

Calendar No. 525

103^D CONGRESS
2^D SESSION

S. 2296

[Report No. 103-317]

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

JULY 19 (legislative day, JULY 11), 1994
Placed on the calendar

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IN THE SENATE OF THE UNITED STATES

JULY 19 (legislative day, JULY 11), 1994

Mr. KENNEDY, from the Committee on Labor and Human Resources, reported the following original bill; which was read twice and placed on the calendar

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Health Security Act”.

3 **SEC. 2. FINDINGS.**

4 The Congress finds as follows:

5 (1) Under the current health care system in the
6 United States—

7 (A) individuals risk losing their health care
8 coverage when they move, when they lose or
9 change jobs, when they become seriously ill, or
10 when the coverage becomes unaffordable;

11 (B) continued escalation of health care
12 costs threatens the economy of the United
13 States, undermines the international competi-
14 tiveness of the Nation, and strains Federal,
15 State, and local budgets;

16 (C) an excessive burden of forms, paper-
17 work, and bureaucratic procedures confuses
18 consumers and overwhelms health care provid-
19 ers;

20 (D) fraud and abuse sap the strength of
21 the health care system; and

22 (E) health care is a critical part of the
23 economy of the United States and interstate
24 commerce, consumes a significant percentage of
25 public and private spending, and affects all in-
26 dustries and individuals in the United States.

1 (2) Under any reform of the health care sys-
2 tem—

3 (A) health insurance and high quality
4 health care should be secure, uninterrupted,
5 and affordable for all individuals in the United
6 States;

7 (B) comprehensive health care benefits
8 that meet the full range of health needs, includ-
9 ing primary, preventive, and specialized care,
10 should be available to all individuals in the
11 United States;

12 (C) the current high quality of health care
13 in the United States should be maintained;

14 (D) individuals in the United States should
15 be afforded a meaningful opportunity to choose
16 among a range of health plans, health care pro-
17 viders, and treatments;

18 (E) regulatory and administrative burdens
19 should be reduced;

20 (F) the rapidly escalating costs of health
21 care should be contained without sacrificing
22 high quality or impeding technological improve-
23 ments;

24 (G) competition in the health care industry
25 should ensure that health plans and health care

1 providers are efficient and charge reasonable
2 prices;

3 (H) a partnership between the Federal
4 Government and each State should allow the
5 State and its local communities to design an ef-
6 fective, high-quality system of care that serves
7 the residents of the State;

8 (I) all individuals should have a respon-
9 sibility to pay their fair share of the costs of
10 health care coverage;

11 (J) a health care system should build on
12 the strength of the employment-based coverage
13 arrangements that now exist in the United
14 States;

15 (K) the penalties for fraud and abuse
16 should be swift and severe; and

17 (L) an individual's medical information
18 should remain confidential and should be pro-
19 tected from unauthorized disclosure and use.

20 **SEC. 3. PURPOSES.**

21 The purposes of this Act are as follows:

22 (1) To guarantee comprehensive and secure
23 health care coverage.

24 (2) To simplify the health care system for con-
25 sumers and health care professionals.

1 (3) To control the cost of health care for em-
2 ployers, employees, and others who pay for health
3 care coverage.

4 (4) To promote individual choice among health
5 plans and health care providers.

6 (5) To ensure high quality health care.

7 (6) To encourage all individuals to take respon-
8 sibility for their health care coverage.

9 **TITLE I—HEALTH CARE**
10 **SECURITY**

SUBTITLE A—UNIVERSAL COVERAGE AND INDIVIDUAL RESPONSIBILITY

PART 1—UNIVERSAL COVERAGE

- Sec. 1001. Entitlement to health benefits.
- Sec. 1002. Individual responsibilities.
- Sec. 1003. Protection of consumer choice.
- Sec. 1004. Health plan principles.
- Sec. 1005. Applicable health plan providing coverage.
- Sec. 1006. Treatment of other nonimmigrants.
- Sec. 1007. Effective date of entitlement.

PART 2—TREATMENT OF FAMILIES AND SPECIAL RULES

- Sec. 1011. General rule of enrollment of family in same health plan.
- Sec. 1012. Treatment of certain families.
- Sec. 1013. Multiple employment situations.
- Sec. 1014. Treatment of residents of States with Statewide single-payer systems.

Subtitle B—Benefits

PART 1—COMPREHENSIVE BENEFIT PACKAGE

- Sec. 1101. Provision of comprehensive benefits by plans.
- Sec. 1102. Hospital services.
- Sec. 1103. Services of health professionals.
- Sec. 1104. Emergency and ambulatory medical and surgical services.
- Sec. 1105. Clinical preventive services.
- Sec. 1106. Mental illness and substance abuse services.
- Sec. 1107. Family planning services and services for pregnant women.
- Sec. 1108. Hospice care.
- Sec. 1109. Home health care.
- Sec. 1110. Extended care services.

- Sec. 1111. Ambulance services.
- Sec. 1112. Outpatient laboratory, radiology, and diagnostic services.
- Sec. 1113. Outpatient prescription drugs and biologicals.
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- Sec. 1151. Definition of benefits.
- Sec. 1152. Acceleration of expanded benefits.
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PART 5—ADDITIONAL PROVISIONS RELATING TO HEALTH CARE PROVIDERS

- Sec. 1161. Override of restrictive State practice laws.
- Sec. 1162. Provision of items or services contrary to religious belief or moral conviction.
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Subtitle C—State Responsibilities

- Sec. 1200. Participating State.

PART 1—GENERAL STATE RESPONSIBILITIES

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- Sec. 1202. Assuring community-rated premiums through establishment of health care coverage areas.
- Sec. 1203. Use of incentives.
- Sec. 1204. Restrictions on funding of additional benefits.
- Sec. 1205. Consumer information and marketing.
- Sec. 1206. State responsibilities with respect to worksite health promotion discounts.
- Sec. 1207. Consumer advocate.
- Sec. 1208. Election procedure for community-rated employers.
- Sec. 1209. Coordinated health care services for children.
- Sec. 1210. State responsibilities for utilization management.
- Sec. 1211. Assuring family choice of health plans.

- Sec. 1212. Oversight of health plan enrollment activities.
- Sec. 1213. Administrative allowance percentage.

PART 2—REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

- Sec. 1221. Single-payer system described.
- Sec. 1222. General requirements for single-payer systems.
- Sec. 1223. Special rules for States operating Statewide single-payer systems.
- Sec. 1224. Special rules for health care coverage area-specific single-payer systems.

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- Sec. 1281. Reduction in cost sharing for low-income families.
- Sec. 1282. Application process for cost-sharing reductions and premium discounts.
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- Sec. 1302. Agreements with health plans.
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- Sec. 1401. Definitions.
- Sec. 1402. Election of large group purchasers.
- Sec. 1403. Employee enrollment requirements.
- Sec. 1404. Responsibilities and authority of employer purchasers.
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- Sec. 1502. Application of requirements.
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- Sec. 1508. Collection, provision of standardized information, and confidentiality.
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- Sec. 1510. Quality assurance standards.
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- Sec. 1512. Financial solvency requirements and consumer protection against provider claims.
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- Sec. 1515. Information and marketing standards.
- Sec. 1516. Enrollment; availability, and renewability.
- Sec. 1517. Administrative provisions.
- Sec. 1518. Information regarding a patient's right to self-determination in health care services.
- Sec. 1519. Rural and medically underserved areas.
- Sec. 1520. Payment adjustments.
- Sec. 1521. Preemption of certain State laws relating to health plans.
- Sec. 1522. Contracts with consumer purchasing cooperatives.
- Sec. 1523. Health plan arrangements with providers.
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1 **Subtitle A—Universal Coverage**
2 **and Individual Responsibility**

3 **PART 1—UNIVERSAL COVERAGE**

4 **SEC. 1001. ENTITLEMENT TO HEALTH BENEFITS.**

5 (a) **IN GENERAL.**—In accordance with this part, each
6 eligible individual is entitled to the comprehensive benefit
7 package under subtitle B through the applicable health
8 plan in which the individual is enrolled consistent with this
9 title.

10 (b) **HEALTH SECURITY CARD.**—Each eligible individ-
11 ual is entitled to a health security card to be issued in
12 accordance with this Act.

13 (c) **ELIGIBLE INDIVIDUAL DEFINED.**—In this Act,
14 the term “eligible individual” means an individual who is
15 residing in the United States and who is—

16 (1)(A) a citizen or national of the United
17 States;

18 (B) a citizen of another country legally residing
19 in the United States (as defined in section 1902(6));

20 or

21 (C) a long-term nonimmigrant (as defined in
22 section 1902(27)); and

23 (2) not an exempt individual (as defined in sec-
24 tion 1902(18)).

1 (d) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
2 UALS.—Subject to section 1012(a), a medicare-eligible in-
3 dividual is entitled to health benefits under the medicare
4 program instead of the entitlement under subsection (a).

5 (e) TREATMENT OF PRISONERS.—A prisoner (as de-
6 fined in section 1902(37)) is entitled to health care serv-
7 ices provided by the authority responsible for the prisoner
8 instead of the entitlement under subsection (a).

9 **SEC. 1002. INDIVIDUAL RESPONSIBILITIES.**

10 (a) IN GENERAL.—In accordance with this Act, each
11 eligible individual (other than a medicare-eligible individ-
12 ual)—

13 (1) must enroll in an applicable health plan for
14 the individual, and

15 (2) must pay any premium required, consistent
16 with this Act, with respect to such enrollment.

17 (b) LIMITATION ON DISENROLLMENT.—No eligible
18 individual shall be disenrolled from an applicable health
19 plan until the individual—

20 (1) is enrolled under another applicable health
21 plan, or

22 (2) becomes a medicare-eligible individual.

23 **SEC. 1003. PROTECTION OF CONSUMER CHOICE.**

24 Nothing in this Act shall be construed as prohibiting
25 the following:

1 (1) An individual from purchasing any health
2 care services.

3 (2) An individual from purchasing supplemental
4 insurance (offered consistent with this Act) to cover
5 health care services not included within the com-
6 prehensive benefit package.

7 (3) An individual who is not an eligible individ-
8 ual from purchasing health insurance.

9 (4) Employers from providing coverage for ben-
10 efits in addition to the comprehensive benefit pack-
11 age (subject to part 2 of subtitle E).

12 (5) An individual from obtaining (at the ex-
13 pense of such individual) health care from any
14 health care provider of such individual's choice.

15 **SEC. 1004. HEALTH PLAN PRINCIPLES.**

16 In accordance with this Act, the following principles
17 shall apply to all health plans:

18 (1) No health plan may discriminate on the
19 basis of medical history, pre-existing medical condi-
20 tions, or genetic predisposition to medical conditions.

21 (2) A health plan—

22 (A) shall offer an annual open enrollment
23 period and accept all eligible individuals for cov-
24 erage;

1 (B) shall not impose a rider that serves to
2 exclude coverage to an individual; and

3 (C) shall not impose waiting periods before
4 coverage begins.

5 (3) A health plan shall ensure that all medically
6 necessary or appropriate services, as defined in the
7 benefits package, are provided, including access to
8 specialty care.

9 (4) Health benefits coverage shall be portable
10 from one health plan to another.

11 Nothing in this section shall be construed so as to relieve
12 a health plan of any obligation or requirement imposed
13 under this Act.

14 **SEC. 1005. APPLICABLE HEALTH PLAN PROVIDING COV-**
15 **ERAGE.**

16 (a) SPECIFICATION OF APPLICABLE HEALTH
17 PLAN.—Except as otherwise provided:

18 (1) GENERAL RULE: COMMUNITY-RATED
19 HEALTH PLANS.—The applicable health plan for a
20 family is a community-rated health plan for the
21 health care coverage area in which the family re-
22 sides.

23 (2) EXPERIENCE-RATED HEALTH PLANS.—In
24 the case of a family member that is eligible to enroll
25 in an experienced-rated health plan under subtitle B,

1 the applicable health plan for the family is such an
2 experienced-rated health plan.

3 (b) CHOICE OF PLANS FOR CERTAIN GROUPS.—

4 (1) MILITARY PERSONNEL AND FAMILIES.—For
5 military personnel and families who elect a Uni-
6 formed Services Health Plan of the Department of
7 Defense under section 1073a(d) of title 10, United
8 States Code, as inserted by section 8001(a) of this
9 Act, that plan shall be the applicable health plan.

10 (2) VETERANS.—For veterans and families who
11 elect to enroll in a veterans health plan under sec-
12 tion 1801 of title 38, United States Code, as in-
13 serted by section 8101(a) of this Act, that plan shall
14 be the applicable health plan.

15 (3) AMERICAN INDIANS.—For those individuals
16 who are eligible to enroll, and who elect to enroll, in
17 a health program of the Indian Health Service under
18 section 8302(b) or 8306(b), that program shall be
19 the applicable health plan.

20 **SEC. 1006. TREATMENT OF OTHER NONIMMIGRANTS.**

21 (a) CERTAIN ALIENS INELIGIBLE FOR BENEFITS.—
22 An alien who is not an eligible individual or otherwise not
23 made eligible under this Act for benefits is not eligible to
24 obtain the comprehensive benefit package through enroll-
25 ment in a health plan under this Act.

1 (b) DIPLOMATS AND OTHER FOREIGN GOVERNMENT
2 OFFICIALS.—Subject to conditions established by the Na-
3 tional Health Board in consultation with the Secretary of
4 State, a nonimmigrant under subparagraph (A) or (G) of
5 section 101(a)(15) of the Immigration and Nationality Act
6 may obtain the comprehensive benefit package through en-
7 rollment in the community-rated health plan for the health
8 care coverage area in which the nonimmigrant resides.

9 (c) RECIPROCAL TREATMENT OF OTHER
10 NONIMMIGRANTS.—With respect to those classes of indi-
11 viduals who are lawful nonimmigrants but who are not
12 long-term nonimmigrants (as defined in section 1902(27))
13 or described in subsection (b), such individuals may obtain
14 such benefits through enrollment with community-rated
15 health plans only in accordance with such reciprocal agree-
16 ments between the United States and foreign states as
17 may be entered into.

18 (d) CONSTRUCTION.—The National Health Board
19 shall adopt procedures that assure that each person who
20 is eligible for enrollment in an applicable health plan is
21 able to enroll in such a plan.

22 **SEC. 1007. EFFECTIVE DATE OF ENTITLEMENT.**

23 (a) COMMUNITY RATE ELIGIBLE INDIVIDUALS.—

24 (1) IN GENERAL.—In the case of community
25 rate eligible individuals residing in a State, the enti-

1 tlement under this part (and requirements under
2 section 1002) shall not take effect until the State
3 becomes a participating State (as defined in section
4 1200).

5 (2) TRANSITIONAL RULE FOR LARGE GROUP
6 SPONSORS.—

7 (A) IN GENERAL.—In the case of a State
8 that becomes a participating State before the
9 general effective date (as defined in subsection
10 (c)) and for periods before such date, under
11 rules established by the Board, an individual
12 who is covered under a plan (described in sub-
13 paragraph (C)) based on the individual (or the
14 individual’s spouse) being a qualifying employee
15 of a qualifying employer, the individual shall
16 not be treated under this Act as a community
17 rate eligible individual.

18 (B) QUALIFYING EMPLOYER DEFINED.—In
19 subparagraph (A), the term “qualifying em-
20 ployer” means an employer that—

21 (i) is described in section 1401(2), or
22 is participating in a multiemployer plan de-
23 scribed in section 1401(6)(B) or plan de-
24 scribed in section 1401(7), and

1 (ii) provides such notice to the State
2 involved as the Board specifies.

3 (C) BENEFITS PLAN DESCRIBED.—A plan
4 described in this subparagraph is an employee
5 benefit plan that—

6 (i) provides (through insurance or
7 otherwise) the comprehensive benefit pack-
8 age, and

9 (ii) provides an employer contribution
10 of at least 80 percent of the premium (or
11 premium equivalent) for coverage.

12 (b) EXPERIENCE-RATE ELIGIBLE INDIVIDUALS.—

13 (1) IN GENERAL.—In the case of experience
14 rate eligible individuals, the entitlement under this
15 part shall not take effect until the general effective
16 date.

17 (2) TRANSITION.—For purposes of this Act and
18 before the general effective date, in the case of an
19 eligible individual who resides in a participating
20 State, the individual is deemed a community rate eli-
21 gible individual until the individual becomes an expe-
22 rience rate eligible individual, unless subsection
23 (a)(2)(A) applies to the individual.

1 (c) GENERAL EFFECTIVE DATE DEFINED.—In this
2 Act, the term “general effective date” means January 1,
3 1998.

4 **PART 2—TREATMENT OF FAMILIES AND SPECIAL**
5 **RULES**

6 **SEC. 1011. GENERAL RULE OF ENROLLMENT OF FAMILY IN**
7 **SAME HEALTH PLAN.**

8 (a) IN GENERAL.—Except as provided in this part
9 or otherwise, all members of the same family (as defined
10 in subsection (b)) shall be enrolled in the same applicable
11 health plan.

12 (b) FAMILY DEFINED.—In this Act, unless otherwise
13 provided, the term “family”—

14 (1) means, with respect to an eligible individual
15 who is not a child (as defined in subsection (c)), the
16 individual; and

17 (2) includes the following persons (if any):

18 (A) The individual’s spouse if the spouse is
19 an eligible individual.

20 (B) The individual’s children (and, if appli-
21 cable, the children of the individual’s spouse) if
22 they are eligible individuals.

23 (c) CLASSES OF FAMILY ENROLLMENT; TERMINOL-
24 OGY.—

1 (1) IN GENERAL.—In this Act, each of the fol-
2 lowing is a separate class of family enrollment:

3 (A) Coverage only of an individual (re-
4 ferred to in this Act as the “individual” enroll-
5 ment or class of enrollment).

6 (B) Coverage of a married couple without
7 children (referred to in this Act as the “couple-
8 only” enrollment or class of enrollment).

9 (C) Coverage of an unmarried individual
10 and one or more children (referred to in this
11 Act as the “single parent” enrollment or class
12 of enrollment).

13 (D) Coverage of a married couple and one
14 or more children (referred to in this Act as the
15 “dual parent” enrollment or class of enroll-
16 ment).

17 (2) REFERENCES TO FAMILY AND COUPLE
18 CLASSES OF ENROLLMENT.—In this Act:

19 (A) FAMILY.—The terms “family enroll-
20 ment” and “family class of enrollment”, refer
21 to enrollment in a class of enrollment described
22 in subparagraph (B), (C), or (D) of paragraph
23 (1).

24 (B) COUPLE.—The term “couple class of
25 enrollment” refers to enrollment in a class of

1 enrollment described in subparagraph (B) or
2 (D) of paragraph (1).

