800,000,000 for fis-
8 cal year 1994, \$1,200,000,000 for fiscal year 1995,
9 \$1,600,000,000 for fiscal year 1996, and \$1,600,000,000
10 for fiscal year 1997.”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 subsection (a) shall become effective with respect to serv-
13 ices furnished by a federally qualified health center or
14 other qualifying entity described in this section beginning
15 on or after October 1, 1993.

16 (c) STUDY AND REPORT ON SERVICES PROVIDED BY
17 COMMUNITY HEALTH CENTERS AND HOSPITALS.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services (hereinafter referred to in this sub-
20 section as the “Secretary”) shall provide for a study
21 to examine the relationship and interaction between
22 community health centers and hospitals in providing
23 services to individuals residing in medically under-
24 served areas. The Secretary shall ensure that the

1 National Rural Research Centers participate in such
2 study.

3 (2) REPORT.—The Secretary shall provide to
4 the appropriate committees of Congress a report
5 summarizing the findings of the study within 90
6 days of the end of each project year and shall in-
7 clude in such report recommendations on methods to
8 improve the coordination of and provision of services
9 in medically underserved areas by community health
10 centers and hospitals.

11 (3) AUTHORIZATION.—There are authorized to
12 be appropriated to carry out the study provided for
13 in this subsection \$150,000 for each of fiscal years
14 1993 and 1994.

15 **SEC. 514. RURAL MENTAL HEALTH OUTREACH GRANTS.**

16 Part D of title V of the Public Health Service Act
17 (42 U.S.C. 290dd et seq.) is amended by adding at the
18 end thereof the following new section:

19 **“SEC. 544. RURAL MENTAL HEALTH OUTREACH GRANTS.**

20 “(a) IN GENERAL.—The Secretary may award com-
21 petitive grants to eligible entities to enable such entities
22 to develop and implement a plan for mental health out-
23 reach programs in rural areas.

24 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
25 a grant under subsection (a) an entity shall—

1 “(1) prepare and submit to the Secretary an
2 application at such time, in such form and contain-
3 ing such information as the Secretary may require,
4 including a description of the activities that the en-
5 tity intends to undertake using grant funds; and

6 “(2) meet such other requirements as the Sec-
7 retary determines appropriate.

8 “(c) PRIORITY.—In awarding grants under sub-
9 section (a), the Secretary shall give priority to applications
10 that place emphasis on mental health services for the el-
11 derly or children. Priority shall also be given to applica-
12 tions that involve relationships between the applicant and
13 rural managed care cooperatives.

14 “(d) MATCHING REQUIREMENT.—An entity that re-
15 ceives a grant under subsection (a) shall make available
16 (directly or through donations from public or private enti-
17 ties), non-Federal contributions toward the costs of the
18 operations of the network in an amount equal to the
19 amount of the grant.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section,
22 \$5,000,000 for each of the fiscal years 1993 through
23 1997.”.

1 **SEC. 515. HEALTH PROFESSIONS TRAINING.**

2 (a) MEDICALLY UNDERSERVED AREA TRAINING IN-
3 CENTIVES.—Subsection (a) of section 791 of the Public
4 Health Service Act (42 U.S.C. 292 et seq.) is amended
5 to read as follows:

6 “(a) PRIORITIES IN AWARDING OF GRANTS.—

7 “(1) ALLOCATION OF COMPETITIVE GRANT FUNDS.—

8 In awarding competitive grants under this title or title
9 VIII, the Secretary shall, among applicants that meet the
10 eligibility requirements under such titles, give priority to
11 entities submitting applications that—

12 “(A) can demonstrate that such entities—

13 “(i) have a high permanent rate for
14 placing graduates in practice settings
15 which serve residents of medically under-
16 served communities; and

17 “(ii) have a curriculum that in-
18 cludes—

19 “(I) the rotation of medical stu-
20 dents and residents to clinical settings
21 the focus of which is to serve medi-
22 cally underserved communities;

23 “(II) the appointment of health
24 professionals whose practices serve
25 medically underserved communities to

1 act as preceptors to supervise training
2 in such settings;

3 “(III) classroom instruction on
4 practice opportunities involving medi-
5 cally underserved communities;

6 “(IV) service contingent scholar-
7 ship or loan repayment programs for
8 students and residents to encourage
9 practice in or service to underserved
10 communities;

11 “(V) the recruitment of students
12 who are most likely to elect to prac-
13 tice in or provide service to medically
14 underserved communities;

15 “(VI) other training methodolo-
16 gies that demonstrate a significant
17 commitment to the expansion of the
18 proportion of graduates that elect to
19 practice in or serve the needs of medi-
20 cally underserved communities; or

21 “(B) contain an organized plan for the ex-
22 peditious development of the placement rate
23 and curriculum described in subparagraph (A).