3 (d) SPOUSE; MARRIED; COUPLE.—

4 (1) IN GENERAL.—In this Act, the terms
5 “spouse” and “married” mean, with respect to a
6 person, another individual who is the spouse of the
7 person or married to the person, as determined
8 under applicable State law.

9 (2) COUPLE.—The term “couple” means an in-
10 dividual and the individual’s spouse.

11 (e) CHILD DEFINED.—

12 (1) IN GENERAL.—In this Act, except as other-
13 wise provided, the term “child” means an eligible in-
14 dividual who (consistent with paragraph (3))—

15 (A) is under 25 years of age, and

16 (B) is a dependent of an eligible individual.

17 The Board may adjust the age limitation in sub-
18 paragraph (A) with respect to part-time or full-time
19 students if the Board, through a Congressional
20 Budget Office study, determines that such limitation
21 necessitates adjustments for cost savings purposes.

22 (2) APPLICATION OF STATE LAW.—Subject to
23 paragraph (3), determinations of whether a person
24 is the child of another person shall be made in ac-
25 cordance with applicable State law.

1 (3) NATIONAL RULES.—The National Health
2 Board may establish such national rules respecting
3 individuals who will be treated as children under this
4 Act as the Board determines to be necessary. Such
5 rules shall be consistent with the following prin-
6 ciples:

7 (A) STEP CHILD.—A child includes a step
8 child who is an eligible individual living with an
9 adult in a regular parent-child relationship.

10 (B) DISABLED CHILD.—A child includes
11 an unmarried dependent eligible individual re-
12 gardless of age who is incapable of self-support
13 because of mental or physical disability which
14 existed before age 21.

15 (C) CERTAIN INTERGENERATIONAL FAMI-
16 LIES.—A child includes the grandchild of an in-
17 dividual if—

18 (i) the parent of the grandchild is a
19 child and the parent and grandchild are
20 living with the grandparent; or

21 (ii) the grandparent has legal custody
22 of the grandchild.

23 (D) TREATMENT OF EMANCIPATED MI-
24 NORS AND MARRIED INDIVIDUALS.—An emanci-

1 pated minor or married individual shall not be
2 treated as a child.

3 (E) CHILDREN PLACED FOR ADOPTION.—

4 A child includes a child who is placed for adop-
5 tion with an eligible individual, except when the
6 child is a child in State supervised care.

7 (f) ADDITIONAL RULES.—The Board shall provide
8 for such additional exceptions and special rules, including
9 rules relating to—

10 (1) families in which members are not residing
11 in the same area or in which children are not resid-
12 ing with their parents,

13 (2) the treatment of eligible individuals who are
14 under 25 years of age and who are not a dependent
15 of an eligible individual,

16 (3) changes in family composition occurring
17 during a year,

18 (4) treatment of children in State supervised
19 care, and

20 (5) treatment of children of parents who are
21 separated or divorced,

22 as the Board finds appropriate.

1 **SEC. 1012. TREATMENT OF CERTAIN FAMILIES.**

2 (a) TREATMENT OF MEDICARE-ELIGIBLE INDIVID-
3 UALS WHO ARE QUALIFYING EMPLOYEES OR SPOUSES OF
4 QUALIFYING EMPLOYEES.—

5 (1) IN GENERAL.—Except as specifically pro-
6 vided, in the case of an individual who is an individ-
7 ual described in paragraph (2) with respect to 2 con-
8 secutive months in a year (and it is anticipated
9 would be in the following month and in such follow-
10 ing month would be a medicare-eligible individual
11 but for this paragraph), the individual shall not be
12 treated as a medicare-eligible individual under this
13 Act during such following month and the remainder
14 of the year.

15 (2) INDIVIDUAL DESCRIBED.—An individual de-
16 scribed in this paragraph with respect to a month is
17 an individual who is a qualifying employee or the
18 spouse or family member of a qualifying employee in
19 the month.

20 (b) SEPARATE TREATMENT FOR CERTAIN GROUPS
21 OF INDIVIDUALS.—In the case of a family that includes
22 one or more individuals in a group described in subsection
23 (c)—

24 (1) all the individuals in each such group within
25 the family shall be treated collectively as a separate
26 family, and

1 (2) all the individuals not described in any such
2 group shall be treated collectively as a separate
3 family.

4 (c) GROUPS OF INDIVIDUALS DESCRIBED.—Each of
5 the following is a group of individuals described in this
6 subsection:

7 (1) AFDC recipients (as defined in section
8 1902(2)).

9 (2) Disabled SSI recipients (as defined in sec-
10 tion 1902(14)) .

11 (3) SSI recipients (as defined in section
12 1902(46)) who are not disabled SSI recipients.

13 (4) Electing veterans (as defined in subsection
14 (d)(1)).

15 (5) Active duty military personnel (as defined
16 in subsection (d)(2)).

17 (6) Electing American Indians (as defined in
18 subsection (d)(3)).

19 (7) Prisoners (as defined in section 1902(37)).

20 (d) SPECIAL RULES.—In this Act:

21 (1) ELECTING VETERANS.—

22 (A) DEFINED.—Subject to subparagraph

23 (B), the term “electing veteran” means a vet-

24 eran who makes an election to enroll with a

25 health plan of the Department of Veterans Af-

1 fairs under chapter 18 of title 38, United
2 States Code, as added by section 8101(a)(1).

3 (B) FAMILY EXCEPTION.—Subparagraph
4 (A) shall not apply with respect to coverage
5 under a health plan referred to in such sub-
6 paragraph if, for the area in which the electing
7 veteran resides, such health plan offers cov-
8 erage to family members of an electing veteran
9 and the veteran elects family enrollment under
10 such plan (instead of individual enrollment).

11 (2) ACTIVE DUTY MILITARY PERSONNEL.—

12 (A) IN GENERAL.—Subject to subpara-
13 graph (B), the term “active duty military per-
14 sonnel” means an individual on active duty in
15 the Uniformed Services of the United States.

16 (B) EXCEPTION.—If an individual de-
17 scribed in subparagraph (A) elects family cov-
18 erage under section 1073a(e)(2)(A) of title 10,
19 United States Code (as added by section
20 8001(a)), then paragraph (5) of subsection (c)
21 shall not apply with respect to such coverage.

22 (3) ELECTING AMERICAN INDIANS.—

23 (A) IN GENERAL.—Subject to subpara-
24 graph (B), the term “electing American In-

1 dian” means an eligible individual who makes
2 an election under section 8302(b) of this Act.

3 (B) FAMILY ELECTION FOR ALL INDIVID-
4 UALS ELIGIBLE TO ELECT.—No such election
5 shall be made with respect to an individual in
6 a family (as defined without regard to this sec-
7 tion) unless such election is made for all eligible
8 individuals (described in section 8302(a)) who
9 are family members of the family.

10 (4) MULTIPLE CHOICE.—Eligible individuals
11 who are permitted to elect coverage under more than
12 one health plan or program referred to in this sub-
13 section may elect which of such plans or programs
14 will be the applicable health plan under this Act.

15 (e) QUALIFYING STUDENTS.—

16 (1) IN GENERAL.—In the case of a qualifying
17 student (described in paragraph (2)), the student
18 may elect to enroll in a community-rate health plan
19 offered for the health care coverage area in which
20 the school is located.

21 (2) QUALIFYING STUDENT.—In paragraph (1),
22 the term “qualifying student” means an individual
23 who—

1 (A) but for this subsection would receive
2 coverage under a health plan as a child of an-
3 other person, and

4 (B) is a full-time student at a school in a
5 health care coverage area that is different from
6 the area (or, in the case of a large group spon-
7 sor, such coverage area as the Board may speci-
8 fy) providing the coverage described in subpara-
9 graph (A).

10 (3) PAYMENT RULES.—

11 (A) CONTINUED TREATMENT AS FAM-
12 ILY.—Except as provided in subparagraph (B),
13 nothing in this subsection shall be construed as
14 affecting the payment liabilities between fami-
15 lies and community-rated health plans.

16 (B) TRANSFER PAYMENT.—In the case of
17 an election under paragraph (1), for transfer
18 payments see section 1238.

19 (f) SPOUSES LIVING IN DIFFERENT HEALTH CARE
20 COVERAGE AREAS.—The Board shall provide for such
21 special rules in applying this Act in the case of a couple
22 in which the spouses reside in different health care cov-
23 erage areas as the Board finds appropriate.

24 (g) CHILDREN IN STATE-SUPERVISED CARE.—

1 (1) IN GENERAL.—In the case of a qualifying
2 child in State-supervised care (as described in para-
3 graph (2)), the child shall be considered as a family
4 of one and enrolled by the State agency who has
5 been awarded temporary or permanent custody of
6 the child (or which has legal responsibility for the
7 child) in a fee-for-service plan unless the State agen-
8 cy has established a special health service delivery
9 system designated to customize and more efficiently
10 provide health services to children in State-super-
11 vised care, in which case the State agency will enroll
12 the child in the plan appropriate to ensure access to
13 such a special health service delivery system.

14 (2) CHILDREN IN STATE-SUPERVISED CARE.—
15 For purposes of paragraph (1), the term “child in
16 State-supervised care” means any child who is resid-
17 ing away from his or her parents and is temporarily
18 or permanently, on a voluntary or involuntary basis,
19 under the responsibility of a public child welfare or
20 juvenile services agency or court. Such term includes
21 children who are not yet made wards of the court or
22 adjudicated as delinquents residing in emergency
23 shelter care, children in the physical custody of pub-
24 lic or private agencies, and children who are with
25 foster parents, or other group or residential care

1 providers. Such term also includes children who are
2 legally adopted and for whom the Federal or State
3 government is providing adoption assistance pay-
4 ments.

5 **SEC. 1013. MULTIPLE EMPLOYMENT SITUATIONS.**

6 (a) MULTIPLE EMPLOYMENT OF AN INDIVIDUAL.—

7 In the case of an individual who—

8 (1)(A) is not married or (B) is married and
9 whose spouse is not a qualifying employee (as de-
10 fined in section 1901(b)(1)),

11 (2) is not a child, and

12 (3) who is a qualifying employee both of a com-
13 munity rate employer and of a experience rate em-
14 ployer (or of 2 large group sponsor employers),

15 the individual may elect the applicable health plan to be
16 either a community-rated health plan (for the health care
17 coverage area in which the individual resides) or an experi-
18 ence-rated health plan (for an employer employing the in-
19 dividual).

20 (b) MULTIPLE EMPLOYMENT WITHIN A FAMILY.—

21 (1) MARRIED COUPLE WITH EMPLOYMENT COM-
22 MUNITY RATE EMPLOYER AND WITH A EXPERIENCE
23 RATE EMPLOYER.—In the case of a married individ-
24 ual—

1 (A) who is a qualifying employee of a com-
2 munity rate employer and whose spouse is a
3 qualifying employee of a experience rate em-
4 ployer, or

5 (B) who is a qualifying employee of an ex-
6 perience rate employer and whose spouse is a
7 qualifying employee of a community rate em-
8 ployer,

9 the individual and the individual's spouse may elect
10 the applicable health plan to be either a community-
11 rated health plan (for the health care coverage area
12 in which the couple resides) or an experience-rated
13 health plan (for an employer employing the individ-
14 ual or the spouse).

15 (2) MARRIED COUPLE WITH DIFFERENT EM-
16 PLOYERS.—In the case of a married individual—

17 (A) who is a qualifying employee of a expe-
18 rience rate employer, and

19 (B) whose spouse is a qualifying employee
20 of a different experience rate employer,

21 the individual and the individual's spouse may elect
22 the applicable health plan to be an experience-rated
23 health plan for an employer employing either the in-
24 dividual or the spouse.

1 **SEC. 1014. TREATMENT OF RESIDENTS OF STATES WITH**
 2 **STATEWIDE SINGLE-PAYER SYSTEMS.**

3 (a) **UNIVERSAL COVERAGE.**—Notwithstanding the
 4 previous provisions of this title, except as provided in part
 5 2 of subtitle C, in the case of an individual who resides
 6 in a State that has a Statewide single-payer system under
 7 section 1223, universal coverage shall be provided consist-
 8 ent with section 1222(3).

9 (b) **INDIVIDUAL RESPONSIBILITIES.**—In the case of
 10 an individual who resides in a single-payer State, the re-
 11 sponsibilities of such individual under such system shall
 12 supersede the obligations of the individual under section
 13 1002.

14 **Subtitle B—Benefits**

15 **PART 1—COMPREHENSIVE BENEFIT PACKAGE**

16 **SEC. 1101. PROVISION OF COMPREHENSIVE BENEFITS BY**
 17 **PLANS.**

18 (a) **IN GENERAL.**—Subject to the provisions of sec-
 19 tion 1603, the comprehensive benefit package shall consist
 20 of the following items and services (as described in this
 21 part), subject to the cost sharing requirements described
 22 in part 3, the exclusions described in part 4, and the du-
 23 ties and authority of the National Health Board described
 24 in part 5:

- 25 (1) Hospital services.
 26 (2) Services of health professionals.

- 1 (3) Emergency and ambulatory medical and
2 surgical services.
- 3 (4) Clinical preventive services.
- 4 (5) Mental illness and substance abuse services.
- 5 (6) Family planning services and services for
6 pregnant women.
- 7 (7) Hospice care.
- 8 (8) Home health care.
- 9 (9) Extended care services.
- 10 (10) Ambulance services.
- 11 (11) Outpatient laboratory, radiology, and diag-
12 nostic services.
- 13 (12) Outpatient prescription drugs and
14 biologicals.
- 15 (13) Outpatient rehabilitation services.
- 16 (14) Durable medical equipment and prosthetic
17 and orthotic devices.
- 18 (15) Vision care.
- 19 (16) Hearing aids for children.
- 20 (17) Dental care.
- 21 (18) Investigational treatments.
- 22 (19) Optional services, such as—
23 (A) health education classes; and
24 (B) extra contractual services.

1 (b) NO OTHER LIMITATIONS OR COST SHARING.—
2 The items and services in the comprehensive benefit pack-
3 age shall not be subject to any duration or scope limitation
4 or any deductible, copayment, or coinsurance amount that
5 is not required or authorized under this Act.

6 **SEC. 1102. HOSPITAL SERVICES.**

7 (a) COVERAGE.—The hospital services described in
8 this section are the following items and services:

9 (1) Inpatient hospital services.

10 (2) Outpatient hospital services.

11 (3) 24-hour a day hospital emergency services.

12 (b) LIMITATION.—The hospital services described in
13 this section do not include hospital services provided for
14 the treatment of a mental or substance abuse disorder
15 (which are subject to section 1106), except for medical de-
16 toxification as required for the management of medical
17 conditions associated with withdrawal from alcohol or
18 drugs (which is not covered under such section).

19 **SEC. 1103. SERVICES OF HEALTH PROFESSIONALS.**

20 (a) COVERAGE.—The items and services described in
21 this section are—

22 (1) inpatient and outpatient health professional
23 services, including consultations, that are provided
24 in—

1 (A) a home, office, or other ambulatory
2 care setting; or

3 (B) an institutional setting; and

4 (2) services and supplies (including drugs and
5 biologicals which cannot be self-administered) fur-
6 nished as an incident to such health professional
7 services, of kinds which are commonly furnished in
8 the office of a health professional and are commonly
9 either rendered without charge or included in the bill
10 of such professional.

11 (b) DEFINITIONS.—Unless otherwise provided in this
12 Act, for purposes of this Act:

13 (1) HEALTH PROFESSIONAL.—The term
14 “health professional” means an individual who pro-
15 vides health professional services.

16 (2) HEALTH PROFESSIONAL SERVICES.—The
17 term “health professional services” means profes-
18 sional services that—

19 (A) are lawfully provided by a physician; or

20 (B) would be described in subparagraph

21 (A) if provided by a physician, but are provided
22 by another person who is legally authorized to
23 provide such services in the State in which the
24 services are provided.

1 **SEC. 1104. EMERGENCY AND AMBULATORY MEDICAL AND**
2 **SURGICAL SERVICES.**

3 The items and services described in this section are
4 24 hour-a-day emergency services, and ambulatory medi-
5 cal and surgical services provided by a facility that is not
6 a hospital and that is legally authorized to provide the
7 services in the State in which they are provided.

8 **SEC. 1105. CLINICAL PREVENTIVE SERVICES.**

9 (a) **COVERAGE.**—The clinical preventive services de-
10 scribed in this section are the following items or services
11 provided consistent with any periodicity schedule or other
12 modification promulgated by the Board under section
13 1153, including regulations establishing periodicity sched-
14 ules for high risk populations:

15 (1) Age appropriate immunizations consistent
16 with the periodicity schedule recommended by the
17 Advisory Council on Immunization Practices, in con-
18 sultation with the American Academy of Pediatrics.

19 (2) Age appropriate tests and clinician visits
20 (including preventive counseling and health advice)
21 for individuals under the age of 20, consistent with
22 a periodicity schedule recommended by the American
23 Academy of Pediatrics and other experts in clinical
24 preventive services for children and adolescents.

25 (3) Clinician visits for individuals age 20 and
26 over as follows:

1 (A) Every 3 years for individuals age 20
2 through 39.

3 (B) Biannually for individuals age 40
4 through 64.

5 (C) Annually for individuals age 65 and
6 over.

7 (4) Cholesterol tests every 5 years for individ-
8 uals age 20 and over.

9 (5) Papanicolaou smears and pelvic exams for
10 females who are at risk for cervical cancer—

11 (A) annually between the ages of 13
12 through 64 unless three consecutive annual pap
13 smears have been negative and it has been de-
14 termined that the female is not at risk for sexu-
15 ally transmitted diseases, in which case cov-
16 erage shall be once every 2 years; and

17 (B) every 2 years for females age 65 and
18 over.

19 (6) Annual screening for chlamydia and gonor-
20 rhea for sexually active females unless such individ-
21 ual is determined by the health care provider not to
22 be at risk for sexually transmitted diseases.

23 (7) Mammograms for females as follows:

24 (A) Ages 40 through 49, every 2 years in
25 consultation with their physician.

1 (B) Ages 50 through 64, every year.

2 (C) Age 65 and over, every 2 years.

3 (b) COLORECTAL CANCER SCREENINGS.—The com-
4 prehensive benefit package shall include any revisions to
5 colorectal cancer screenings that are recommended by the
6 U.S. Preventive Services Task Force in the periodic up-
7 date of the Guide to Clinical Preventive Services planned
8 for release in November, 1994. The National Health
9 Board shall utilize any subsequent U.S. Preventive Serv-
10 ices Task Force updates as its primary guidance in updat-
11 ing these clinical preventive services.

12 (c) CLINICIAN VISIT.—For purposes of this section,
13 the term “clinician visit” includes the following health pro-
14 fessional services (as defined in section 1102(c)):

15 (1) A complete medical history.

16 (2) An appropriate physical examination.

17 (3) Risk assessment, including for domestic vio-
18 lence.

19 (4) Targeted health advice and counseling, in-
20 cluding nutrition counseling.

21 (5) The administration of age-appropriate im-
22 munizations and tests specified in subsection (a).

1 **SEC. 1106. MENTAL ILLNESS AND SUBSTANCE ABUSE SERV-**
2 **ICES.**

3 (a) **COVERAGE.**—The mental illness and substance
4 abuse services that are described in this section are the
5 following items and services for eligible individuals, as de-
6 fined in section 1001(c), including individuals with mul-
7 tiple mental disorders or mental retardation and mental
8 illness, who satisfy the eligibility requirements in sub-
9 section (b):

10 (1) Inpatient mental illness and substance
11 abuse treatment (described in subsection (d)).

12 (2) Residential mental illness and substance
13 abuse treatment (described in subsection (e)).

14 (3) Intensive nonresidential mental illness and
15 substance abuse treatment (described in subsection
16 (f)).

17 (4) Outpatient mental illness and substance
18 abuse treatment (described in subsection (g)), in-
19 cluding case management, screening and assessment,
20 crisis services, and collateral services.

21 (b) **ELIGIBILITY.**—The eligibility requirements re-
22 ferred to in subsection (a) are as follows:

23 (1) **INPATIENT, RESIDENTIAL, NONRES-**
24 **IDENTIAL, AND OUTPATIENT TREATMENT.**—An eligi-
25 ble individual is eligible to receive coverage for inpa-
26 tient and residential mental illness and substance

1 abuse treatment, intensive nonresidential mental ill-
2 ness and substance abuse treatment, or outpatient
3 mental illness and substance abuse treatment (ex-
4 cept case management, screening and assessment,
5 crisis services, and collateral services) if the individ-
6 ual—

7 (A) has, or has had during the 1-year pe-
8 riod preceding the date of such treatment, a
9 diagnosable mental disorder or a diagnosable
10 substance abuse disorder or, in the case of a
11 child 5 years of age or less, is at risk of a men-
12 tal disorder; and

13 (B) is experiencing, or is at significant risk
14 of experiencing, functional impairment in fam-
15 ily, work, school, or community activities.

16 For purposes of this paragraph, an individual who
17 has a diagnosable mental disorder or a diagnosable
18 substance abuse disorder, is receiving treatment for
19 such disorder, but does not satisfy the functional im-
20 pairment criterion in subparagraph (B) shall be
21 treated as satisfying such criterion if the individual
22 would satisfy such criterion without such treatment.

23 (2) CASE MANAGEMENT.—An eligible individual
24 is eligible to receive coverage for case management
25 if the individual is eligible to receive coverage for,

1 and is receiving, mental illness and substance abuse
2 treatment with respect to a diagnosable mental dis-
3 order or a diagnosable substance abuse disorder.

4 (3) SCREENING AND ASSESSMENT AND CRISIS
5 SERVICES.—All eligible individuals enrolled under a
6 health plan are eligible to receive coverage for out-
7 patient mental illness and substance abuse treat-
8 ment consisting of screening and assessment and
9 crisis services.

10 (4) COLLATERAL SERVICES.—An eligible indi-
11 vidual is eligible to receive coverage for outpatient
12 mental illness and substance abuse treatment con-
13 sisting of collateral services if the individual is a
14 family member (described in section 1011(b)) of an
15 individual who is receiving inpatient and residential
16 mental illness and substance abuse treatment, inten-
17 sive nonresidential mental illness and substance
18 abuse treatment, or outpatient mental illness and
19 substance abuse treatment.

20 (c) HEALTH PROFESSIONAL.—

21 (1) IN GENERAL.—The National Health Board
22 shall specify those health professional services de-
23 scribed in section 1103 that shall be treated as inpa-
24 tient, residential, intensive nonresidential, and out-

1 patient mental illness and substance abuse treat-
2 ment.

3 (2) RULE OF CONSTRUCTION.—Nothing in sec-
4 tion 1861(e) of the Social Security Act, including
5 paragraph (4), shall be construed as requiring that
6 individuals receiving items and services under this
7 section be under the care of a physician when such
8 individuals are under the care of a mental health or
9 substance abuse health professional in a State in
10 which such care is permitted by State law.

11 (d) INPATIENT TREATMENT.—

12 (1) DEFINITION.—For purposes of this subtitle,
13 the term “inpatient mental illness and substance
14 abuse treatment” means the items and services de-
15 scribed in paragraphs (1) through (3) of section
16 1861(b) of the Social Security Act when provided
17 with respect to a diagnosable mental disorder or a
18 diagnosable substance abuse disorder to an inpatient
19 of a hospital or psychiatric hospital.

20 (2) LIMITATIONS.—Coverage for inpatient men-
21 tal illness and substance abuse treatment is subject
22 to the following limitations:

23 (A) INPATIENT HOSPITAL TREATMENT FOR
24 SUBSTANCE ABUSE.—Such treatment, when
25 provided in a hospital or a psychiatric hospital

1 with respect to a diagnosable substance abuse
2 disorder, is covered under this section only for
3 detoxification requiring the management of psy-
4 chiatric conditions associated with withdrawal
5 from alcohol or drugs. The items and services
6 described in this section do not include medical
7 detoxification as required for the management
8 of medical conditions associated with with-
9 drawal from alcohol or drugs (which is covered
10 under section 1102).

11 (B) ANNUAL LIMIT.—Prior to January 1,
12 2001, such treatment, when furnished to an in-
13 patient of a hospital or psychiatric hospital is
14 subject to an aggregate annual limit of 34 days,
15 15 of which may not be reduced in substitution
16 for other covered services. On or after such
17 date, such annual aggregate limit shall not
18 apply.

19 (e) RESIDENTIAL TREATMENT.—

20 (1) DEFINITION.—For purposes of this subtitle,
21 the term “residential mental illness and substance
22 abuse treatment” means the items and services pro-
23 vided with respect to a diagnosable mental disorder
24 or a diagnosable substance abuse disorder to a resi-
25 dent of a residential treatment center, residential de-

1 toxification center, crisis residential program, mental
2 illness residential treatment program, therapeutic
3 family home, therapeutic community, group treat-
4 ment home, community residential treatment pro-
5 gram, or recovery center for substance abuse.

6 (2) ANNUAL LIMIT.—

7 (A) IN GENERAL.—Prior to January 1,
8 2001, the number of covered days of residential
9 mental illness and substance abuse treatment
10 that are available to an individual under the 34-
11 day limit described in the first sentence of sub-
12 section (d)(2)(B), shall be reduced by 1 day for
13 each 4 covered days of residential mental illness
14 and substance abuse treatment that are pro-
15 vided to the individual, until such number is re-
16 duced to 15. After such number is reduced to
17 15, no residential treatment may be covered, ex-
18 cept as provided in subparagraph (B). On or
19 after such date, such annual aggregate limit
20 shall not apply.

21 (B) NONAPPLICATION.—The limit con-
22 tained in subparagraph (A) shall not apply to
23 mental health and substance abuse treatment
24 provided in a therapeutic community, halfway
25 house, recovery center or other comparably in-

1 expensive residential mental health and sub-
2 stance abuse treatment facility, as determined
3 by the National Health Board.

4 (f) INTENSIVE NONRESIDENTIAL TREATMENT.—

5 (1) DEFINITION.—For purposes of this subtitle,
6 the term “intensive nonresidential mental illness and
7 substance abuse treatment” means diagnostic or
8 therapeutic items or services provided with respect
9 to a diagnosable mental disorder or a diagnosable
10 substance abuse disorder to an individual—

11 (A) participating in a partial hospitaliza-
12 tion program, a mental health consumer-run
13 service center, a day treatment program, a psy-
14 chiatric rehabilitation program, or an ambula-
15 tory detoxification program; or

16 (B) receiving home-based mental illness
17 services or behavioral aide mental illness serv-
18 ices.

19 (2) LIMITATIONS.—Coverage for intensive
20 nonresidential mental illness and substance abuse
21 treatment is subject to the following limitations:

22 (A) TREATMENT PURPOSES.—Such treat-
23 ment is covered only when provided—

24 (i) to avert the need for treatment in
25 residential or inpatient settings;

1 (ii) to facilitate the earlier discharge
2 of an individual receiving inpatient or resi-
3 dential care;

4 (iii) to restore the functioning of an
5 individual with a diagnosable mental dis-
6 order or a diagnosable substance abuse
7 disorder; or

8 (iv) to assist such an individual to de-
9 velop the skills and gain access to the sup-
10 port services the individual needs to
11 achieve the maximum level of functioning
12 of the individual within the community.

13 (B) DETOXIFICATION.—Intensive
14 nonresidential substance abuse treatment con-
15 sisting of detoxification is covered only if it is
16 provided in the context of a treatment program.

17 (g) OUTPATIENT TREATMENT.—

18 (1) DEFINITION.—For purposes of this subtitle,
19 the term “outpatient mental illness and substance
20 abuse treatment” means the following services pro-
21 vided with respect to a diagnosable mental disorder
22 or a diagnosable substance abuse disorder in an out-
23 patient setting:

24 (A) Screening and assessment.

25 (B) Diagnosis.

1 (C) Medications management.

2 (D) Substance abuse counseling and re-
3 lapse prevention.

4 (E) Crisis services.

5 (F) Somatic treatment services.

6 (G) Psychotherapy.

7 (H) Case management.

8 (I) Collateral services.

9 (2) LIMITATIONS.—Coverage for outpatient
10 mental illness and substance abuse treatment is sub-
11 ject to the following limitations:

12 (A) HEALTH PROFESSIONAL SERVICES.—
13 Such treatment is covered only when it con-
14 stitutes health professional services (as defined
15 in section 1103(b)(2)).

16 (B) DETOXIFICATION.—Outpatient sub-
17 stance abuse treatment consisting of detoxifica-
18 tion is covered only if it is provided in the con-
19 text of a treatment program.

20 (h) MANAGEMENT OF CARE FOR MENTAL ILLNESS
21 AND SUBSTANCE ABUSE.—

22 (1) PROVISION OF TREATMENT.—Quality man-
23 aged care techniques shall be utilized by health plans
24 to ensure that all necessary care is provided in the

1 most appropriate, cost effective setting, and that un-
2 necessary care is not provided.

3 (2) QUALITY MANAGED CARE.—The term
4 “quality managed care” refers to the administration
5 of benefits through the methods of central intake,
6 preauthorization, and utilization review. Health
7 plans may contract with specialized behavioral care
8 entities to administer benefits if such entities are
9 certified by the State as proficient in the use of
10 quality managed care techniques that facilitate the
11 provision of clinically appropriate, cost-effective, and
12 confidential treatment, providing continuity of care
13 between and among treatment providers.

14 (3) TREATMENT DECISIONS.—

15 (A) Treatment placement decisions shall be
16 based primarily on medical necessity. Criteria
17 used for placement shall be based on uniform
18 assessment tools recognized by treatment and
19 other professional organizations in the fields of
20 mental illness and substance abuse or approved
21 for use by the National Health Board and shall
22 be publicly available.

23 (B) All treatment assessment and place-
24 ment decisions or review of such decisions shall
25 be made by personnel—

1 (i) licensed, certified, or otherwise
2 credentialed by the State in the field for
3 which the assessment or treatment is
4 sought (such as mental health or substance
5 abuse) and qualified to review utilization of
6 the specific treatment delivered; and

7 (ii) with no financial stake in the out-
8 come of such decisions.

9 (4) RULE OF CONSTRUCTION.—Nothing in this
10 section shall be construed as prohibiting health plans
11 from providing mental health and substance abuse
12 treatment through fee-for-service arrangements.

13 (i) SPECIAL DELIVERY REQUIREMENTS FOR SERV-
14 ICES PROVIDED TO CHILDREN.—

15 (1) REQUIRING SERVICES TO BE PROVIDED
16 THROUGH ORGANIZED SYSTEMS OF CARE.—Health
17 plans shall ensure that the mental illness and sub-
18 stance abuse services described in this section and
19 furnished to an eligible person are furnished through
20 organized systems of care, as described in paragraph
21 (2), if the eligible person is a person under 22 years
22 of age who has a serious emotional disturbance or
23 a substance abuse disorder, and who is, or is at im-
24 minent risk of being, involved with one or more pub-

1 lic child-serving agencies, including child welfare,
2 special education, and juvenile or criminal justice.

3 (2) REQUIREMENTS OF SYSTEM OF CARE.—As
4 used in this subsection, the term “organized system
5 of care” means a community-based service delivery
6 network, which may consist of public and private
7 providers, that meets the following requirements:

8 (A) The system has established linkages
9 with existing mental illness and substance
10 abuse service delivery programs in the plan
11 service area (or is in the process of developing
12 or operating a system with appropriate public
13 agencies in the area to coordinate the delivery
14 of such services to individuals in the area).

15 (B) The system provides for the participa-
16 tion and coordination of multiple agencies and
17 providers that serve the needs of children in the
18 area, including agencies and providers involved
19 with child welfare, education, juvenile or crimi-
20 nal justice, health care, mental health, and sub-
21 stance abuse prevention and treatment.

22 (C) The system provides for the involve-
23 ment of the families of children to whom mental
24 illness and substance abuse services are pro-

1 vided in the planning of treatment and the de-
2 livery of services.

3 (D) The system provides for the develop-
4 ment and implementation of individualized
5 treatment plans by multidisciplinary and multi-
6 agency teams, that are recognized and followed
7 by the applicable agencies and providers in the
8 area.

9 (E) The system ensures the delivery and
10 coordination of the range of mental illness and
11 substance abuse services required by individuals
12 under 22 years of age who have a serious emo-
13 tional disturbance or a substance abuse dis-
14 order.

15 (F) The system provides for the manage-
16 ment of the individualized treatment plans de-
17 scribed in subparagraph (D) and for a flexible
18 response to changes in treatment needs over
19 time.

20 (3) FULL IMPLEMENTATION OF PLAN.—Subject
21 to paragraph (2)(F), the State shall assure that
22 public or philanthropic resources are available to im-
23 plement each child's plan, including residential treat-
24 ment in excess of the limit set forth in subsection (e)

1 if the State determines that such treatment is clini-
2 cally appropriate.

3 (4) RULE OF CONSTRUCTION.—The organized
4 system of care shall not exclude health professionals
5 whose services are covered by the health plan se-
6 lected by the child or the child’s legal guardian.

7 (5) REQUIREMENTS OF STATES.—The State
8 shall ensure that public agencies furnishing services
9 to children with serious emotional disturbances, in-
10 cluding mental health, child welfare, special edu-
11 cation, juvenile justice, and other agencies, establish
12 policies that result in effective collaboration and co-
13 ordination among such agencies and the health plans
14 established in the State. Such collaboration may in-
15 clude policies to blend public funds with health plan
16 resources to meet such children’s needs or risk ad-
17 justment payments to health plans.

18 **SEC. 1107. FAMILY PLANNING SERVICES AND SERVICES**
19 **FOR PREGNANT WOMEN.**

20 The services described in this section are the follow-
21 ing items and services:

22 (1) Voluntary comprehensive family planning
23 services, including family planning counseling and
24 education.

1 (2) Contraceptive drugs and devices, subject to
2 approval by the Secretary under the Federal Food,
3 Drug, and Cosmetic Act.

4 (3) Services for pregnant women.

5 **SEC. 1108. HOSPICE CARE.**

6 The hospice care described in this section is the items
7 and services described in paragraph (1) of section
8 1861(dd) of the Social Security Act, as defined in para-
9 graphs (2), (3), and (4)(A) of such section, except that
10 all references to the Secretary of Health and Human Serv-
11 ices in such paragraphs shall be treated as references to
12 the National Health Board.

13 **SEC. 1109. HOME HEALTH CARE.**

14 (a) **COVERAGE.**—The home health care described in
15 this section is—

16 (1) the items and services described in section
17 1861(m) of the Social Security Act; and

18 (2) home infusion drug therapy services.

19 (b) **LIMITATIONS.**—Coverage for home health care is
20 subject to the following limitations:

21 (1) **INPATIENT TREATMENT ALTERNATIVE.**—

22 Such care is covered only as an alternative to inpa-
23 tient treatment in a hospital, skilled nursing facility,
24 or rehabilitation facility as a result of an illness, in-
25 jury, disorder or other health condition.

1 (2) REEVALUATION.—At the end of each 60-
2 day period of home health care, the need for contin-
3 ued care shall be reevaluated by the person who is
4 primarily responsible for providing the home health
5 care. Additional periods of care are covered only if
6 such person determines that the requirement in
7 paragraph (1) is satisfied.

8 **SEC. 1110. EXTENDED CARE SERVICES.**

9 (a) COVERAGE.—The extended care services de-
10 scribed in this section are the items and services described
11 in section 1861(h) of the Social Security Act when pro-
12 vided to an inpatient of a skilled nursing facility or a reha-
13 bilitation facility.

14 (b) LIMITATIONS.—Coverage for extended care serv-
15 ices is subject to the following limitations:

16 (1) HOSPITAL SERVICES ALTERNATIVE.—Such
17 services are covered only as an alternative to treat-
18 ment for inpatient hospital services as a result of an
19 illness, injury, disorder or other health condition.

20 (2) ANNUAL LIMIT.—Such services are subject
21 to an aggregate annual limit of 100 days, except
22 that such limit may be waived if the need for contin-
23 ued care is re-evaluated by the prescribing health
24 care professional and determined to be a cost effec-
25 tive alternative to necessary hospital services.

1 **SEC. 1111. AMBULANCE SERVICES.**

2 The ambulance services described in this section are
3 covered only when indicated by the medical condition of
4 the individual concerned. Such services include—

5 (1) ground transportation by ambulance; or

6 (2) air or water transportation by an aircraft or
7 vessel equipped for transporting an injured or sick
8 individual in cases in which there is no other method
9 of transportation or where the use of another meth-
10 od of transportation is contraindicated by the medi-
11 cal condition of the individual concerned.

12 **SEC. 1112. OUTPATIENT LABORATORY, RADIOLOGY, AND DI-**
13 **AGNOSTIC SERVICES.**

14 The items and services described in this section are
15 laboratory, radiology, and diagnostic services (including
16 genetic testing and counseling) provided upon prescription
17 to individuals who are not inpatients of a hospital, hospice,
18 skilled nursing facility, or rehabilitation facility.