24 “(2) SERVICE IN MEDICALLY UNDERSERVED
25 COMMUNITIES.—Not less than 50 percent of the

1 amounts appropriated for fiscal year 1996, and for
2 each subsequent fiscal year, for competitive grants
3 under this title or title VIII, shall be used to award
4 grants to institutions that are otherwise eligible for
5 grants under such titles, and that can demonstrate
6 that—

7 “(A) not less than 15 percent of the grad-
8 uates of such institutions during the preceding
9 2-year period are engaged in full-time practice
10 serving the needs of medically underserved com-
11 munities; or

12 “(B) the number of the graduates of such
13 institutions that are practicing in a medically
14 underserved community has increased by not
15 less than 50 percent over that proportion of
16 such graduates for the previous 2-year period.

17 “(3) WAIVERS.—A health professions school
18 may petition the Secretary for a temporary waiver of
19 the priorities of this subsection. Such waiver shall be
20 approved if the health professions school dem-
21 onstrates that the State in which such school is lo-
22 cated is not suffering from a shortage of primary
23 care providers, as determined by the Secretary. Such
24 waiver shall not be for a period in excess of 2 years.

25 “(4) DEFINITIONS.—As used in this subsection:

1 “(A) GRADUATE.—The term ‘graduate’
2 means, unless otherwise specified, an individual
3 who has successfully completed all training and
4 residency requirements necessary for full certifi-
5 cation in the health professions discipline that
6 such individual has selected.

7 “(B) MEDICALLY UNDERSERVED COMMU-
8 NITY.—The term ‘medically underserved com-
9 munity’ means—

10 “(i) an area designated under section
11 332 as a health professional shortage area;

12 “(ii) an area designated as a medi-
13 cally underserved area under this Act;

14 “(iii) populations served by migrant
15 health centers under section 329, commu-
16 nity health centers under section 330, or
17 Federally qualified health centers under
18 section 1905(l)(2)(B) of the Social Secu-
19 rity Act;

20 “(iv) a community that is certified as
21 underserved by the Secretary for purposes
22 of participation in the rural health clinic
23 program under title XVIII of the Social
24 Security Act; or

1 “(v) a community that meets the cri-
2 teria for the designation described in sub-
3 paragraph (A) or (B) but that has not
4 been so designated.”.

5 (b) MEDICALLY UNDERSERVED AREA TRAINING
6 GRANTS.—Part E of title VII of such Act is amended by
7 adding at the end thereof the following new section:

8 **“SEC. 779. MEDICALLY UNDERSERVED AREA TRAINING**
9 **GRANT PROGRAM.**

10 “(a) GRANTS.—The Secretary shall award grants to
11 health professions institutions to expand training pro-
12 grams that are targeted at those individuals desiring to
13 practice in or serve the needs of medically underserved
14 communities.

15 “(b) PLAN.—As part of an application submitted for
16 a grant under this section, the applicant shall prepare and
17 submit a plan that describes the proposed use of funds
18 that may be provided to the applicant under the grant.

19 “(c) PRIORITY.—In awarding grants under this sec-
20 tion, the Secretary shall give priority to applicants that
21 demonstrate the greatest likelihood of expanding the pro-
22 portion of graduates who choose to practice in or serve
23 the needs of medically underserved areas.

24 “(d) USE OF FUNDS.—An institution that receives
25 a grant under this section shall use amounts received

1 under such grant to establish or enhance procedures or
2 efforts to—

3 “(1) rotate health professions students from
4 such institution to clinical settings the focus of
5 which is to serve the residents of medically under-
6 served communities;

7 “(2) appoint health professionals whose prac-
8 tices serve medically underserved areas to serve as
9 preceptors to supervise training in such settings;

10 “(3) provide classroom instruction on practice
11 opportunities involving medically underserved com-
12 munities;

13 “(4) provide service contingent scholarship or
14 loan repayment programs for students and residents
15 to encourage practice in or service to underserved
16 communities;

17 “(5) recruit students who are most likely to
18 elect to practice in or provide service to medically
19 underserved communities; or

20 “(6) provide other training methodologies that
21 demonstrate a significant commitment to the expan-
22 sion of the proportion of graduates that elect to
23 practice in or serve the needs of medically under-
24 served communities.

25 “(e) ADMINISTRATION.—

1 “(1) REQUIRED CONTRIBUTION.—An institu-
2 tion that receives a grant under this section shall
3 contribute, from non-Federal sources, either in cash
4 or in-kind, an amount equal to the amount of the
5 grant to the activities to be undertaken with the
6 grant funds.

7 “(2) LIMITATION.—An institution that receives
8 a grant under this section, shall use amounts re-
9 ceived under such grant to supplement, not sup-
10 plant, amounts made available by such institution
11 for activities of the type described in subsection (d)
12 in the fiscal year preceding the year for which the
13 grant is received.

14 “(f) DEFINITIONS.—As used in this section:

15 “(1) GRADUATE.—The term ‘graduate’ means,
16 unless otherwise specified, an individual who has
17 successfully completed all training and residency re-
18 quirements necessary for full certification in the
19 health professions discipline that such individual has
20 selected.