19 **SEC. 1113. OUTPATIENT PRESCRIPTION DRUGS AND**
20 **BIOLOGICALS.**

21 The items described in this section are the following:

22 (1) Covered outpatient drugs described in sec-
23 tion 1861(t) of the Social Security Act—

24 (A) except that, for purposes of this sec-
25 tion, a medically accepted indication with re-
26 spect to the use of a covered outpatient drug in-

1 cludes any use which has been approved by the
2 Food and Drug Administration for the drug,
3 and includes another use of the drug if—

4 (i) the drug has been approved by the
5 Food and Drug Administration; and

6 (ii) such use is supported by one or
7 more citations which are included (or ap-
8 proved for inclusion) in one or more of the
9 following compendia: the American Hos-
10 pital Formulary Service-Drug Information,
11 the American Medical Association Drug
12 Evaluations, the United States Pharma-
13 copoeia-Drug Information, and other au-
14 thoritative compendia as identified by the
15 Secretary, unless the Secretary has deter-
16 mined that the use is not medically appro-
17 priate or the use is identified as not indi-
18 cated in one or more such compendia; or

19 (iii) such use is medically accepted
20 based on supportive clinical evidence in
21 peer reviewed medical literature appearing
22 in publications which have been identified
23 for purposes of this clause by the Sec-
24 retary; and

1 (B) notwithstanding any exclusion from
2 coverage that may be made with respect to such
3 a drug under title XVIII of such Act pursuant
4 to section 1862(a)(18) of such Act.

5 (2) Blood clotting factors when provided on an
6 outpatient basis.

7 (3) Medical foods prescribed by a physician that
8 comply with the requirements of the Federal Food,
9 Drug, and Cosmetic Act and that treat inborn errors
10 of metabolism identified by the Secretary as render-
11 ing a person unable to sustain life without signifi-
12 cant mental or physical impairment by the ingestion
13 of conventional foods.

14 (4) Accessories and supplies that are used di-
15 rectly with drugs and biologics to achieve the thera-
16 peutic benefit of such drugs or biologics.

17 **SEC. 1114. OUTPATIENT REHABILITATION SERVICES.**

18 (a) **COVERAGE.**—The outpatient rehabilitation serv-
19 ices described in this section are—

20 (1) outpatient occupational therapy;

21 (2) outpatient physical therapy;

22 (3) outpatient respiratory therapy; and

23 (4) outpatient speech-language pathology serv-
24 ices and audiology services.

1 (b) LIMITATIONS.—Coverage for outpatient rehabili-
2 tation services is subject to the following limitations:

3 (1) RESTORATION OF CAPACITY OR MINIMIZA-
4 TION OF LIMITATIONS.—Such services include only
5 items or services used to restore functional capacity
6 or minimize limitations on physical and cognitive
7 functions as a result of an illness, injury, disorder
8 or other health condition.

9 (2) MAINTENANCE OF FUNCTION OR PREVEN-
10 TION OF DETERIORATION.—To the extent that the
11 services described in paragraph (1) are for the pur-
12 pose of maintaining functioning or preventing dete-
13 rioration, such services shall be limited to—

14 (A) the initial evaluation and periodic over-
15 sight of the patient’s needs by a qualified reha-
16 bilitation health professional;

17 (B) the designing by the qualified rehabili-
18 tation health professional of a maintenance or
19 prevention program that is appropriate consid-
20 ering the capacity and tolerance of the patient
21 and the treatment objectives;

22 (C) the instruction of the patient, family
23 members, or support personnel in carrying out
24 the program; and

25 (D) reevaluations.

1 (3) REEVALUATION.—

2 (A) IN GENERAL.—At the end of each 60-
3 day period of outpatient rehabilitation services
4 (other than services described in paragraph
5 (2)), the need for continued services shall be re-
6 evaluated by the person who is primarily re-
7 sponsible for providing the services. Additional
8 periods of services are covered only if such per-
9 son determines that the requirement in para-
10 graph (1) is satisfied.

11 (B) QUALIFIED REHABILITATION HEALTH
12 PROFESSIONAL.—Periodically, outpatient reha-
13 bilitation services described in paragraph (2)
14 shall be reevaluated by a qualified rehabilitation
15 health professional.

16 **SEC. 1115. DURABLE MEDICAL EQUIPMENT, PROSTHETIC**
17 **DEVICES, ORTHOTICS, AND PROSTHETICS.**

18 (a) COVERAGE.—The items and services described in
19 this section are—

20 (1) durable medical equipment;

21 (2) prosthetic devices (other than dental de-
22 vices) which replace all or part of the function of an
23 internal body organ (including devices that are sur-
24 gically inserted, devices that are physically attached
25 to the body, such as colostomy bags and supplies di-

1 rectly related to colostomy care, and external de-
2 vices);

3 (3) orthotics (leg, arm, back and neck braces)
4 and prosthetics (artificial legs, arms and eyes);

5 (4)(A) accessories and supplies which are used
6 directly with equipment or devices described in para-
7 graphs (1) through (3) to achieve the therapeutic
8 benefits of such equipment or devices or to assure
9 the proper functioning of such equipment or device;

10 (B) replacement of such equipment or devices
11 when required in cases of loss irreparable damage,
12 wear, or because of a change in the patient's condi-
13 tion; and

14 (C) repair and maintenance of such equipment
15 and devices; and

16 (5) fitting (including adjustments) and training
17 for use of the items described in paragraphs (1)
18 through (4).

19 (b) LIMITATION.—An item or service described in
20 this section is covered only if it improves functional ability
21 or prevents or minimizes deterioration in function.

22 (c) DURABLE MEDICAL EQUIPMENT.—For purposes
23 of this subtitle, the term “durable medical equipment” has
24 the meaning given such term in section 1861(n) of the
25 Social Security Act.

1 **SEC. 1116. VISION CARE.**

2 (a) COVERAGE.—The vision care described in this
3 section is routine eye examinations, diagnosis, and treat-
4 ment for defects in vision.

5 (b) LIMITATION.—Eyeglasses and contact lenses are
6 covered only for individuals less than 18 years of age, ac-
7 cording to a periodicity schedule established by the Board.

8 **SEC. 1117. HEARING AIDS FOR CHILDREN.**

9 The items described in this section are hearing aids
10 for individuals up to age 18 when recommended by a phy-
11 sician or audiologist.

12 **SEC. 1118. DENTAL CARE.**

13 (a) COVERAGE.—The dental care described in this
14 section is the following:

15 (1) Emergency dental treatment, including sim-
16 ple extractions, for acute infections, bleeding, and
17 injuries to natural teeth and oral structures for con-
18 ditions requiring immediate attention to prevent
19 risks to life or significant medical complications, as
20 specified by the National Health Board.

21 (2) Prevention and diagnosis of dental disease,
22 including oral dental examinations, radiographs,
23 dental sealants, fluoride application, and dental pro-
24 phylaxis.

1 (3) Treatment of dental disease, including rou-
2 tine fillings, prosthetics for genetic defects, periodon-
3 tal maintenance, and endodontic services.

4 (4) Space maintenance procedures to prevent
5 orthodontic complications.

6 (5) Interceptive orthodontic treatment to pre-
7 vent severe malocclusion.

8 (b) LIMITATIONS.—Coverage for dental care is sub-
9 ject to the following limitations:

10 (1) Prior to January 1, 2001, the items and
11 services described in paragraphs (2) and (3) of sub-
12 section (a) are covered only for individuals less than
13 18 years of age. On or after such date, such items
14 and services are covered for all eligible individuals
15 enrolled under a health plan, except that dental
16 sealants and endodontic services are not covered for
17 individuals 18 years of age or older.

18 (2) The items and services described in sub-
19 section (a)(4) are covered only for individuals at
20 least 3 years of age but less than 13 years of age
21 when determined to be medically necessary or appro-
22 priate to prevent future need for more costly services
23 otherwise covered under this section.

24 (3) Prior to January 1, 2001, the items and
25 services described in subsection (a)(5) are not cov-

1 ered. On or after such date, such items and services
2 are covered only for individuals at least 6 years of
3 age, but less than 12 years of age.

4 **SEC. 1119. INVESTIGATIONAL TREATMENTS.**

5 (a) **COVERAGE.**—The items and services described in
6 this section are qualifying investigational treatments (as
7 defined in subsection (c)) that are administered for a dis-
8 ease, disorder, or other health conditions. A health plan
9 shall allow individuals, when medically appropriate, to par-
10 ticipate in an investigational therapy, and shall cover the
11 patient care provided pursuant to investigational treat-
12 ments as described in subsection (b).

13 (b) **PATIENT CARE DURING INVESTIGATIONAL**
14 **TREATMENTS.**—The comprehensive benefit package in-
15 cludes an item or service described in any other section
16 of this part, subject to the limitations and cost sharing
17 requirements applicable to the item or service, when the
18 item or service is provided to an individual in the course
19 of an investigational treatment, if—

20 (1) the treatment is a qualifying investigational
21 treatment; and

22 (2) the item or service is required to provide
23 patient care pursuant to the design of the trial, ex-
24 cept those services normally paid for by other fund-
25 ing sources (as defined by the National Health

1 Board) such as the cost of the investigational agent
2 or device itself, and the costs of managing the re-
3 search.

4 Items or services subject to the exception in paragraph
5 (2), may be covered in addition to patient care at the dis-
6 cretion of the health plan so long as the plan makes a
7 determination based on objective protocols applied consist-
8 ently to all enrollees.

9 (c) DEFINITIONS.—For purposes of this subtitle:

10 (1) QUALIFYING INVESTIGATIONAL TREAT-
11 MENT.—The term “qualifying investigational treat-
12 ment” means a treatment—

13 (A) the effectiveness of which has not been
14 determined; and

15 (B) that is under clinical investigation as
16 part of an approved research trial.

17 (2) APPROVED RESEARCH TRIAL.—The term
18 “approved research trial” means—

19 (A) a research trial approved by the Sec-
20 retary of Health and Human Services, the Di-
21 rector of the National Institutes of Health, the
22 Commissioner of the Food and Drug Adminis-
23 tration, the Secretary of Veterans Affairs, the
24 Secretary of Defense, or a qualified nongovern-

1 mental research entity as defined in guidelines
2 of the National Institutes of Health; or

3 (B) a peer-reviewed and approved research
4 program, as defined by the Secretary of Health
5 and Human Services, conducted for the primary
6 purpose of determining whether or not a treat-
7 ment is safe, efficacious, or having any other
8 characteristic of a treatment which must be
9 demonstrated in order for the treatment to be
10 medically necessary or appropriate.

11 Nothing in this section shall be construed as limiting
12 the authority of the Commissioner of Food and
13 Drugs over clinical investigations of products within
14 the Commissioner's jurisdiction.

15 **SEC. 1120. OPTIONAL SERVICES.**

16 (a) HEALTH EDUCATION.—Health education and
17 training programs, including community-based programs,
18 may be provided at the discretion of the health plan to
19 encourage the reduction of behavioral risk factors and to
20 promote health activities. Such education and training
21 programs may include smoking cessation, nutrition coun-
22 seling, stress management, support groups, and physical
23 training classes. This subsection shall not be construed to
24 include or limit education or training that is provided in
25 the course of the delivery of health professional services

1 under section 1102. Health care providers may refer plan
2 members to health education programs that best meet
3 their needs based on an assessment of individual risks and
4 learning styles. Health plans shall inform health providers
5 about the availability of such health education programs
6 annually, either at the time of paying the first claim to
7 that provider, or in the case of a network plan, at the
8 time of contracting with the provider.

9 (b) EXTRA CONTRACTUAL SERVICES.—

10 (1) IN GENERAL.—A health plan may provide
11 coverage to individuals enrolled under the plan for
12 extra contractual items and services determined ap-
13 propriate by the plan and the individual (or in ap-
14 propriate circumstances the parent or legal guardian
15 of the individual).

16 (2) DEFINITION.—As used in this section, the
17 term “extra contractual items and services” means,
18 with respect to a health plan, case management
19 services and those medically appropriate alternatives
20 (either alternative items or services or alternative
21 care settings) to traditional covered items or services
22 that are determined by the health plan to be the
23 most cost effective way to provide appropriate treat-
24 ment to the enrolled individual.

1 (c) DISPUTED CLAIMS.—A decision by a health plan
2 to permit or deny the provision of optional services shall
3 not be subject to a benefit discrimination review or other
4 review unless such review involves a claim of discrimina-
5 tion under this Act.

6 **PART 2—COST SHARING**

7 **SEC. 1131. COST SHARING.**

8 (a) IN GENERAL.—Each health plan shall offer to in-
9 dividuals enrolled under the plan one, but not more than
10 one, of the following cost sharing schedules, which sched-
11 ule shall be offered to all such enrollees:

12 (1) Lower cost sharing (described in section
13 1132).

14 (2) Higher cost sharing (described in section
15 1133).

16 (3) Combination cost sharing (described in sec-
17 tion 1134).

18 (b) COST SHARING FOR LOW-INCOME FAMILIES.—
19 For provisions relating to reducing cost sharing for certain
20 low-income families, see section 1281.

21 (c) DEDUCTIBLES, COST SHARING, AND OUT-OF-
22 POCKET LIMITS ON COST SHARING.—

23 (1) APPLICATION ON AN ANNUAL BASIS.—The
24 deductibles and out-of-pocket limits on cost sharing
25 for a year under the schedules referred to in sub-

1 section (a) shall be applied based upon expenses in-
2 curred for items and services furnished in the year.

3 (2) INDIVIDUAL AND FAMILY GENERAL
4 DEDUCTIBLES.—

5 (A) INDIVIDUAL.—Subject to subpara-
6 graph (B), with respect to an individual en-
7 rolled under a health plan (regardless of the
8 class of enrollment), any individual general de-
9 ductible in the cost sharing schedule offered by
10 the plan represents the amount of countable ex-
11 penses (as defined in subparagraph (C)) that
12 the individual may be required to incur in a
13 year before the plan incurs liability for expenses
14 for such items and services furnished to the in-
15 dividual.

16 (B) FAMILY.—In the case of an individual
17 enrolled under a health plan under a family
18 class of enrollment (as defined in section
19 1011(c)(2)(A)), the individual general deduct-
20 ible under subparagraph (A) shall not apply to
21 countable expenses incurred by any member of
22 the individual's family in a year at such time as
23 the family has incurred, in the aggregate,
24 countable expenses in the amount of the family
25 general deductible for the year.

1 (C) COUNTABLE EXPENSE.—In this para-
2 graph, the term “countable expense” means,
3 with respect to an individual for a year, an ex-
4 pense for an item or service covered by the
5 comprehensive benefit package that is subject
6 to the general deductible and for which, but for
7 such deductible and any other cost sharing
8 under this subtitle, a health plan is liable for
9 payment. The amount of countable expenses for
10 an individual for a year under this paragraph
11 shall not exceed the individual general deduct-
12 ible for the year.

13 (3) COINSURANCE AND COPAYMENTS.—After a
14 general or separate deductible that applies to an
15 item or service covered by the comprehensive benefit
16 package has been satisfied for a year, subject to
17 paragraph (4), coinsurance and copayments are
18 amounts (expressed as a percentage of an amount
19 otherwise payable or as a dollar amount, respec-
20 tively) that an individual may be required to pay
21 with respect to the item or service.

22 (4) INDIVIDUAL AND FAMILY LIMITS ON COST
23 SHARING.—

24 (A) INDIVIDUAL.—Subject to subpara-
25 graph (B), with respect to an individual en-

1 rolled under a health plan (regardless of the
2 class of enrollment), the individual out-of-
3 pocket limit on cost sharing in the cost sharing
4 schedule offered by the plan represents the
5 amount of expenses that the individual may be
6 required to incur under the plan in a year be-
7 cause of a general deductible, separate
8 deductibles, copayments, and coinsurance before
9 the plan may no longer impose any cost sharing
10 with respect to items or services covered by the
11 comprehensive benefit package that are pro-
12 vided to the individual.

13 (B) FAMILY.—In the case of an individual
14 enrolled under a health plan under a family
15 class of enrollment (as defined in section
16 1011(c)(2)(A)), the family out-of-pocket limit
17 on cost sharing in the cost sharing schedule of-
18 fered by the plan represents the amount of ex-
19 penses that members of the individual’s family,
20 in the aggregate, may be required to incur
21 under the plan in a year because of a general
22 deductible, separate deductibles, copayments,
23 and coinsurance before the plan may no longer
24 impose any cost sharing with respect to items
25 or services covered by the comprehensive benefit

1 package that are provided to any member of the
2 individual's family.

3 (C) AMOUNT OF OUT OF POCKET LIM-
4 ITS.—The amount of the out of pocket limit de-
5 scribed—

6 (i) in subparagraph (A) is \$2,500,

7 and

8 (ii) in subparagraph (B), is \$3,000.

9 **SEC. 1132. LOWER COST SHARING.**

10 (a) IN GENERAL.—The lower cost sharing schedule
11 referred to in section 1131 that is offered by a health
12 plan—

13 (1) shall have a deductible of \$250 per inpa-
14 tient hospital admission, and shall not have any
15 other required deductibles;

16 (2) except as provided in paragraph (4)—

17 (A) shall prohibit payment of any coinsur-
18 ance; and

19 (B) subject to section 1152, shall require
20 payment of the copayment for items or services
21 as follows—

22 (i) for items and services described in
23 sections 1102(a)(1), 1104, 1105,
24 1106(g)(1)(H), 1107, 1108, 1109, 1110,
25 1111, 1112, 1115, 1117, and for clinician

1 visits and associated services related to
2 prenatal care and one postpartum visit, no
3 copayment is permitted;

4 (ii) for items and services described in
5 sections 1102(a)(2), 1103, 1106 (subject
6 to clause (i)), 1113, 1114, 1115, and
7 1116, the copayment is \$10 per visit (or
8 per prescription in the case of items de-
9 scribed in section 1113);

10 (iii) for services described in section
11 1118(a)(4) and 1118(a)(5), the copayment
12 is \$20 per visit;

13 (iv) for items and services described in
14 section 1102(a)(3) and 1104, the
15 copayment is \$25 per visit unless the pa-
16 tient has an emergency medical condition
17 as defined in section 1867(e)(1) of the So-
18 cial Security Act; and

19 (v) for items and services described in
20 sections 1119, all cost sharing rules shall
21 be determined by the health plans; and

22 (3) shall require payment of coinsurance for an
23 out-of-network item or service (as defined in section
24 1502(f)) in an amount that is a percentage (deter-
25 mined under subsection (b)) of the applicable pay-

1 ment rate for the item or service established under
2 section 1211(b), but only if the item or service is
3 subject to coinsurance under the higher cost sharing
4 schedule described in section 1133 or is a clinical
5 preventive service as defined in section 1104.

6 (b) OUT-OF-NETWORK COINSURANCE PERCENT-
7 AGE.—

8 (1) IN GENERAL.—The National Health Board
9 shall determine a percentage referred to in sub-
10 section (a)(3). The percentage—

11 (A) may not be less than 20 percent; and

12 (B) shall be the same with respect to all
13 out-of-network items and services that are sub-
14 ject to coinsurance, except as provided in para-
15 graph (2).

16 (2) EXCEPTION.—The National Health Board
17 may provide for a percentage that is greater than a
18 percentage determined under paragraph (1) in the
19 case of an out-of-network item or service for which,
20 under the higher cost sharing schedule described in
21 section 1133, the coinsurance is greater than 20 per-
22 cent of the applicable payment rate.

23 **SEC. 1133. HIGHER COST SHARING.**

24 The higher cost sharing schedule referred to in sec-
25 tion 1131 that is offered by a health plan—

1 (1) shall have an annual individual general de-
2 ductible of \$200 and an annual family general de-
3 ductible of \$400 that apply with respect to expenses
4 incurred for all items and services in the comprehen-
5 sive benefit package except—

6 (A) an item or service with respect to
7 which a separate individual deductible applies
8 under paragraph (2); or

9 (B) an item or service described in para-
10 graph (3), (4), or (5) with respect to which a
11 deductible does not apply;

12 (2) shall require an individual to incur expenses
13 in a year for outpatient prescription drugs and
14 biologicals (described in section 1113) equal to \$250
15 before the plan provides benefits for such items to
16 the individual;

17 (3) shall require an individual to incur expenses
18 in a year for dental care described in section 1118,
19 except the items and services for prevention and di-
20 agnosis of dental disease described in section
21 1118(a)(2), equal to \$50 before the plan provides
22 benefits for such care to the individual;

23 (4) may not require any deductible for clinical
24 preventive services (described in section 1105);

1 (5) may not require any deductible for family
2 planning services as defined in section 1107(1), cli-
3 nician visits and associated services related to pre-
4 natal care or 1 post-partum visit under section
5 1107;

6 (6) may not require any deductible for the
7 items and services for prevention and diagnosis of
8 dental disease described in section 1126(a)(2);

9 (7) shall prohibit payment of any copayment;
10 and

11 (8) subject to section 1152, shall require pay-
12 ment of coinsurance for an item or service as fol-
13 lows—

14 (A) for items and services described in sec-
15 tion 1105, family planning services and clinical
16 visits and associated services related to prenatal
17 care and one post partum visit, and case man-
18 agement services under section 1106, no coin-
19 surance is permitted;

20 (B) for items and services described in sec-
21 tion 1118(a)(4) and 1118(a)(5), the coinsur-
22 ance is 40 percent of the applicable payment
23 rate;

24 (C) for outpatient services under section
25 1106(g)(1)(G)—

1 (i) the coinsurance with respect to the
2 first five outpatient psychotherapy visits is
3 20 percent of the applicable payment rate;

4 (ii) the coinsurance with respect to
5 any subsequent outpatient psychotherapy
6 visits is 50 percent of the applicable pay-
7 ment rate; and

8 (iii) the coinsurance with respect to
9 children for outpatient psychotherapy visits
10 is 20 percent of the applicable payment
11 rate; and

12 (D) for all other items and services, the co-
13 insurance is 20 percent of the applicable pay-
14 ment rate.

15 For purposes of this section, the term “applicable payment
16 rate”, when used with respect to an item or service, means
17 the applicable payment rate for the item or service estab-
18 lished under section 1523(e).

19 **SEC. 1134. COMBINATION COST SHARING.**

20 (a) IN GENERAL.—The combination cost sharing
21 schedule referred to in section 1131 that is offered by a
22 health plan shall require different cost sharing for in-net-
23 work items and services than for out-of-network items and
24 services.

1 (b) IN-NETWORK ITEMS AND SERVICES.—With re-
2 spect to an in-network item or service (as defined in sec-
3 tion 1514(c)(1)), the combination cost sharing schedule
4 that is offered by a health plan—

5 (1) shall have a deductible of \$250 per inpa-
6 tient hospital admission, and shall not have any
7 other required deductibles;

8 (2) shall prohibit payment of any coinsurance;
9 and

10 (3) shall require payment of a copayment in ac-
11 cordance with the lower cost sharing schedule de-
12 scribed in section 1132.

13 (c) OUT-OF-NETWORK ITEMS AND SERVICES.—With
14 respect to an out-of-network item or service (as defined
15 in section 1514(c)(2)), the combination cost sharing
16 schedule that is offered by a health plan—

17 (1) shall require an individual and a family to
18 incur expenses before the plan provides benefits for
19 the item or service in accordance with the
20 deductibles under the higher cost sharing schedule
21 described in section 1133;

22 (2) shall prohibit payment of any copayment;
23 and

24 (3) shall require payment of coinsurance in ac-
25 cordance with such schedule, except with respect to

1 clinical preventive services obtained out-of-network
2 that shall be subject to a coinsurance percentage as
3 determined by the National Health Board under sec-
4 tion 1132.

5 **SEC. 1135. INDEXING DOLLAR AMOUNTS RELATING TO**
6 **COST SHARING.**

7 (a) IN GENERAL.—Any deductible, copayment, out-
8 of-pocket limit on cost sharing, or other amount expressed
9 in dollars in this subtitle for items or services provided
10 in a year after 1994 shall be such amount increased by
11 the product of the factors described in subsection (b) for
12 the year and for each previous year after 1994, minus 1.
13 Any increase (or decrease) under this subsection shall be
14 rounded.

15 (b) FACTOR.—

16 (1) IN GENERAL.—The factor described in this
17 subsection for a year is 1 plus the general health
18 care inflation factor (as specified in section
19 6001(a)(3) and determined under paragraph (2)) for
20 the year.

21 (2) DETERMINATION.—In computing such fac-
22 tor for a year, the percentage increase in the CPI
23 for a year (referred to in section 6001(b)) shall be
24 determined based upon the percentage increase in
25 the average of the CPI for the 12-month period end-

1 ing with August 31 of the previous year over such
2 average for the preceding 12-month period.

3 **PART 3—EXCLUSIONS**

4 **SEC. 1141. EXCLUSIONS.**

5 (a) **MEDICAL NECESSITY.**—The comprehensive bene-
6 fit package does not include—

7 (1) an item or service that is not medically nec-
8 essary or appropriate; or

9 (2) an item or service that the National Health
10 Board may determine is not medically necessary or
11 appropriate in a regulation promulgated under sec-
12 tion 1154.

13 (b) **ADDITIONAL EXCLUSIONS.**—The comprehensive
14 benefit package does not include the following items and
15 services:

16 (1) Custodial care, except in the case of hospice
17 care under section 1107.

18 (2) Surgery and other procedures performed
19 solely for cosmetic purposes and hospital or other
20 services incident thereto, unless—

21 (A) required to correct a congenital anom-
22 aly; or

23 (B) required to restore or correct a part of
24 the body that has been altered as a result of—

25 (i) accidental injury;

1 (ii) disease; or
2 (iii) surgery that is otherwise covered
3 under this subtitle.

4 (3) Hearing aids, except as provided in section
5 1117.

6 (4) Eyeglasses and contact lenses for individ-
7 uals at least 18 years of age.

8 (5) In vitro fertilization services.

9 (6) Sex change surgery and related services.

10 (7) Private duty nursing.

11 (8) Personal comfort items, except in the case
12 of hospice care under section 1107.

13 (9) Any dental procedures involving orthodontic
14 care, inlays, gold or platinum fillings, bridges,
15 crowns, pin/post retention, dental implants, surgical
16 periodontal procedures, or the preparation of the
17 mouth for the fitting or continued use of dentures,
18 except as specifically described in section 1118.

19 **PART 4—ROLE OF THE NATIONAL HEALTH**
20 **BOARD**

21 **SEC. 1151. DEFINITION OF BENEFITS.**

22 (a) IN GENERAL.—The National Health Board may
23 promulgate such regulations or establish such guidelines
24 as may be necessary to assure uniformity in the applica-
25 tion of the comprehensive benefit package across all health

1 plans. All plans shall comply with any regulation or guide-
2 lines established by the Board under this section.

3 (b) FLEXIBILITY IN DELIVERY.—The regulations or
4 guidelines under subsection (a) shall permit a health plan
5 to deliver covered items and services to individuals enrolled
6 under the plan using the providers and methods that the
7 plan determines to be appropriate and consistent with
8 standards of quality care and so long as the plan complies
9 with the provisions of this Act.

10 **SEC. 1152. ACCELERATION OF EXPANDED BENEFITS.**

11 (a) IN GENERAL.—Subject to subsection (b), at any
12 time prior to January 1, 2001, the National Health
13 Board, in its discretion, may by regulation expand the
14 comprehensive benefit package by—

15 (1) adding any item or service that is added to
16 the package as of January 1, 2001; and

17 (2) requiring that a cost sharing schedule de-
18 scribed in part 2 of this subtitle reflect (wholly or
19 in part) any of the cost sharing requirements that
20 apply to the schedule as of January 1, 2001.

21 No such expansion shall be effective except as of January
22 1 of a year.

23 (b) CONDITION.—The Board may not expand the
24 benefit package under subsection (a) which is to become
25 effective with respect to a year, by adding any item or

1 service or altering any cost sharing schedule, unless the
2 Board estimates that the additional increase in per capita
3 health care expenditures resulting from the addition or al-
4 teration, for each health care coverage area for the year,
5 will not cause any health care coverage area to exceed its
6 per capita target (as determined under section 6003).

7 **SEC. 1153. AUTHORITY WITH RESPECT TO CLINICAL PRE-**
8 **VENTIVE SERVICES.**

9 (a) IN GENERAL.—With respect to clinical preventive
10 services described in section 1104, the National Health
11 Board—

12 (1) shall specify and define specific items and
13 services as clinical preventive services for high risk
14 populations within 1 year of the date of enactment
15 of this Act and shall establish and update a periodic-
16 ity schedule for such items and services;

17 (2) shall establish and update periodicity sched-
18 ules for the age-appropriate immunizations;

19 (3) shall establish a periodicity schedule for age
20 appropriate tests and clinician visits for individuals
21 under the age of 20;

22 (4) shall establish rules with respect to coverage
23 for an immunization, test, or clinician visit that is
24 not provided to an individual during the age range

1 for such immunization, test, or clinician visit that is
2 specified in such section; and

3 (5) may otherwise modify the items and services
4 described in such section, taking into account age
5 and other risk factors, but may not modify the cost
6 sharing for any such item or service.

7 (b) CONSULTATION.—In performing the functions de-
8 scribed in subsection (a), the National Health Board shall
9 consult with experts in clinical preventive services, includ-
10 ing those specified in section 1105.

11 **SEC. 1154. ESTABLISHMENT OF STANDARDS REGARDING**
12 **MEDICAL NECESSITY.**

13 The National Health Board may promulgate such
14 regulations as may be necessary to carry out section
15 1141(a)(2) (relating to the exclusion of certain services
16 that are not medically necessary or appropriate).

17 **SEC. 1155. BALANCE BILLING.**

18 The Board shall provide for methods to ensure the
19 prohibition of balance billing.

20 **PART 5—ADDITIONAL PROVISIONS RELATING TO**
21 **HEALTH CARE PROVIDERS**

22 **SEC. 1161. OVERRIDE OF RESTRICTIVE STATE PRACTICE**
23 **LAWS.**

24 No State may, through licensure or otherwise, re-
25 strict the practice of any class of health professionals be-

1 yond what is justified by the skills and training of such
2 professionals.

3 **SEC. 1162. PROVISION OF ITEMS OR SERVICES CONTRARY**
4 **TO RELIGIOUS BELIEF OR MORAL CONVIC-**
5 **TION.**

6 A health professional or a health facility may not be
7 required to provide an item or service in the comprehen-
8 sive benefit package if the professional or facility objects
9 to doing so on the basis of a religious belief or moral con-
10 viction.

11 **SEC. 1163. DUTY TO DISCLOSE INCORRECT TEST RESULTS.**

12 (a) IN GENERAL.—Any facility, including hospitals,
13 clinics, and clinical laboratories, which provides diagnostic
14 testing or other health care items or services covered
15 under this Act shall promptly notify the individual pro-
16 vider who ordered the test of any errors in the test results.
17 The individual provider who ordered the test must prompt-
18 ly notify the patient of the error if the new results affect
19 the patient's diagnosis or treatment.

20 (b) REGULATIONS.—To carry out subsection (a), the
21 Secretary shall promptly issue proposed regulations, and
22 within 9 months of the date of enactment of this Act shall
23 issue final regulations.

1 **Subtitle C—State Responsibilities**

2 **SEC. 1200. PARTICIPATING STATE.**

3 (a) IN GENERAL.—For purposes of the approval of
4 a State health care system by the Board under section
5 1611, a State is a “participating State” if the State meets
6 the applicable requirements of this subtitle.

7 (b) SUBMISSION OF SYSTEM DOCUMENT.—

8 (1) IN GENERAL.—In order to be approved as
9 a participating State under section 1611, a State
10 shall submit to the National Health Board a docu-
11 ment (in a form and manner specified by the Board)
12 that describes the State health care system that the
13 State is establishing (or has established).

14 (2) DEADLINE.—If a State is not a participat-
15 ing State with a State health care system in oper-
16 ation by January 1, 1998, the provisions of subpart
17 C of part 1 of subtitle F (relating to responsibilities
18 in absence of State systems) shall take effect.

19 (3) SUBMISSION OF INFORMATION SUBSEQUENT
20 TO APPROVAL.—A State approved as a participating
21 State under section 1611 shall submit to the Board
22 an annual update to the State health care system
23 not later than February 15 of each year following
24 the first year for which the State is a participating
25 State. The update shall contain—

1 (A) such information as the Board may re-
 2 quire to determine that the system shall meet
 3 the applicable requirements of this Act for the
 4 succeeding year; and

5 (B) such information as the Board may re-
 6 quire to determine that the State operated the
 7 system during the previous year in accordance
 8 with the Board's approval of the system for
 9 such previous year.

10 **PART 1—GENERAL STATE RESPONSIBILITIES**

11 **SEC. 1201. GENERAL STATE RESPONSIBILITIES.**

12 A participating State is responsible for:

13 (1) HEALTH CARE COVERAGE AREA.—Estab-
 14 lishing one or more health care coverage areas (in
 15 accordance with section 1202).

16 (2) HEALTH PLANS.—Certifying and overseeing
 17 health plans in accordance with subtitle F.

18 (3) PROVIDERS.—Assessing such licensing fees
 19 as may be necessary to adequately fund State health
 20 profession boards. (Nothing in this paragraph shall
 21 preempt State authority to license or register health
 22 care providers.) State health professional boards
 23 shall—

1 (A) investigate complaints with a reason-
2 able probability of validity, and issue appro-
3 priate sanctions;

4 (B) have adequate public, consumer, and
5 non-physician representatives; and

6 (C) report all final disciplinary actions to
7 the National Practitioner Data Bank.

8 (4) PREMIUM ADJUSTMENT.—Administering
9 risk adjustment, reinsurance and other premium ad-
10 justment programs consistent with this Act.

11 (5) REDUCTIONS IN COST SHARING.—Admin-
12 istering reductions in cost sharing in accordance
13 with section 1281 and 1282 and a premium dis-
14 count program in accordance with subtitle B of title
15 VI.

16 (6) COOPERATIVES.—Certification of at least
17 one consumer purchasing cooperative in each area,
18 consistent with the provisions of subtitle D.

19 (7) OTHER RESPONSIBILITIES.—Carrying out
20 all other responsibilities of participating States spec-
21 ified under this Act.

1 **SEC. 1202. ASSURING COMMUNITY-RATED PREMIUMS**
2 **THROUGH ESTABLISHMENT OF HEALTH**
3 **CARE COVERAGE AREAS.**

4 (a) IN GENERAL.—In accordance with this section,
5 a participating State shall provide for the division of the
6 State into 1 or more health care coverage areas.

7 (b) MULTIPLE AREAS.—With respect to a health care
8 coverage area—

9 (1) no metropolitan statistical area in a State
10 may be incorporated into more than 1 such area in
11 the State;

12 (2) the number of individuals residing within
13 such an area may not be less than 150,000; and

14 (3) no area incorporated in a health care cov-
15 erage area may be incorporated into another such
16 area.

17 (c) BOUNDARIES.—

18 (1) IN GENERAL.—In establishing boundaries
19 for health care coverage areas, a State shall comply
20 with the antidiscrimination requirements of section
21 1914.

22 (2) COORDINATING MULTIPLE HEALTH CARE
23 COVERAGE AREAS.—Nothing in this section shall be
24 construed as preventing a State from coordinating
25 the activities of one or more health care coverage
26 areas in the State.

1 (3) INTERSTATE HEALTH CARE COVERAGE
2 AREAS.—Health care coverage areas with respect to
3 interstate areas shall be established in accordance
4 with rules established by the Board.

5 (4) COORDINATION IN MULTI-STATE AREAS.—
6 One or more States may coordinate their operations
7 in contiguous health care coverage areas. Such co-
8 ordination may include, the following activities,
9 adoption of joint operating rules, contracting with
10 health plans, enforcement activities, and establish-
11 ment of fee schedules for health providers.

12 **SEC. 1203. USE OF INCENTIVES.**

13 (a) USE OF INCENTIVES TO ENROLL AND SERVE
14 DISADVANTAGED GROUPS.—A State may provide—

15 (1) for an additional adjustment to the risk-ad-
16 justment methodology under section 1641(b), or in
17 accordance with the standards under section 1642,
18 and other financial incentives to community-rated
19 health plans to ensure that such plans enroll individ-
20 uals who are members of disadvantaged groups or
21 populations vulnerable to discrimination due to their
22 health status, and

23 (2) for appropriate extra services, such as out-
24 reach to encourage enrollment and transportation
25 and interpreting services to ensure access to care,

1 for certain population groups that face barriers to
2 access because of geographic location, income levels,
3 disability or racial or cultural differences.

4 (b) USE OF INCENTIVES TO ADDRESS NEEDS IN
5 AREAS WITH INADEQUATE HEALTH SERVICES.—

6 (1) PAYMENT ADJUSTMENT.—To ensure that
7 plans are available to all eligible individuals residing
8 in all portions of a health care coverage area, a
9 State may adjust payments to plans or use other fi-
10 nancial incentives to encourage health plans to ex-
11 pand into areas that have inadequate health services.