21 “(2) MEDICALLY UNDERSERVED COMMUNITY.—
22 The term ‘medically underserved community’
23 means—

24 “(A) an area designated under section 332
25 as a health professional shortage area;

1 “(B) an area designated as a medically un-
2 derserved area under this Act;

3 “(C) populations served by migrant health
4 centers under section 329, community health
5 centers under section 330, or Federally quali-
6 fied health centers under section 1905(l)(2)(B)
7 of the Social Security Act;

8 “(D) a community that is certified as un-
9 derserved by the Secretary for purposes of par-
10 ticipation in the rural health clinic program
11 under title XVIII of the Social Security Act; or

12 “(E) a community that meets the criteria
13 for the designation described in subparagraph
14 (A) or (B) but that has not been so designated.

15 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 \$15,000,000 for each of the fiscal years 1993 and 1994,
18 and such sums as may be necessary for each of the fiscal
19 years 1995 through 1997.”.

20 (c) HEALTH PROFESSIONS TRAINING GRANTS.—
21 Part E of title VII of such Act (as amended by subsection
22 (b)) is further amended by adding at the end thereof the
23 following new section:

1 **“SEC. 780. HEALTH PROFESSIONS INTEGRATION GRANT**
2 **PROGRAM.**

3 “(a) GRANTS.—The Secretary shall award grants to
4 eligible regional consortia to enhance and expand coordi-
5 nation among various health professions programs, par-
6 ticularly in medically underserved rural areas.

7 “(b) ELIGIBLE REGIONAL CONSORTIUM.—

8 “(1) IN GENERAL.—To be eligible to receive a
9 grant under subsection (a), an entity must—

10 “(A) be a regional consortium consisting of
11 at least one medical school and at least one
12 other health professions school that is not a
13 medical school; and

14 “(B) prepare and submit an application
15 containing a plan of the type described in para-
16 graph (2).

17 “(2) PLAN.—As part of the application submit-
18 ted by a consortium under paragraph (1)(B), the
19 consortium shall prepare and submit a plan that de-
20 scribes the proposed use of funds that may be pro-
21 vided to the consortium under the grant.

22 “(c) USE OF FUNDS.—A consortium that receives a
23 grant under this section shall use amounts received under
24 such grant to establish or enhance—

25 “(1) strategies for better clinical cooperation
26 among different types of health professionals;

1 “(2) classroom instruction on integrated prac-
2 tice opportunities, particularly targeted toward rural
3 areas;

4 “(3) integrated clinical clerkship programs that
5 make use of students in differing health professions
6 schools; or

7 “(4) other training methodologies that dem-
8 onstrate a significant commitment to the expansion
9 of clinical cooperation among different types of
10 health professionals, particularly in underserved
11 rural areas.

12 “(d) LIMITATION.—A consortium that receives a
13 grant under this section, shall use amounts received under
14 such grant to supplement, not supplant, amounts made
15 available by such institution for activities of the type de-
16 scribed in subsection (c) in the fiscal year preceding the
17 year for which the grant is received.

18 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 \$7,000,000 for each of the fiscal years 1993 and 1994,
21 and such sums as may be necessary for each of the fiscal
22 years 1995 through 1997.”.

1 **SEC. 516. RURAL HEALTH EXTENSION NETWORKS.**

2 Title XVII of the Public Health Service Act (42
3 U.S.C. 300u et seq.) is amended by adding at the end
4 thereof the following new section:

5 **“SEC. 1709. RURAL HEALTH EXTENSION NETWORKS.**

6 “(a) GRANTS.—The Secretary, acting through the
7 Health Resources and Services Administration, may
8 award competitive grants to eligible entities to enable such
9 entities to facilitate the development of networks among
10 rural and urban health care providers to preserve and
11 share health care resources and enhance the quality and
12 availability of health care in rural areas. Such networks
13 may be statewide or regionalized in focus.

14 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
15 a grant under subsection (a) an entity shall—

16 “(1) be a rural health extension network that
17 meets the requirements of subsection (c);

18 “(2) prepare and submit to the Secretary an
19 application at such time, in such form and contain-
20 ing such information as the Secretary may require;
21 and

22 “(3) meets such other requirements as the Sec-
23 retary determines appropriate.

24 “(c) NETWORKS.—For purposes of subsection (b)(1),
25 a rural health extension network shall be an association
26 or consortium of three or more rural health care providers,

1 and may include one or more urban health care provider,
2 for the purposes of applying for a grant under this section
3 and using amounts received under such grant to provide
4 the services described in subsection (d).