12 (2) ENCOURAGING NEW PLANS.—Subject to
13 section 1202(c), to encourage the establishment of a
14 new health plan in an area that has inadequate
15 health services, a State may—

16 (A) organize health providers to create
17 such a plan in such an area that is targeted at
18 such area;

19 (B) provide assistance with the establish-
20 ment and administration of such a plan; and

21 (C) arrange favorable financing for such a
22 plan.

1 **SEC. 1204. RESTRICTIONS ON FUNDING OF ADDITIONAL**
2 **BENEFITS.**

3 If a participating State provides benefits (either di-
4 rectly or through community-rated health plans or other-
5 wise) in addition to those covered under the comprehensive
6 benefit package, the State may not provide for payment
7 for such benefits through funds provided under this Act.

8 **SEC. 1205. CONSUMER INFORMATION AND MARKETING.**

9 (a) CONSUMER INFORMATION.—Before each open en-
10 rollment period, each State shall ensure the availability to
11 eligible enrollees of information, in an easily understood
12 and useful form, that allows such enrollees (and other
13 community-rate eligible individuals) to make valid com-
14 parisons among community-rated health plans and veter-
15 ans and Uniformed Services health plans offered in the
16 State, including information about plan price, the charac-
17 teristics and availability of participating health profes-
18 sionals and institutions, any restrictions on access to pro-
19 viders or services and a summary of the annual quality
20 performance report described in section 5005. Such infor-
21 mation shall be made available in a brochure, published
22 not less often than annually, in accordance with section
23 1603(e). In the case of a health care coverage area that
24 includes a significant number or proportion of residents
25 with limited English speaking proficiency, the State shall
26 ensure the availability of all written materials in languages

1 other than English as appropriate to the health care cov-
2 erage area.

3 (b) **MARKETING.**—Each participating State shall en-
4 sure that health plans meet the marketing requirements
5 under section 1515.

6 **SEC. 1206. STATE RESPONSIBILITIES WITH RESPECT TO**
7 **WORKSITE HEALTH PROMOTION DISCOUNTS.**

8 Each State shall provide for the administration of
9 wellness discounts in accordance with rules established by
10 the Secretary in accordance with section 1687. Such du-
11 ties shall include the receipt of employer self-certification
12 forms, enforcement of compliance, dispute resolution and
13 implementation of wellness discounts in a manner consist-
14 ent with section 1687.

15 **SEC. 1207. CONSUMER ADVOCATE.**

16 (a) **IN GENERAL.**—The Secretary shall establish (by
17 grant or contract) and oversee a National Center of
18 Consumer Advocacy to provide technical assistance, ade-
19 quate training and support to States and Offices of
20 Consumer Advocacy in each State (hereafter referred to
21 in this section as the “Office”) to carry out the duties
22 of this section, including providing public education to
23 consumers concerning this Act. The National Center of
24 Consumer Advocacy shall be a national non-profit organi-
25 zation with public education and health policy expertise

1 and shall have sufficient staff to carry out its duties and
2 a demonstrated ability to represent and work with a broad
3 spectrum of consumers, including vulnerable and under
4 served populations. The Office in each State shall perform
5 public outreach and provide education and assistance re-
6 garding consumer rights and responsibilities under this
7 Act, and assist consumers in dealing with problems that
8 arise with consumer purchasing cooperatives, large group
9 purchasers, health plans, and health care providers operat-
10 ing in such State.

11 (b) CONTRACTS.—

12 (1) SOLICITATION.—The Secretary shall solicit
13 contracts from private non-profit organizations to
14 fulfill the duties of the Office in the State. The Sec-
15 retary may develop such regulations and guidelines
16 as necessary to oversee the process of considering
17 and awarding competitive contracts under this sec-
18 tion. In awarding such contracts, the Secretary shall
19 consult with the State and National Center of
20 Consumer Advocacy, and shall, at a minimum, con-
21 sider the demonstrated ability of the organization to
22 represent and work with a broad spectrum of con-
23 sumers, including vulnerable and underserved popu-
24 lations.

1 (2) CONTRACT PERIOD.—The contract period
2 for the State Offices of Consumer Advocacy and the
3 National Center of Consumer Advocacy under this
4 section shall be not less than 4 years and not more
5 than 7 years.

6 (c) FUNCTIONS AND RESPONSIBILITIES.—Each Of-
7 fice shall have sufficient staff, local offices throughout the
8 State, and a State-wide toll-free hotline to carry out the
9 duties of this section. Through direct contact and the hot-
10 line, the Office shall provide the following services in the
11 State, including appropriate assistance to individuals with
12 limited English language ability—

13 (1) outreach and education relating to
14 consumer rights and responsibilities under this Act,
15 including such rights and services available through
16 the Office;

17 (2) assistance with enrollment in health plans,
18 or obtaining services or reimbursement from health
19 plans;

20 (3) assistance with filing an application for pre-
21 mium or cost sharing subsidies;

22 (4) information to enrollees about existing
23 grievance procedures and coordination with other en-
24 tities to assist in identifying, investigating, and re-

1 solving enrollee grievances under this Act (including
2 grievances before State medical boards);

3 (5) regular and timely access in the area to the
4 services provided through the Office and its local of-
5 fices and timely responses from representatives of
6 the Office to complaints;

7 (6) referrals to appropriate local providers of
8 legal assistance and to appropriate State and Fed-
9 eral agencies which may be of assistance to ag-
10 grievied individuals in the area; and

11 (7) conduct public hearings no less frequently
12 than once a year to identify and address community
13 health care needs.

14 (d) ACCESS TO INFORMATION.—The Secretary and
15 the States shall ensure that, for purposes of carrying out
16 the Office’s duties under this section, the Office (and offi-
17 cers and employees of the Office in local offices) have ap-
18 propriate access to relevant information subject to protec-
19 tions for confidentiality of enrollee information.

20 (e) EVALUATION AND REPORT.—The Secretary shall
21 have the right to evaluate the quality and effectiveness of
22 the organization in carrying out the functions specified in
23 the contract. The Office shall report to the Secretary and
24 the State annually on the nature and patterns of consumer
25 complaints received in the Office and its local offices dur-

1 ing each year and any policy, regulatory, and legislative
2 recommendations for needed improvements together with
3 a record of the activities of the Office.

4 (f) FUNDING.—The funding for the establishment of
5 an Office in each State is specified in section 1213, of
6 which \$5,000,000 shall be for the National Center for
7 Consumer Advocacy.

8 (g) CONFLICTS OF INTEREST.—The Secretary shall
9 ensure that no individual involved in the designation of
10 the Office, the Office itself, or of any delegate thereof is
11 subject to a conflict of interest, including affiliation with
12 (through ownership or common control) a health care fa-
13 cility, managed care organization, health insurance com-
14 pany or association of health care facilities or providers.
15 No grantee under this part may have a direct involvement
16 with the licensing, certification, or accreditation of a
17 health care facility, a health care plan, or a provider of
18 health care services.

19 (h) LEGAL COUNSEL.—The Secretary shall ensure
20 that adequate legal counsel is available, and is able, with-
21 out conflict of interest, to assist the Office, and the local
22 offices thereof in the performance of their official duties.

23 (i) COORDINATION.—The Office shall coordinate its
24 activities with all appropriate entities including Quality
25 Improvement Foundations (established under section

1 5008) and the State's long term care ombudsman or other
2 agency esignated to carry out client advocacy activities
3 pursuant to section 2106.

4 (j) CONSTRUCTION.—Nothing in this section shall re-
5 place grievance procedures established or otherwise re-
6 quired under this Act.

7 **SEC. 1208. ELECTION PROCEDURE FOR COMMUNITY-RATED**
8 **EMPLOYERS.**

9 (a) IN GENERAL.—Each participating State shall es-
10 tablish a procedure (consistent with rules established by
11 the Board) through which exempt employers, as defined
12 in section 6117, may make an election to be treated as
13 a community-rated employer. Such procedure shall set
14 forth the form and manner that such election shall be
15 made.

16 (b) NOTIFICATION.—The procedure shall require that
17 employees of a exempt employer are notified of an election
18 or a termination of an election under this section prior
19 to the first annual open enrollment period (as defined in
20 section 1660) following such election or termination.

21 (c) TERMINATION.—The procedures shall permit ex-
22 empt employers to terminate an election made under this
23 section. If an employer terminates an election, the termi-
24 nation shall be effective on the first date of the year fol-
25 lowing such termination.

1 **SEC. 1209. COORDINATED HEALTH CARE SERVICES FOR**
2 **CHILDREN.**

3 (a) DESIGNATION OF STATE AGENCY.—The State
4 shall designate an agency (hereafter referred to in this as
5 the “lead agency”) to coordinate the delivery of medical
6 and social services to children with special health care
7 needs. The lead agency shall:

8 (1) Serve as an information resource for chil-
9 dren with special health care needs and their fami-
10 lies and health providers, providing technical assist-
11 ance regarding available specialty and support serv-
12 ices and referral networks for these children and
13 their families.

14 (2) Coordinate activities with all other State
15 agencies which provide services to children with spe-
16 cial health care needs and their families, and estab-
17 lish mechanisms to identify and maximize resources
18 available for these children and families.

19 (3) Provide assistance to the State in fulfilling
20 functions under section 1201 in certifying and mon-
21 itoring the performance of health plans in delivering
22 appropriate services to children in a timely and effi-
23 cient manner.

24 (4) Make recommendations to States, plans,
25 and providers to identify what services are lacking
26 for children with special health care needs.

1 (b) PROVISION OF ACTIVITIES.—The lead agency
2 shall provide the activities under subsection (a) for all chil-
3 dren with special health care needs or children under fos-
4 ter care who are referred by a qualified health plan, other
5 health or social service provider, or publicly funded pro-
6 grams where children receive services.

7 **SEC. 1210. STATE RESPONSIBILITIES FOR UTILIZATION**
8 **MANAGEMENT.**

9 (a) IN GENERAL.—A State shall certify or recertify
10 a health plan only if the State reviews the utilization man-
11 agement activities of the plan and determines that such
12 activities meet the standards described in subsection (b),
13 or such other standards as the National Health Board or
14 other appropriate Federal agency may determine.

15 (b) STANDARDS DESCRIBED.—The standards de-
16 scribed in this subsection are as follows:

17 (1) A health plan may not employ or contract
18 with a utilization management organization or utili-
19 zation management reviewer whose conditions of em-
20 ployment or contract terms include reducing or lim-
21 iting medically necessary or appropriate services pro-
22 vided to individuals enrolled in a health plan.

23 (2) Each health plan shall disclose to a partici-
24 pating provider or an enrollee, upon request, the uti-
25 lization review protocols for controlling utilization

1 and costs used to review a plan of treatment rec-
2 ommended by the provider, and shall provide a de-
3 scription of plan protocols for controlling utilization
4 and costs upon request to providers, enrollees, and
5 prospective enrollees.

6 (3) Each health plan shall describe to an en-
7 rollee, prospective enrollee, or participating provider,
8 upon request, the type of financial arrangements, if
9 any, used by the plan for controlling utilization and
10 costs.

11 (4) The protocols described in paragraph (2)
12 shall be applied consistently among utilization man-
13 agement reviewers within any and each utilization
14 management organization with which a plan con-
15 tracts.

16 (5) Utilization management reviewers with
17 whom a plan contracts shall be available to consum-
18 ers during normal business hours for
19 preauthorizations and other purposes, and during
20 non-business hours the health plan shall make avail-
21 able a procedure for accessing medical care,
22 preauthorization, or other related services.

1 **SEC. 1211. ASSURING FAMILY CHOICE OF HEALTH PLANS.**

2 (a) IN GENERAL.—A participating State shall ensure
3 that all community-rated individuals have a choice of
4 health plans in which to enroll.

5 (b) GUARANTEE OF A FEE-FOR-SERVICE OPTION.—

6 (1) IN GENERAL.—Each State shall ensure that
7 at least one fee-for-service plan (as defined in para-
8 graph (2)) is offered in each health care coverage
9 area.

10 (2) FEE-FOR-SERVICE PLAN DEFINED.—

11 (A) IN GENERAL.—For purposes of this
12 Act, the term “fee-for-service plan” means a
13 health plan that—

14 (i) provides coverage for all items and
15 services included in the comprehensive ben-
16 efit package that are furnished by any law-
17 ful health care provider of the enrollee’s
18 choice, subject to reasonable restrictions
19 (described in subparagraph (B)), and

20 (ii) makes payment to such a provider
21 without regard to whether or not there is
22 a contractual arrangement between the
23 plan and the provider.

24 (B) REASONABLE RESTRICTIONS DE-
25 SCRIBED.—The reasonable restrictions on cov-
26 erage permitted under a fee-for-service plan (as

1 specified by the National Health Board) are as
2 follows:

3 (i) Utilization review.

4 (ii) Prior approval for specified serv-
5 ices.

6 (iii) Exclusion of providers on the
7 basis of poor quality of care, based on evi-
8 dence obtainable by the plan.

9 Clause (ii) shall not be construed as permitting
10 a plan to require prior approval for health care
11 services through a gatekeeper or other process
12 for services that are not specified for services
13 that are not specified.

14 (3) RULE OF CONSTRUCTION.—Nothing in this
15 Act shall be construed to prevent a health plan from
16 providing for a different basis or level of payment
17 than the fee schedule established under this section
18 as part of a contractual agreement with participat-
19 ing providers under the plan.

20 **SEC. 1212. OVERSIGHT OF HEALTH PLAN ENROLLMENT AC-**
21 **TIVITIES.**

22 (a) IN GENERAL.—Each participating State shall
23 provide for the general oversight of health plan enrollment
24 activities, implement regulations promulgated by the
25 Board under section 1660, and assure that each commu-

1 nity-rated individual who resides in the State is enrolled
2 in a community-rated plan or other applicable health plan
3 of the individual's choosing. In carrying out this sub-
4 section, States shall ensure that individuals are permitted
5 to enroll directly in health plans of their choice.

6 (b) ENROLLMENT THROUGH PROVIDERS.—Each
7 State shall establish a mechanism for enrolling eligible in-
8 dividuals who are not enrolled in a plan when the individ-
9 ual seeks health services in accordance with rules promul-
10 gated by the Board.

11 (c) ENFORCEMENT OF ENROLLMENT REQUIRE-
12 MENT.—In the case of a community-rated individual who
13 resides in a State and fails to enroll in an applicable health
14 plan as required under section 1002(a) such State shall
15 require the payment of an amount equal to twice the fam-
16 ily share of premiums that would have been payable under
17 subtitle B of title VI if the individual had enrolled on a
18 timely basis in the plan, unless the individual establishes
19 to the satisfaction of the State good cause or financial
20 hardship for the failure to enroll on a timely basis. The
21 State shall provide, from the amounts collected under
22 paragraph (2), for payments to plans under subsection
23 (b).

1 **SEC. 1213. ADMINISTRATIVE ALLOWANCE PERCENTAGE.**

2 (a) SPECIFICATION BY STATE.—Before obtaining
3 bids under section 6004 from health plans for a year, each
4 State shall establish the administrative allowance for State
5 administrative functions with respect to the oversight of
6 health plan activities, the determination of enrollment, the
7 determination of subsidy eligibility, and other responsibil-
8 ities under this Act.

9 (b) ADMINISTRATIVE ALLOWANCE PERCENTAGE.—
10 Subject to subsection (c), the State shall compute an ad-
11 ministrative allowance percentage for each year equal to—

12 (1) the administrative allowance determined
13 under subsection (a) for the year, divided by

14 (2) the total of the amounts payable to commu-
15 nity-rated health plans under subpart A (as esti-
16 mated by the State).

17 (c) LIMITATION TO 1.5 PERCENT.—In no case shall
18 an administrative allowance percentage exceed 1.5 per-
19 cent.

20 (d) DISTRIBUTION OF PERCENTAGE.—The adminis-
21 trative allowance percentage shall be divided as follows:

22 (1) 1.48 percent for State administrative func-
23 tions, and

24 (2) .02 percent for the Office of the Consumer
25 Advocate described in section 1207.

1 (e) RECEIPT OF FUNDS.—A State shall perform the
2 duties required of States under this Act as a condition
3 of receiving funds described in subsection (d)(1).

4 **PART 2—REQUIREMENTS FOR STATE SINGLE-**
5 **PAYER SYSTEMS**

6 **SEC. 1221. SINGLE-PAYER SYSTEM DESCRIBED.**

7 The Board shall approve the application of a State
8 to operate a single-payer system if the Board finds that
9 the system—

10 (1) meets the requirements of section 1222;

11 (2)(A) meets the requirements for a Statewide
12 single-payer system under section 1223, in the case
13 of a system offered throughout a State; or

14 (B) meets the requirements for an area specific
15 single-payer system under section 1224, in the case
16 of a system offered in a single health care coverage
17 area of a State.

18 **SEC. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER**
19 **SYSTEMS.**

20 Each single-payer system shall meet the following
21 requirements:

22 (1) ESTABLISHMENT BY STATE.—The system is
23 established under State law, and State law provides
24 for mechanisms to enforce the requirements of the
25 system.

1 (2) OPERATION BY STATE.—The system is op-
2 erated by the State or a designated agency of the
3 State.

4 (3) ENROLLMENT OF ELIGIBLE INDIVIDUALS.—

5 (A) MANDATORY ENROLLMENT OF ALL
6 COMMUNITY-RATED INDIVIDUALS.—The system
7 provides for the enrollment of all eligible indi-
8 viduals residing in the State (or, in the case of
9 an area-specific single-payer system, in the
10 health care coverage area) for whom the appli-
11 cable health plan would otherwise be a health
12 care coverage area health plan.

13 (B) OPTIONAL ENROLLMENT OF MEDI-
14 CARE-ELIGIBLE INDIVIDUALS.—At the option of
15 the State, the system may provide for the en-
16 rollment of Medicare-eligible individuals resid-
17 ing in the State (or, in the case of an area-spe-
18 cific single-payer system, in the health care cov-
19 erage area) if the Secretary of Health and
20 Human Services has approved an application
21 submitted by the State under section 1893 of
22 the Social Security Act (as added by section
23 4001(a)) for the integration of Medicare bene-
24 ficiaries into plans of the State. Nothing in this
25 subparagraph shall be construed as requiring

1 that a State have a single-payer system in order
2 to provide for such integration.

3 (C) OPTIONAL ENROLLMENT OF EXPERI-
4 ENCE-RATED INDIVIDUALS IN STATEWIDE
5 PLANS.—At the option of the State, a Statewide
6 single-payer system may provide for the enroll-
7 ment of individuals residing in the State who
8 are otherwise eligible to enroll in an experience-
9 rated health plan under subtitle E.