5 “(d) SERVICES.—

6 “(1) IN GENERAL.—An entity that receives a
7 grant under subsection (a) shall use amounts re-
8 ceived under such grant to—

9 “(A) provide education and community de-
10 cision-making support for health care providers
11 in the rural areas served by the network;

12 “(B) utilize existing health care provider
13 education programs, including but not limited
14 to, the program for area health education cen-
15 ters under section 746, to provide educational
16 services to health care providers in the areas
17 served by the network;

18 “(C) make appropriately trained
19 facilitators available to health care providers lo-
20 cated in the areas served by the network to as-
21 sist such providers in developing cooperative ap-
22 proaches to health care in such area;

23 “(D) facilitate linkage building through the
24 organization of discussion and planning groups
25 and the dissemination of information concern-

1 ing the health care resources where available,
2 within the area served by the network;

3 “(E) support telecommunications and con-
4 sultative projects to link rural hospitals and
5 other health care providers, and urban or ter-
6 tiary hospitals in the areas served by the net-
7 work; or

8 “(F) carry out any other activity deter-
9 mined appropriate by the Secretary.

10 “(2) EDUCATION.—In carrying out activities
11 under paragraph (1)(B), an entity shall support the
12 development of an information and resource sharing
13 system, including elements targeted towards high
14 risk populations and focusing on health promotion,
15 to facilitate the ability of rural health care providers
16 to have access to needed health care information.
17 Such activities may include the provision of training
18 to enable individuals to serve as coordinators of
19 health education programs in rural areas.

20 “(3) COLLECTION AND DISSEMINATION OF
21 DATA.—The chief executive officer of a State shall
22 designate a State agency that shall be responsible
23 for collecting and regularly disseminating informa-
24 tion concerning the activities of the rural health ex-
25 tension networks in that State.

1 “(e) MATCHING REQUIREMENT.—An entity that re-
2 ceives a grant under subsection (a) shall make available
3 (directly or through donations from public or private enti-
4 ties), non-Federal contributions towards the costs of the
5 operations of the network in an amount equal to the
6 amount of the grant.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section,
9 \$10,000,000 for each of the fiscal years 1993 through
10 1997.

11 “(g) DEFINITION.—As used in this section and sec-
12 tion 1710, the term ‘rural health care providers’ means
13 health care professionals and hospitals located in rural
14 areas. The Secretary shall ensure that for purposes of this
15 definition, rural areas shall include any area that meets
16 any applicable Federal or State definition of rural area.”.

17 **SEC. 517. RURAL MANAGED CARE COOPERATIVES.**

18 Title XVII of the Public Health Service Act (42
19 U.S.C. 300u et seq.) as amended by section 516 is further
20 amended by adding at the end thereof the following new
21 section:

22 **“SEC. 1710. RURAL MANAGED CARE COOPERATIVES.**

23 “(a) GRANTS.—The Secretary, acting through the
24 Health Resources and Services Administration, may
25 award competitive grants to eligible entities to enable such

1 entities to develop and administer cooperatives in rural
2 areas that will establish an effective case management and
3 reimbursement system designed to support the economic
4 viability of essential public or private health services, fa-
5 cilities, health care systems and health care resources in
6 such rural areas.

7 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
8 a grant under subsection (a) an entity shall—

9 “(1) prepare and submit to the Secretary an
10 application at such time, in such form and contain-
11 ing such information as the Secretary may require,
12 including a description of the cooperative that the
13 entity intends to develop and operate using grant
14 funds; and

15 “(2) meet such other requirements as the Sec-
16 retary determines appropriate.

17 “(c) COOPERATIVES.—

18 “(1) IN GENERAL.—Amounts provided under a
19 grant awarded under subsection (a) shall be used to
20 establish and operate a cooperative made up of all
21 types of health care providers, hospitals, primary ac-
22 cess hospitals, other alternate rural health care fa-
23 cilities, physicians, rural health clinics, rural nurse
24 practitioners and physician assistant practitioners,
25 public health departments and others located in, but

1 not restricted to, the rural areas to be served by the
2 cooperative.

3 “(2) BOARD OF DIRECTORS.—A cooperative es-
4 tablished under paragraph (1) shall be administered
5 by a board of directors elected by the members of
6 the cooperative, a majority of whom shall represent
7 rural providers from the local community and in-
8 clude representatives from the local community.
9 Such directors shall serve at the pleasure of such
10 members.

11 “(3) EXECUTIVE DIRECTOR.—The members of
12 a cooperative established under paragraph (1) shall
13 elect an executive director who shall serve as the
14 chief operating officer of the cooperative. The execu-
15 tive director shall be responsible for conducting the
16 day to day operation of the cooperative including—

17 “(A) maintaining an accounting system for
18 the cooperative;

19 “(B) maintaining the business records of
20 the cooperative;

21 “(C) negotiating contracts with provider
22 members of the cooperative; and

23 “(D) coordinating the membership and
24 programs of the cooperative.

25 “(4) REIMBURSEMENTS.—

1 “(A) NEGOTIATIONS.—A cooperative es-
2 tablished under paragraph (1) shall facilitate
3 negotiations among member health care provid-
4 ers and third party payers concerning the rates
5 at which such providers will be reimbursed for
6 services provided to individuals for which such
7 payers may be liable.

8 “(B) AGREEMENTS.—Agreements reached
9 under subparagraph (A) shall be binding on the
10 members of the cooperative.