10 (D) OPTIONS INCLUDED IN STATE SYSTEM
11 DOCUMENT.—A State may not exercise any of
12 the options described in subparagraphs (A) or
13 (B) for a year unless the State included a de-
14 scription of the option in the submission of its
15 system document to the Board for the year
16 under section 1200(b).

17 (E) EXCLUSION OF CERTAIN INDIVID-
18 UALS.—A single-payer system may not require
19 the enrollment of electing veterans, active duty
20 military personnel, and electing American Indi-
21 ans (as defined in 1012(d)).

22 (4) DIRECT PAYMENT TO PROVIDERS.—

23 (A) IN GENERAL.—With respect to provid-
24 ers who furnish items and services included in
25 the comprehensive benefit package to individ-

1 uals enrolled in the system, the State shall
2 make payments directly to such providers and
3 assume (subject to subparagraph (B)) all finan-
4 cial risk associated with making such payments.

5 (B) CAPITATED PAYMENTS PERMITTED.—
6 Nothing in subparagraph (A) shall be construed
7 to prohibit providers furnishing items and serv-
8 ices under the system from receiving payments
9 on a capitated, at-risk basis based on prospec-
10 tively determined rates.

11 (5) PROVISION OF COMPREHENSIVE BENEFIT
12 PACKAGE.—

13 (A) IN GENERAL.—The system shall pro-
14 vide for coverage of the comprehensive benefit
15 package, including the cost sharing provided
16 under the package (subject to subparagraph
17 (B)), to all individuals enrolled in the system.

18 (B) IMPOSITION OF REDUCED COST SHAR-
19 ING.—The system may decrease the cost shar-
20 ing otherwise provided in the comprehensive
21 benefit package with respect to any individuals
22 enrolled in the system or any class of services
23 included in the package, so long as the system
24 does not increase the cost sharing otherwise im-

1 posed with respect to any other individuals or
2 services.

3 (6) COST CONTAINMENT.—The system shall
4 provide for mechanisms to ensure, in a manner sat-
5 isfactory to the Board, that—

6 (A) the rate of growth in health care
7 spending will not be higher than the target es-
8 tablished under this Act;

9 (B) the expenditures described in subpara-
10 graph (A) are computed and effectively mon-
11 itored;

12 (C) automatic, mandatory, nondiscretion-
13 ary reductions in payments to health care pro-
14 viders will be imposed to the extent required to
15 assure that such per capita expenditures do not
16 exceed the applicable target referred to in sub-
17 paragraph (A); and

18 (D) Federal payments to a single payer
19 State or health care coverage area shall be lim-
20 ited to the payments that would have been
21 made in the absence of the implementation of
22 the single payer system.

23 (7) REQUIREMENTS GENERALLY APPLICABLE
24 TO HEALTH PLANS.—The system shall meet the re-

1 requirements applicable to a health plan under section
2 1502(1), except that—

3 (A) the system does not have the authority
4 provided to health plans under section 1516(d)
5 (relating to permissible limitations on the en-
6 rollment of eligible individuals on the basis of
7 limits on the plan’s capacity);

8 (B) the system is not required to meet the
9 requirements of section 1515 (relating to re-
10 strictions on the marketing of plan materials);
11 and

12 (C) the system is not required to meet the
13 requirements of section 1512(a) (relating to
14 plan solvency).

15 **SEC. 1223. SPECIAL RULES FOR STATES OPERATING STATE-**
16 **WIDE SINGLE-PAYER SYSTEM.**

17 (a) IN GENERAL.—In the case of a State operating
18 a Statewide single-payer system—

19 (1) the State shall operate the system through-
20 out the State;

21 (2) except as provided in subsection (b), the
22 State shall meet the requirements for participating
23 States under part 1; and

24 (3) the State shall assume the functions de-
25 scribed in subsection (c) that are otherwise required

1 to be performed by health care coverage areas in
2 participating States that do not operate a Statewide
3 single-payer system.

4 (b) EXCEPTIONS TO CERTAIN REQUIREMENTS FOR
5 PARTICIPATING STATES.—In the case of a State operating
6 a Statewide single-payer system, the State is not required
7 to meet the following requirements otherwise applicable to
8 participating States under part 1:

9 (1) ESTABLISHMENT OF HEALTH CARE COV-
10 ERAGE AREAS.—The requirements of section 1202
11 (relating to the establishment of health care cov-
12 erage areas).

13 (2) HEALTH PLANS.—The requirements of sub-
14 title F (relating to health plans), other than require-
15 ments relating to coordination of workers' compensa-
16 tion services and automobile liability insurance.

17 (3) FINANCIAL SOLVENCY.—Requirements re-
18 lating to the financial solvency of health plans in the
19 State.

20 (4) OTHER REFERENCES INAPPLICABLE.—All
21 other references in this Act to health plans, or other
22 entities, and the requirements applicable thereto,
23 that would not exist under a State single payer sys-
24 tem, shall not be applicable to a single payer system,
25 except as provided in subsection (c).

1 (c) ASSUMPTION BY STATE OF CERTAIN REQUIRE-
2 MENTS APPLICABLE TO HEALTH CARE COVERAGE
3 AREAS.—A State operating a Statewide single-payer sys-
4 tem shall be subject to the following requirements other-
5 wise applicable to health care coverage areas in other par-
6 ticipating States subject to the requirement that all ref-
7 erences to health care coverage areas shall, with respect
8 to this section, be deemed to refer to the single payer
9 State, and references to health plans shall not apply under
10 this section or shall be considered as references, where ap-
11 propriate, to health caregivers:

12 (1) ENROLLMENT; ISSUANCE OF HEALTH SECU-
13 RITY CARDS.—The requirements of subsection (a) of
14 section 1211 and section 1406 shall apply to the
15 State, eligible individuals residing in the State, and
16 the single-payer system operated by the State in the
17 same manner as such requirements apply to a health
18 care coverage area, health care coverage area eligible
19 individuals, and health care coverage area health
20 plans.

21 (2) REDUCTIONS IN COST SHARING FOR LOW-
22 INCOME INDIVIDUALS.—The requirement of section
23 1281 shall apply to the State in the same manner
24 as such requirement applies to a health care cov-
25 erage area.

1 (3) DATA COLLECTION; QUALITY.—The data
2 collection and quality requirements of this Act shall
3 apply to the State and the single-payer system oper-
4 ated by the State in the same manner as such re-
5 quirement applies to a health care coverage area and
6 health plans offered in a health care coverage area.

7 (4) ANTI-DISCRIMINATION.—In carrying out
8 such activities as it may have in common with enti-
9 ties in other States as required under part 2 of sub-
10 title D, a State may not discriminate against health
11 caregivers on the basis of mix of health profes-
12 sionals, or location of the headquarters of the plan,
13 except as the State may specifically provide other-
14 wise to assure an equitable distribution of services or
15 organizational arrangement.

16 (5) COORDINATION OF ENROLLMENT ACTIVI-
17 TIES.—A State shall coordinate its activities, includ-
18 ing enrollment and disenrollment activities—

19 (A) in a manner specified by the Board;
20 and

21 (B) in a manner that ensures continuous,
22 nonduplicative coverage of eligible individuals
23 and that minimizes administrative procedures
24 and paperwork.

25 (d) FINANCING.—

1 (1) IN GENERAL.—A State operating a State-
 2 wide single-payer system shall provide for the financ-
 3 ing of the system using, at least in part, a payroll-
 4 based financing system that requires employers to
 5 pay at least the amount that the employers would be
 6 required to pay if the employers were subject to the
 7 requirements of subtitle B of title VI defined as the
 8 applicable percentage of the per capita cost of health
 9 care.

10 (2) USE OF FINANCING METHODS.—Such a
 11 State may use, consistent with paragraph (1), any
 12 other method of financing.

13 (e) SINGLE-PAYER STATE DEFINED.—In this Act,
 14 the term “single-payer State” means a State with a State-
 15 wide single-payer system in effect that has been approved
 16 by the Board in accordance with this part.

17 **SEC. 1224. SPECIAL RULES FOR HEALTH CARE COVERAGE**
 18 **AREA-SPECIFIC SINGLE-PAYER SYSTEMS.**

19 (a) IN GENERAL.—In the case of a State operating
 20 a health care coverage area specific single-payer system—

21 (1) the State shall meet the requirements for
 22 participating States under part 1; and

23 (2) the health care coverage area in which the
 24 system is operated shall meet the requirements of
 25 subsection (b).

1 (b) REQUIREMENTS FOR HEALTH CARE COVERAGE
2 AREA IN WHICH SYSTEM OPERATES.—A health care cov-
3 erage area in which an area-specific single payer system
4 is operated shall meet the requirements applicable to
5 health care coverage areas under subtitle C, except that
6 the health care coverage area is not required to meet the
7 following requirements of such subtitle:

8 (1) CONTRACTS WITH HEALTH PLANS.—The re-
9 quirements of section 1302 (relating to contracts
10 with health plans).

11 (2) CHOICE OF HEALTH PLANS OFFERED.—The
12 requirements of section 1211 (relating to offering a
13 choice of health plans to eligible enrollees).

14 (3) ADDRESSING NEEDS OF AREAS WITH INAD-
15 EQUATE HEALTH SERVICES.—The health care cov-
16 erage area does not have any of the authorities de-
17 scribed in section 1203 (relating to adjusting pay-
18 ments to plans and encouraging the establishment of
19 new plans).

20 **PART 3—REDUCTIONS IN COST SHARING AND**
21 **PREMIUMS**

22 **SEC. 1281. REDUCTION IN COST SHARING FOR LOW-INCOME**
23 **FAMILIES.**

24 (a) REDUCTION.—

1 (1) IN GENERAL.—Subject to subsection (b), in
2 the case of a family that is enrolled in a community-
3 rated health plan and that is either (A) an AFDC
4 or SSI family or (B) is determined under this sub-
5 part to have family adjusted income below 200 per-
6 cent of the applicable poverty level, the family is en-
7 titled to a reduction in cost sharing in accordance
8 with this section.

9 (2) TIMING OF REDUCTION.—The reduction in
10 cost sharing shall only apply to items and services
11 furnished after the date the application for such re-
12 duction is approved under section 1282(c) and be-
13 fore the date of termination of the reduction under
14 this subpart, or, in the case of an AFDC or SSI
15 family, during the period in which the family is such
16 a family.

17 (3) INFORMATION TO PROVIDERS AND
18 PLANS.—Each State shall provide, through elec-
19 tronic means and otherwise, health care providers
20 and community-rated health plans with access to
21 such information as may be necessary in order to
22 provide for the cost sharing reductions under this
23 section.

24 (b) LIMITATION.—No reduction in cost sharing under
25 subsection (c)(1) shall be available for—

1 (1) families residing in a health care coverage
2 area if the cooperative for the area determines that
3 there are sufficient low-cost plans (as defined in sec-
4 tion 6104(b)(3)) that are lower or combination cost
5 sharing plans available in the area to enroll AFDC
6 and SSI families and families with family adjusted
7 income below 150 percent of the applicable poverty
8 level; or

9 (2) for families with family adjusted income be-
10 tween 150 and 200 percent of the applicable poverty
11 level.

12 (c) AMOUNT OF COST SHARING REDUCTION.—

13 (1) IN GENERAL.—Subject to paragraph (2),
14 the reduction in cost sharing under this section shall
15 be such reduction as will reduce cost sharing to the
16 level of a lower or combination cost sharing plan.

17 (2) SPECIAL TREATMENT OF CERTAIN FAMI-
18 LIES.—

19 (A) AFDC, SSI AND FAMILIES BELOW POV-
20 ERTY.—In the case of a family that—

21 (i) is enrolled in a community-rated
22 health plan;

23 (ii) is an AFDC, SSI family or a fam-
24 ily that is determined under this subpart
25 to have a family adjusted income below

1 100 percent of the applicable poverty level;
2 and

3 (iii) is enrolled in a lower or combina-
4 tion cost sharing plan or receiving a reduc-
5 tion in cost sharing under paragraph (1);
6 the amount of cost sharing applied with respect
7 to an item or service (other than with respect
8 to hospital emergency room services for which
9 there is no emergency medical condition, as de-
10 fined in section 1867(e)(1) of the Social Secu-
11 rity Act) shall be an amount equal to 20 per-
12 cent of the cost sharing amount otherwise ap-
13 plicable under subtitle B, rounded to the near-
14 est dollar.

15 (B) FAMILIES WITH INCOMES BETWEEN
16 100 AND 150 PERCENT OF POVERTY.—In the
17 case of a family that—

18 (i) is enrolled in a community-rated
19 health plan;

20 (ii) is determined under this subpart
21 to have family adjusted income between
22 100 and 150 percent of the applicable pov-
23 erty level;

24 (iii) is not an AFDC or SSI family;
25 and

1 (iv) is enrolled in a lower or combina-
2 tion cost sharing plan or receiving a reduc-
3 tion in cost sharing under paragraph (1);
4 the amount of cost sharing applied with respect
5 to an item or service (other than with respect
6 to hospital emergency room services for which
7 there is no emergency medical condition, as de-
8 fined in section 1867(e)(1) of the Social Secu-
9 rity Act) shall be an amount equal to 40 per-
10 cent of the cost sharing amount otherwise ap-
11 plicable under subtitle B, rounded to the near-
12 est dollar.

13 (C) FAMILIES WITH INCOMES BETWEEN
14 150 AND 200 PERCENT OF POVERTY.—In the
15 case of a family that—

16 (i) is enrolled in a community-rated
17 health plan;

18 (ii) is determined under this subpart
19 to have family adjusted income between
20 150 and 200 percent of the applicable pov-
21 erty level; and

22 (iii) is not an AFDC or SSI family;
23 the amount of cost sharing applied with respect
24 to an item or service (other than with respect
25 to hospital emergency room services for which

1 there is no emergency medical condition, as de-
2 fined in section 1867(e)(1) of the Social Secu-
3 rity Act) shall be an amount equal to 40 per-
4 cent of the cost sharing amount otherwise ap-
5 plicable under subtitle B, rounded to the near-
6 est dollar.

7 (d) ADMINISTRATION.—

8 (1) IN GENERAL.—In the case of an approved
9 family (as defined in section 1282(b)(2)) enrolled in
10 a community-rated health plan, the State shall pay
11 the plan for cost sharing reductions (other than cost
12 sharing reductions under subsection (c)(2)(A), (B)
13 and (C)) provided under this section out of Federal
14 subsidy payments provided in section 9100(b)(2)(A).
15 Payments made by health plans to providers shall
16 include appropriate payments for cost sharing reduc-
17 tions.

18 (2) ESTIMATED PAYMENTS, SUBJECT TO REC-
19 ONCILIATION.—Such payment shall be made initially
20 on the basis of reasonable estimates of cost sharing
21 reductions incurred by such a plan with respect to
22 approved families and shall be reconciled not less
23 often than quarterly based on actual claims for
24 items and services provided.

1 (e) NO COST SHARING FOR AMERICAN INDIANS AND
2 CERTAIN VETERANS AND MILITARY PERSONNEL.—The
3 provisions of section 6104(a)(3) shall apply to cost sharing
4 reductions under this section in the same manner as such
5 provisions apply to premium discounts under section 6104.

6 **SEC. 1282. APPLICATION PROCESS FOR COST-SHARING RE-**
7 **DUCTIONS AND PREMIUM DISCOUNTS.**

8 (a) IN GENERAL.—A community-rated family may
9 apply for a determination of the family adjusted income
10 or wage adjusted income of the family, for the purpose
11 of establishing eligibility for cost sharing reductions under
12 section 1281, and for premium discounts and reductions
13 in liability under sections 6104 and 6112.

14 (b) ACTION ON APPLICATION.—

15 (1) IN GENERAL.—States shall act on such ap-
16 plications and ensure due process in a timely man-
17 ner prescribed by the Board.

18 (2) APPROVED FAMILY DEFINED.—As used in
19 this part, the term “approved family” means a fam-
20 ily for which an application under this section has
21 been approved and not yet terminated.

22 (c) HELP IN COMPLETING APPLICATIONS.—Each
23 State shall ensure adequate distribution and assist individ-
24 uals in the filing of applications and income reconciliation
25 statements under this subpart.

1 (d) FAMILY ADJUSTED INCOME.—

2 (1) IN GENERAL.—Except as otherwise pro-
3 vided, in this Act the term “family adjusted income”
4 means, with respect to a family, the sum of the ad-
5 justed incomes (as defined in paragraph (2)) for all
6 members of the family (determined without regard
7 to section 1012).

8 (2) ADJUSTED INCOME.—In paragraph (1), the
9 term “adjusted income” means, with respect to an
10 individual, adjusted gross income (as defined in sec-
11 tion 62(a) of the Internal Revenue Code of 1986)—

12 (A) determined without regard to sections
13 135, 162(l), 911, 931, and 933 of such Code,
14 and

15 (B) increased by the amount of interest re-
16 ceived or accrued by the individual which is ex-
17 empt from tax.

18 (3) PRESENCE OF ADDITIONAL DEPEND-
19 ENTS.—At the option of an individual, a family may
20 include (and not be required to separate out) the in-
21 come of other individuals who are claimed as de-
22 pendents of the family for income tax purposes, but
23 such individuals shall not be counted as part of the
24 family for purposes of determining the size of the
25 family.

1 (e) REQUIREMENT FOR PERIODIC CONFIRMATION
2 AND VERIFICATION AND NOTICES.—

3 (1) CONFIRMATION AND VERIFICATION RE-
4 QUIREMENT.—The continued eligibility of a family
5 for cost sharing reductions, premium discounts and
6 reductions in liability under this section shall be con-
7 ditioned upon the family's eligibility being—

8 (A) confirmed periodically by the State;
9 and

10 (B) verified (through the filing of a new
11 application under this section) by the State at
12 the time income reconciliation statements are
13 required to be filed under section 1283.

14 (2) NOTICES OF CHANGES IN INCOME AND EM-
15 PLOYMENT STATUS.—Each approved family shall
16 promptly notify the State of any material increase
17 (as defined by the Secretary) in the family adjusted
18 income or wage adjusted income of the family.

19 (f) PENALTIES FOR INACCURATE INFORMATION.—

20 (1) INTEREST FOR UNDERSTATEMENTS.—Each
21 individual who knowingly understates income re-
22 ported in an application to a State under this sub-
23 part or otherwise makes a material misrepresenta-
24 tion of information in such an application shall be
25 liable to the State for excess payments made based

1 on such understatement or misrepresentation, and
2 for interest on such excess payments at a rate speci-
3 fied by the Secretary.

4 (2) PENALTIES FOR MISREPRESENTATION.—In
5 addition to the liability established under paragraph
6 (1), each individual who knowingly misrepresents
7 material information in an application under this
8 subpart to a State shall be liable to the State for
9 \$2,000 or, if greater, three times the excess pay-
10 ments made based on such misrepresentation.