11 “(C) EMPLOYERS.—Employer entities may
12 become members of a cooperative established
13 under paragraph (a) in order to provide,
14 through a member third party payer, health in-
15 surance coverage for employees of such entities.
16 Deductibles shall only be charged to employees
17 covered under such insurance if such employees
18 receive health care services from a provider that
19 is not a member of the cooperative if similar
20 services would have been available from a mem-
21 ber provider.

22 “(D) MALPRACTICE INSURANCE.—A coop-
23 erative established under subsection (a) shall be
24 responsible for identifying and implementing a
25 malpractice insurance program that shall in-

1 clude a requirement that such cooperative as-
2 sume responsibility for the payment of a por-
3 tion of the malpractice insurance premium of
4 providers members.

5 “(5) MANAGED CARE AND PRACTICE STAND-
6 ARDS.—A cooperative established under paragraph
7 (1) shall establish joint case management and pa-
8 tient care practice standards programs that health
9 care providers that are members of such cooperative
10 must meet to be eligible to participate in agreements
11 entered into under paragraph (4). Such standards
12 shall be developed by such provider members and
13 shall be subject to the approval of a majority of the
14 board of directors. Such programs shall include cost
15 and quality of care guidelines including a require-
16 ment that such providers make available
17 preadmission screening, selective case management
18 services, joint patient care practice standards devel-
19 opment and compliance and joint utilization review.

20 “(6) CONFIDENTIALITY.—Patients records,
21 records of peer review, utilization review, and quality
22 assurance proceedings conducted by the cooperative
23 should be considered confidential and protected from
24 release outside of the cooperative. The provider
25 members of the cooperative shall be indemnified by

1 the cooperative for the good faith participation by
2 such members in such the required activities.

3 “(d) LINKAGES.—A cooperative shall create linkages
4 among member health care providers, employers, and pay-
5 ers for the joint consultation and formulation of the types,
6 rates, costs, and quality of health care provided in rural
7 areas served by the cooperative.

8 “(e) MATCHING REQUIREMENT.—An entity that re-
9 ceives a grant under subsection (a) shall make available
10 (directly or through donations from public or private enti-
11 ties), non-Federal contributions towards the costs of the
12 operations of the network in an amount equal to the
13 amount of the grant.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section,
16 \$15,000,000 for each of the fiscal years 1993 through
17 1997.”.

18 **TITLE VI—MALPRACTICE** 19 **REFORM**

20 **SEC. 601. PRELITIGATION SCREENING PANEL GRANTS.**

21 Part B of title IX of the Public Health Service Act
22 (42 U.S.C. 299b et seq.) is amended by adding at the end
23 the following new section:

1 **“SEC. 915. PRELITIGATION SCREENING PANEL GRANTS.**

2 “(a) ESTABLISHMENT.—The Assistant Secretary,
3 acting through the Administrator, shall establish a pro-
4 gram of grants to assist States in establishing prelitigation
5 panels.

6 “(b) USE OF FUNDS.—A State may use a grant
7 awarded under subsection (a) to establish prelitigation
8 panels that—

9 “(1) identify claims of professional negligence
10 that merit compensation;

11 “(2) encourage early resolution of meritorious
12 claims prior to commencement of a lawsuit; and

13 “(3) encourage early withdrawal or dismissal of
14 nonmeritorious claims.

15 “(c) AWARD OF GRANTS.—The Secretary shall allo-
16 cate grants under this section in accordance with criteria
17 issued by the Secretary.

18 “(d) APPLICATION.—To be eligible to receive a grant
19 under this section, a State, acting through the appropriate
20 State health authority, shall submit an application at such
21 time, in such manner, and containing such agreements,
22 assurances, and information as the Assistant Secretary
23 determines to be necessary to carry out this section.

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of the 1994
2 through 1997 fiscal years.”.

3 **TITLE VII—HEALTH PROMOTION**
4 **AND DISEASE PREVENTION**

5 **SEC. 701. DISEASE PREVENTION AND HEALTH PROMOTION**
6 **PROGRAMS TREATED AS MEDICAL CARE.**

7 (a) IN GENERAL.—For purposes of section 213(d)(1)
8 of the Internal Revenue Code of 1986 (defining medical
9 care), qualified expenditures (as defined by the Secretary
10 of Health and Human Services) for disease prevention and
11 health promotion programs shall be considered amounts
12 paid for medical care.

13 (b) EFFECTIVE DATE.—Subsection (a) shall apply to
14 amounts paid in taxable years beginning after December
15 31, 1992.

16 **SEC. 702. WORKSITE WELLNESS GRANT PROGRAM.**

17 (a) GRANTS.—The Secretary of Health and Human
18 Services (hereafter referred to as the “Secretary”) shall
19 award grants to States (through State health departments
20 or other State agencies working in consultation with the
21 State health agency) to enable such States to provide as-
22 sistance to businesses with not to exceed 100 employees
23 for the establishment and operation of worksite wellness
24 programs for their employees.

1 (b) APPLICATION.—To be eligible for a grant under
2 subsection (a), a State shall prepare and submit to the
3 Secretary an application at such time, in such manner,
4 and containing such information as the Secretary may re-
5 quire, including—

6 (1) a description of the manner in which the
7 State intends to use amounts received under the
8 grant; and

9 (2) assurances that the State will only use
10 amounts provided under such grant to provide as-
11 sistance to businesses that can demonstrate that
12 they are in compliance with minimum program char-
13 acteristics (relative to scope and regularity of serv-
14 ices offered) that are developed by the Secretary in
15 consultation with experts in public health and rep-
16 resentatives of small business.

17 Grants shall be distributed to States based on the popu-
18 lation of individuals employed by small businesses.

19 (c) PROGRAM CHARACTERISTICS.—In developing
20 minimum program characteristics under subsection (b)(2),
21 the Secretary shall ensure that all activities established or
22 enhanced under a grant under this section have clearly
23 defined goals and objectives and demonstrate how receipt
24 of such assistance will help to achieve established State

1 or local health objectives based on the National Health
2 Promotion and Disease Prevention Objectives.

3 (d) USE OF FUNDS.—Amounts received under a
4 grant awarded under subsection (a) shall be used by a
5 State to provide grants to businesses (as described in sub-
6 section (a)), nonprofit organizations, or public authorities,
7 or to operate State-run worksite wellness programs.

8 (e) SPECIAL EMPHASIS.—In funding business work-
9 site wellness projects under this section, a State shall give
10 special emphasis to—

11 (1) the development of joint wellness programs
12 between employers;

13 (2) the development of employee assistance pro-
14 grams dealing with substance abuse;

15 (3) maximizing the use and coordination with
16 existing community resources such as nonprofit
17 health organizations; and

18 (4) encourage participation of dependents of
19 employees and retirees in wellness programs.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section,
22 such sums as may be necessary in each of the fiscal years
23 1994 through 1998.

1 **SEC. 703. EXPANDING AND IMPROVING SCHOOL HEALTH**
2 **EDUCATION.**

3 (a) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out subsection
5 (b), such sums as may be necessary for each of the fiscal
6 years 1994 through 1998.

7 (b) GENERAL USE OF FUNDS.—The Secretary of
8 Health and Human Services shall use amounts appro-
9 priated under subsection (a) to expand comprehensive
10 school health education programs administered by the
11 Centers for Disease Control and Prevention under sections
12 301 and 311 of the Public Health Service Act (42 U.S.C.
13 241 and 243).

14 (c) SPECIFIC USE OF FUNDS.—In meeting the re-
15 quirement of subsection (b), the Secretary of Health and
16 Human Services shall expand the number of children re-
17 ceiving planned, sequential kindergarten through 12th
18 grade comprehensive school education as a component of
19 comprehensive programs of school health, including

20 (1) physical education programs that promote
21 lifelong physical activity;

22 (2) healthy school food service selections;

23 (3) programs that promote a healthy and safe
24 school environment;

25 (4) schoolsite health promotion for faculty and
26 staff;

1 (5) integrated school and community health
2 promotion efforts; and

3 (6) school nursing disease prevention and
4 health promotion services.

5 (d) COORDINATION OF EXISTING PROGRAMS.—The
6 Secretary of Health and Human Services, the Secretary
7 of Education and the Secretary of Agriculture shall work
8 cooperatively to coordinate existing school health edu-
9 cation programs within their Departments in a manner
10 that maximized the efficiency and effectiveness of Federal
11 expenditures in this area.

12 **TITLE VIII—PRESCRIPTION**
13 **DRUG COST CONTAINMENT**

14 **SEC. 801. REDUCTION IN POSSESSIONS TAX CREDIT FOR**
15 **EXCESSIVE PHARMACEUTICAL INFLATION.**

16 (a) IN GENERAL.—Section 936 of the Internal Reve-
17 nue Code of 1986 (relating to Puerto Rico and possession
18 tax credit) is amended by adding at the end the following
19 new subsection:

20 “(i) REDUCTION FOR EXCESSIVE PHARMACEUTICAL
21 INFLATION.—

22 “(1) IN GENERAL.—In the case of any manu-
23 facturer of single source drugs or innovator multiple
24 source drugs, the amount by which the credit under
25 this section for the taxable year (determined without

1 regard to this subsection) exceeds the manufactur-
2 er's wage base for such taxable year shall be reduced
3 by the product of—

4 “(A) the amount of such excess, multiplied
5 by

6 “(B) the sum of the reduction percentages
7 for each single source drug or innovator mul-
8 tiple source drug of the manufacturer for such
9 taxable year.

10 “(2) MANUFACTURER'S WAGE BASE.—For pur-
11 poses of this subsection—

12 “(A) IN GENERAL.—The manufacturer's
13 wage base for any taxable year is equal to the
14 total amount of wages paid during such taxable
15 year by the manufacturer to eligible employees
16 in Puerto Rico with respect to the manufacture
17 of single source drugs and innovator multiple
18 source drugs.

19 “(B) ELIGIBLE EMPLOYEES.—The term
20 ‘eligible employee’ means any employee of the
21 manufacturer (as defined in section 3121(d))
22 who is a bona fide resident of Puerto Rico and
23 subject to tax by Puerto Rico on income from
24 sources within and without Puerto Rico during
25 the entire taxable year.

1 “(C) WAGES.—The term ‘wages’ has the
2 meaning given such term by section 3121(a).

3 “(3) REDUCTION PERCENTAGE.—For purposes
4 of this subsection—

5 “(A) IN GENERAL.—The reduction per-
6 centage for any drug for any taxable year is the
7 percentage determined by multiplying—

8 “(i) the sales percentage for such
9 drug for such taxable year, by

10 “(ii) the price increase percentage for
11 such drug for such taxable year.

12 “(B) SALES PERCENTAGE.—The sales per-
13 centage for any drug for any taxable year is the
14 percentage determined by dividing—

15 “(i) the total sales of such drug by
16 the manufacturer for such taxable year, by

17 “(ii) the total sales of all single source
18 drugs and innovator multiple source drugs
19 by the manufacturer for such taxable year.

20 “(C) PRICE INCREASE PERCENTAGE.—The
21 price increase percentage for any drug for any
22 taxable year is the percentage determined by
23 multiplying—

24 “(i) 20, times

25 “(ii) the excess (if any) of—

1 “(I) the percentage increase in
2 the average manufacturer’s price for
3 such drug for the taxable year over
4 such average price for the base tax-
5 able year, over

6 “(II) the percentage increase in
7 the Consumer Price Index (as defined
8 in section 1(g)(5)) for the taxable
9 year over the base taxable year.

10 “(D) TOTAL SALES.—

11 “(i) DOMESTIC SALES ONLY.—Total
12 sales shall only include sales for use or
13 consumption in the United States.

14 “(ii) SALES TO RELATED PARTIES
15 NOT INCLUDED.—Total sales shall not in-
16 clude sales to any related party (as defined
17 in section 267(b)).

18 “(E) AVERAGE MANUFACTURER’S
19 PRICE.—The term ‘average manufacturer’s
20 price’ for any taxable year means the average
21 price paid to the manufacturer by wholesalers
22 or direct buyers and purchasers for each single
23 source drug or innovator multiple source drug
24 sold to the various classes of purchasers.

1 “(F) BASE TAXABLE YEAR.—The base tax-
2 able year for any single source drug or innova-
3 tor multiple source drug is the later of—

4 “(i) the last taxable year ending in
5 1991, or

6 “(ii) the first taxable year beginning
7 after the date on which the marketing of
8 such drug begins.

9 “(4) OTHER DEFINITIONS.—For purposes of
10 this subsection—

11 “(A) MANUFACTURER.—

12 “(i) IN GENERAL.—The term ‘manu-
13 facturer’ means any person which is en-
14 gaged in—

15 “(I) the production, preparation,
16 propagation, compounding, conver-
17 sion, or processing of prescription
18 drug products, either directly or indi-
19 rectly by extraction from substances
20 of natural origin, or independently by
21 means of chemical synthesis, or by a
22 combination of extraction and chemi-
23 cal synthesis, or

1 “(II) in the packaging, repackag-
2 ing, labeling, relabeling, or distribu-
3 tion of prescription drug products.

4 Such term does not include a wholesale
5 distributor of drugs or a retail pharmacy
6 licensed under State law.

7 “(ii) CONTROLLED GROUPS.—For
8 purposes of clause (i)—

9 “(I) CONTROLLED GROUP OF
10 CORPORATIONS.—All corporations
11 which are members of the same con-
12 trolled group of corporations shall be
13 treated as 1 person. For purposes of
14 the preceding sentence, the term ‘con-
15 trolled group of corporations’ has the
16 meaning given to such term by section
17 1563(a), except that ‘more than 50
18 percent’ shall be substituted for ‘at
19 least 80 percent’ each place it appears
20 in section 1563(a)(1), and the deter-
21 mination shall be made without re-
22 gard to subsections (a)(4) and
23 (e)(3)(C) of section 1563.

24 “(II) PARTNERSHIPS, PROPRI-
25 ETORSHIPS, ETC., WHICH ARE UNDER

1 COMMON CONTROL.—Under regula-
2 tions prescribed by the Secretary, all
3 trades or business (whether or not in-
4 corporated) which are under common
5 control shall be treated as 1 person.
6 The regulations prescribed under this
7 subclause shall be based on principles
8 similar to the principles which apply
9 in the case of subclause (I).

10 “(B) SINGLE SOURCE DRUG.—The term
11 ‘single source drug’ means a drug or biological
12 which is produced or distributed under an origi-
13 nal new drug application or product licensing
14 application, including a drug product or biologi-
15 cal marketed by any cross-licensed producers or
16 distributors operating under the new drug ap-
17 plication or product licensing application.

18 “(C) INNOVATOR MULTIPLE SOURCE
19 DRUG.—The term ‘innovator multiple source
20 drug’ means a multiple source drug (within the
21 meaning of section 1927(k)(7)(A)(i) of the So-
22 cial Security Act) that was originally marketed
23 under an original new drug application or a
24 product licensing application approved by the
25 Food and Drug Administration.

1 “(5) SPECIAL RULES.—For purposes of this
2 subsection—

3 “(A) DOSAGE TREATMENT.—Except as
4 provided by the Secretary, each dosage form
5 and strength of a single source drug or innova-
6 tor multiple source drug shall be treated as a
7 separate drug.

8 “(B) ROUNDING OF PERCENTAGES.—Any
9 percentage shall be rounded to the nearest hun-
10 dredth of a percent.”.

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

14 **TITLE IX—FINANCING**

15 **SEC. 901. REPEAL OF DOLLAR LIMITATION ON AMOUNT OF** 16 **WAGES SUBJECT TO HOSPITAL INSURANCE** 17 **TAX.**

18 (a) HOSPITAL INSURANCE TAX.—

19 (1) Paragraph (1) of section 3121(a) of the In-
20 ternal Revenue Code of 1986 (defining wages) is
21 amended—

22 (A) by inserting “in the case of the taxes
23 imposed by sections 3101(a) and 3111(a)” after
24 “(1)”,

1 (B) by striking “applicable contribution
2 base (as determined under subsection (x))”
3 each place it appears and inserting “contribu-
4 tion and benefit base (as determined under sec-
5 tion 230 of the Social Security Act)”, and

6 (C) by striking “such applicable contribu-
7 tion base” and inserting “such contribution and
8 benefit base”.

9 (2) Section 3121 of such Code is amended by
10 striking subsection (x).

11 (b) SELF-EMPLOYMENT TAX.—

12 (1) Subsection (b) of section 1402 of such Code
13 is amended—

14 (A) by striking “(1) that part of net” and
15 inserting “(1) in the case of the tax imposed by
16 section 1401(a), that part of net”,

17 (B) by striking “applicable contribution
18 base (as determined under subsection (k))” and
19 inserting “contribution and benefit base (as de-
20 termined under section 230 of the Social Secu-
21 rity Act)”,

22 (C) by inserting “and” after “section
23 3121(b),”, and

24 (D) by striking “and (C) includes” and all
25 that follows through “3111(b)”.

1 (2) Section 1402 of such Code is amended by
2 striking subsection (k).

3 (c) RAILROAD RETIREMENT TAX.—

4 (1) Subparagraph (A) of section 3231(e)(2) of
5 such Code is amended by adding at the end thereof
6 the following new clause:

7 “(iii) HOSPITAL INSURANCE TAXES.—

8 Clause (i) shall not apply to—

9 “(I) so much of the rate applica-
10 ble under section 3201(a) or 3221(a)
11 as does not exceed the rate of tax in
12 effect under section 3101(b), and

13 “(II) so much of the rate applica-
14 ble under section 3211(a)(1) as does
15 not exceed the rate of tax in effect
16 under section 1402(b).”

17 (2) Clause (i) of section 3231(e)(2)(B) of such
18 Code is amended to read as follows:

19 “(i) TIER 1 TAXES.—Except as pro-
20 vided in clause (ii), the term ‘applicable
21 base’ means for any calendar year the con-
22 tribution and benefit base determined
23 under section 230 of the Social Security
24 Act for such calendar year.”

1 (d) INCREASED REVENUES NOT DEPOSITED IN HOS-
2 PITAL INSURANCE TRUST FUND.—Section 1817(a) of the
3 Social Security Act (42 U.S.C. 1395i(a)) is amended by
4 adding at the end the following new sentence: “For pur-
5 poses of this subsection, the amount of taxes imposed by
6 sections 1401(b), 3101(b), 3111(b) of the Internal Reve-
7 nue Code of 1986 shall be determined without regard to
8 the amendments made by section 221 of the Managed
9 Competition Act of 1992.”.

10 (e) TECHNICAL AMENDMENTS.—

11 (1) Paragraph (1) of section 6413(c) of the In-
12 ternal Revenue Code of 1986 is amended by striking
13 “section 3101 or section 3201” and inserting “sec-
14 tion 3101(a) or section 3201(a) (to the extent the
15 rate applicable under section 3201(a) as does not ex-
16 ceed the rate of tax in effect under section
17 3101(a))”.

18 (2) Subparagraphs (B) and (C) of section
19 6413(c)(2) of such Code are each amended by strik-
20 ing “section 3101” each place it appears and insert-
21 ing “section 3101(a)”.

22 (3) Subsection (c) of section 6413 of such Code
23 is amended by striking paragraph (3).

24 (4) Sections 3122 and 3125 of such Code are
25 each amended by striking “applicable contribution

1 base limitation” and inserting “contribution and
2 benefit base limitation”.

3 (f) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to 1994 and later calendar years.

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