11 (g) TERMINATION OF COST SHARING REDUCTION
12 AND PREMIUM DISCOUNTS.—The State shall, after notice
13 to the family, terminate the reduction of cost sharing, pre-
14 mium discounts or reduction in liability for an approved
15 family if the family fails to provide for confirmation or
16 verification on a timely basis or the State otherwise deter-
17 mines that the family is no longer eligible for such reduc-
18 tion.

19 (h) TREATMENT OF AFDC AND SSI RECIPIENTS.—

20 (1) NO APPLICATION REQUIRED.—AFDC and
21 SSI families may not be required to submit an appli-
22 cation under this section.

23 (2) NOTICE REQUIREMENT FOR SSI RECIPI-
24 ENTS.—The Secretary shall notify each State, in a
25 manner specified by the Secretary of the identity

1 (and period of eligibility under the SSI program) of
2 each SSI recipient, unless such a recipient elects (in
3 a manner specified by the Secretary) not to accept
4 the reduction in cost sharing or premium discounts
5 under this part.

6 (i) RULES.—The Secretary shall issue rules related
7 to the application procedure, confirmation and verification
8 of eligibility, ensuring due process in enforcement of pen-
9 alties for inaccurate information, and other issues related
10 to the implementation of cost sharing reductions, premium
11 discounts and reductions in liability under this subpart.

12 **SEC. 1283. END-OF-YEAR RECONCILIATION.**

13 (a) IN GENERAL.—In the case of a family whose ap-
14 plication for a premium discount or reduction of liability
15 for a year has been approved before the end of the year
16 under this subpart, the family shall, subject to subsection
17 (c), file with the State an income reconciliation statement
18 to verify the family's adjusted income or wage-adjusted
19 income, as appropriate, for the previous year. Such a
20 statement shall contain such information as the Secretary
21 shall require. Each State shall coordinate the submission
22 of such statements with the notice and payment of family
23 payments due under section 1237.

24 (b) RECONCILIATION OF PREMIUM DISCOUNT AND
25 LIABILITY ASSISTANCE BASED ON ACTUAL INCOME.—

1 Based on and using the income reported in the reconcili-
2 ation statement filed under subsection (a) with respect to
3 a family, the State shall compute the amount of premium
4 discount or reduction in liability that should have been
5 provided under section 6104 or section 6113 with respect
6 for the family for the year involved. If the amount of such
7 discount or liability reduction computed is—

8 (1) greater than the amount that has been pro-
9 vided, the family is liable to pay (directly or through
10 an increase in future family share of premiums or
11 other payments) a total amount equal to the amount
12 of the excess payment, or

13 (2) less than the amount that has been pro-
14 vided, the State shall pay to the family (directly or
15 through a reduction in future family share of pre-
16 miums or other payments) a total amount equal to
17 the amount of the deficit.

18 (c) NO RECONCILIATION FOR AFDC AND SSI FAMI-
19 LIES; NO RECONCILIATION FOR COST SHARING REDUC-
20 TIONS.—No reconciliation statement is required under
21 this section—

22 (1) with respect to cost sharing reductions pro-
23 vided under section 1281, or

1 (2) for a family that only claims a premium dis-
2 count or liability reduction under this subpart on the
3 basis of being an AFDC or SSI family.

4 (d) DISQUALIFICATION FOR FAILURE TO FILE.—In
5 the case of any family that is required to file a statement
6 under this section in a year and that fails to file such a
7 statement by the deadline specified, members of the family
8 shall not be eligible for premium reductions under section
9 6104 or reductions in liability under section 6113 until
10 such statement is filed. A State, using rules established
11 by the Secretary, shall waive the application of this sub-
12 section if the family establishes, to the satisfaction of the
13 State under such rules, good cause for the failure to file
14 the statement on a timely basis.

15 (e) PENALTIES FOR FALSE INFORMATION.—Any in-
16 dividual that provides false information in a statement
17 under subsection (a) is subject to the same liabilities as
18 are provided under section 1282 for a misrepresentation
19 of material fact described in such section.

20 (f) NOTICE OF REQUIREMENT.—Each State shall
21 provide for written notice, at the end of each year, of the
22 requirement of this section to each family which had re-
23 ceived premium discount or reduction in liability under
24 this subpart in any month during the preceding year and
25 to which such requirement applies.

1 (g) TRANSMITTAL OF INFORMATION; VERIFICA-
2 TION.—

3 (1) IN GENERAL.—Each participating State
4 shall transmit annually to the Secretary such infor-
5 mation relating to the income of families for the pre-
6 vious year as the Secretary may require to verify
7 such income under this subpart.

8 (2) VERIFICATION.—Each participating State
9 may use such information as it has available to it,
10 including information made available to the State
11 under section 6103(l)(7)(D)(x) of the Internal Reve-
12 nue Code of 1986, in verifying income of families
13 with applications filed under this subpart. The Sec-
14 retary of the Treasury may, consistent with section
15 6103 of the Internal Revenue Code of 1986, permit
16 return information to be disclosed and used by a
17 participating State in verifying such income but only
18 in accordance with such section.

19 (h) CONSTRUCTION.—Nothing in this section shall be
20 construed as authorizing reconciliation of any cost sharing
21 reduction provided under this subpart.

22 **SEC. 1284. ELIGIBILITY ERROR RATES.**

23 Each State shall make eligibility determinations for
24 premium discounts, liability reductions, and cost sharing
25 reductions under sections 6104 and 6123, section 6113,

1 and section 1281, respectively, in a manner that maintains
2 the error rates below an applicable maximum permissible
3 error rate specified by the Secretary (or the Secretary of
4 Labor with respect to section 6123). In specifying such
5 a rate, the Secretary shall take into account maximum
6 permissible error rates recognized by the Federal Govern-
7 ment under comparable State-administered programs.

8 **Subtitle D—Consumer Purchasing** 9 **Cooperatives**

10 **PART 1—GENERAL REQUIREMENTS**

11 **SEC. 1301. DESIGNATION AND ORGANIZATION OF CO-** 12 **OPERATIVES.**

13 (a) DESIGNATION OF COOPERATIVES.—A State shall
14 certify consumer purchasing cooperatives (in this Act re-
15 ferred to as “cooperatives”) in accordance with this part.
16 Each cooperative shall be chartered under State law and
17 operated as a not-for-profit corporation.

18 (b) BOARD OF DIRECTORS.—Each cooperative shall
19 be governed by a Board of Directors to be composed in
20 equal numbers of representatives of community-rated em-
21 ployers, eligible employees, and eligible individuals.

22 (c) MEMBERSHIP.—A cooperative shall accept all eli-
23 gible employers and eligible individuals residing within the
24 area served by the cooperative as members if such employ-
25 ers, employees or individuals request such membership.

1 Members of a cooperative shall have voting rights to select
2 Board members consistent with rules established by the
3 State.

4 (d) DUTIES OF COOPERATIVES.—Each cooperative
5 shall—

6 (1) enter into agreements with health plans
7 under section 1302;

8 (2) enter into agreements with community-rated
9 employers;

10 (3) enroll eligible individuals in health plans;

11 (4) make payments to health plans on behalf of
12 community-rated employers and eligible individuals;

13 (5) provide for coordination with other coopera-
14 tives;

15 (6) provide information on health plans, in ac-
16 cordance with section 1205; and

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

19 (e) LIMITATION ON ACTIVITIES.—A cooperative shall
20 not—

21 (1) perform any activity (including review, ap-
22 proval, or enforcement) relating to payment rates for
23 providers;

1 (2) perform any activity (including certification
2 or enforcement) relating to compliance of health
3 plans with the requirements of this Act;

4 (3) assume insurance risk; or

5 (4) perform other activities identified by the
6 State as being inconsistent with the performance of
7 its duties under this Act.

8 (f) RULES OF CONSTRUCTION.—

9 (1) SINGLE ORGANIZATION SERVING MULTIPLE
10 HEALTH CARE COVERAGE AREA.—Nothing in this
11 section shall be construed as preventing a single not-
12 for-profit corporation from being the cooperative for
13 more than one health care coverage area.

14 (2) MULTIPLE COOPERATIVES.—Nothing in this
15 section shall be construed to prevent a State from
16 designating or establishing more than one coopera-
17 tive in a health care coverage area.

18 (3) VOLUNTARY PARTICIPATION.—Nothing in
19 this section shall be construed as requiring any indi-
20 vidual or community-rated employer to purchase a
21 health plan exclusively through a cooperative.

22 **SEC. 1302. AGREEMENTS WITH HEALTH PLANS.**

23 (a) AGREEMENTS.—

24 (1) IN GENERAL.—Except as provided in para-
25 graph (2)(A) of subsection (c)—

1 (A) each cooperative for a health care cov-
2 erage area shall enter into an agreement under
3 this section with each certified community-rated
4 health plan and each health plan of the Depart-
5 ment of Veterans Affairs and Uniformed
6 Health Services Plan that serves residents of
7 the health care coverage area; and

8 (B) a cooperative may not refuse to enter
9 into such an agreement with a health plan
10 which is certified by a State as offering cov-
11 erage in the health care coverage area, nor may
12 a community-rated health plan refuse to enter
13 into an agreement with a cooperative in accord-
14 ance with section 1522.

15 (2) COMMUNITY-RATED PREMIUM.—Except as
16 provided in paragraph (2)(B) of subsection (c), a co-
17 operative shall offer plans at the community-rate (as
18 defined in section 6000(a)(3)) filed by the plan.

19 (3) TERMINATION OF AGREEMENT.—The State
20 shall establish a process for the termination of
21 agreements entered into under this section and a
22 process for appealing such termination under this
23 paragraph. In accordance with rules established by
24 the State—

1 (A) a cooperative may terminate an agree-
2 ment with a health plan if the health plan's cer-
3 tification for the health care coverage area in-
4 volved is terminated or if the health plan fails
5 to fulfill the requirements of the agreement;
6 and

7 (B) a health plan may appeal the termi-
8 nation of an agreement with a cooperative
9 under this paragraph to the State in accordance
10 with rules and procedures established by the
11 State.

12 (b) RECEIPT OF GROSS PREMIUMS.—

13 (1) IN GENERAL.—Under an agreement be-
14 tween a cooperative and a health plan, payment of
15 premiums shall be made directly to the cooperative
16 in accordance with rules promulgated by the Board.

17 (2) FORWARDING OF PREMIUMS.—Under an
18 agreement between a health plan and a cooperative,
19 the cooperative shall forward to each health plan in
20 which an eligible individual has been enrolled the
21 amounts collected on the behalf of enrollees in such
22 plans.

23 (c) NEGOTIATING COOPERATIVES.—

24 (1) IN GENERAL.—A State may designate a co-
25 operative as a “negotiating cooperative” if such co-

1 rated employer and a cooperative shall include provisions
2 consistent with the requirements of this subtitle.

3 (b) ELECTION OF ENROLLMENT.—Qualified employ-
4 ees of a community-rated employer may elect to enroll in
5 a plan offered through the cooperative with which the em-
6 ployer has entered into an agreement, through a coopera-
7 tive sponsored by the FEHBP or directly with a health
8 plan selected by the employer (if such plan is not offered
9 by the cooperative selected by the employer). Qualified em-
10 ployees not residing in the health care coverage area
11 served by the cooperative selected by the employer shall
12 enroll in a health plan consistent with rules promulgated
13 by the Board. The cooperative selected by the employer
14 shall be responsible for forwarding premium payments to
15 the appropriate plan or cooperative for each qualified em-
16 ployee.

17 (c) FORWARDING INFORMATION ON ELIGIBLE EM-
18 PLOYEES.—Under an agreement between an employer and
19 a cooperative, the employer must forward to the appro-
20 priate cooperative such information as may be required by
21 the Secretary or the Board.

22 **SEC. 1304. ENROLLING INDIVIDUALS IN HEALTH PLANS**
23 **THROUGH A COOPERATIVE.**

24 (a) IN GENERAL.—Each cooperative shall offer com-
25 munity-rate eligible individuals the opportunity to enroll

1 in any health plan which has an agreement with the coop-
2 erative for the health care coverage area in which the indi-
3 vidual resides.

4 (b) ENROLLMENT PROCESS.—Each cooperative shall
5 establish an enrollment process in accordance with rules
6 established by the Board, including a process for enrolling
7 those qualified employees of a community-rated employer
8 who elect not to participate in the cooperative with which
9 the employer has entered into an agreement.

10 (c) ENROLLMENT FEES.—The Board shall promul-
11 gate rules regarding payment of cooperative fees by em-
12 ployees exercising an election under section 1303(b).

13 **SEC. 1305. COOPERATIVE FEE.**

14 (a) IN GENERAL.—Each cooperative shall charge
15 members a uniform membership fee to cover the cost of
16 activities undertaken by the cooperative (including all ad-
17 ministrative costs incurred by the cooperative).

18 (b) DISCLOSURE.—Each cooperative shall, prior to
19 the time of enrollment, publish the membership fee of such
20 cooperative. Such fees shall be calculated and identified
21 as a separate charge from the premium charged by the
22 health plans offered by the cooperative. A comparison of
23 fees charged by each cooperative in a health care coverage
24 area shall be incorporated into the plan brochure described
25 in section 1205.

1 (c) MULTIPLE COOPERATIVES.—In health care cov-
2 erage areas in which States have certified multiple co-
3 operatives, such cooperatives may compete for members
4 on the basis of the fees described in this section.

5 **SEC. 1306. COORDINATION AMONG COOPERATIVES.**

6 The State shall establish rules consistent with this
7 section for coordination among cooperatives with respect
8 to enrollment, payment of premiums, and provision of out-
9 of-area benefits and services.

10 **SEC. 1307. THIRD-PARTY CONTRACTING TO PERFORM**
11 **DUTIES.**

12 (a) IN GENERAL.—Each cooperative may contract
13 with qualified, independent third parties for any service
14 necessary to carry out the powers and duties of the cooper-
15 ative pursuant to the requirements established under this
16 section.

17 (b) RESTRICTION ON PERSONS ELIGIBLE FOR
18 THIRD-PARTY CONTRACT.—No person may act, directly
19 or through an affiliated company, both as a health plan
20 serving the cooperative and as an independent third party
21 contractor as described in subsection (a) within a given
22 health care coverage area.

1 **PART 2—ACCESS TO HEALTH PLANS SPONSORED**

2 **BY FEHBP**

3 **SEC. 1321. DESIGNATION OF FEHBP AS A CONSUMER PUR-**

4 **CHASING COOPERATIVE.**

5 (a) IN GENERAL.—The Federal Employees Health
6 Benefits Program (FEHBP) shall serve as a consumer
7 purchasing cooperative in each health care coverage area
8 designated by each State. The responsibilities and authori-
9 ties provided to the FEHBP under this part shall be car-
10 ried out by the Federal Office of Personnel Management.

11 (b) RESPONSIBILITIES AND AUTHORITIES OF
12 FEHBP-SPONSORED COOPERATIVES.—

13 (1) EXEMPTION FROM COOPERATIVE ORGANIZA-
14 TIONAL REQUIREMENTS.—The organizational re-
15 quirements specified in part 1 with respect to State
16 certification (under section 1301(a)), governance
17 (under section 1301(b)), and restrictions on the au-
18 thority of cooperatives to negotiate with health plans
19 (under section 1302(a)), shall not apply to a cooper-
20 ative sponsored by the FEHBP.

21 (2) GENERAL RESPONSIBILITIES AND AUTHORI-
22 TIES.—A cooperative sponsored by the FEHBP
23 shall undertake all the duties and retain all the
24 privileges specified in part 1, including section 1302
25 (regarding requirements of plans to contract with,
26 and not undersell, cooperatives).

1 (c) SATISFACTION OF STATE REQUIREMENT TO
2 CERTIFY A COOPERATIVE.—Compliance with the require-
3 ments of this part with respect to the establishment of
4 a cooperative sponsored by the FEHBP shall satisfy a
5 State’s requirement to certify at least one consumer pur-
6 chasing cooperative under section 1201(6).

7 (d) REQUIREMENT OF OPM.—The Federal Office of
8 Personnel Management is hereby authorized to take such
9 actions as are appropriate to fulfill its responsibilities
10 under this part.

11 **SEC. 1322. SPECIAL RULES FOR FEHBP SUPPLEMENTAL**
12 **PLANS.**

13 (a) FEHBP SUPPLEMENTAL PLANS.—

14 (1) DEVELOPMENT.—The Office of Personnel
15 Management shall develop FEHBP supplemental
16 health benefit policies. The Office of Personnel Man-
17 agement shall meet and confer with representatives
18 of Federal employees regarding the supplemental
19 health benefit policies and the cost sharing policies
20 to be offered (including premium contributions, if
21 any, to be made by the Federal Government with re-
22 spect to such policies for Federal employees and an-
23 nuitants) through a process to be established by the
24 National Partnership Council.

1 (2) OFFERING.—The Federal Government shall
2 offer FEHBP supplemental health benefit policies
3 developed in accordance with paragraph (1) and cost
4 sharing policies as provided in section 1523 to Fed-
5 eral employees, annuitants, and any other commu-
6 nity rate eligible individual (as defined in section
7 1902(9)).

8 (b) DEFINITIONS.—For purposes of this section:

9 (1) ANNUITANT.—The term “annuitant” means
10 an “annuitant” as defined by section 8901 of title
11 5, United States Code.

12 (2) FEHBP.—The term “FEHBP” means the
13 health insurance program under chapter 89 of title
14 5, United States Code.

15 (3) FEDERAL EMPLOYEE.—The term “Federal
16 employee” means an “employee” as defined by sec-
17 tion 8901 of title 5, United States Code.

18 **Subtitle E—Employer Purchasers**

19 **PART 1—DEFINITIONS AND RESPONSIBILITIES** 20 **OF EMPLOYER PURCHASERS**

21 **SEC. 1401. DEFINITIONS.**

22 (a) LARGE GROUP PURCHASER DEFINED.—In this
23 Act, the term “large group purchaser” means—

24 (1) an employer that—

1 (A) is a current large employer (as defined
2 in subsection (e)(2)),

3 (B) is a dual choice employer (as defined
4 in subsection (e)(4)) that has elected to become
5 a large employer, and

6 (C) is not an excluded employer described
7 in subsection (b)(2); or

8 (2) an eligible purchaser (described in sub-
9 section (b) if—

10 (A) the sponsor elects, in a form and man-
11 ner specified by the Secretary of Labor consist-
12 ent with this subpart, to be treated as a large
13 group purchaser under this title and such elec-
14 tion has not been terminated under section
15 1403; and

16 (B) the purchaser has filed with the Sec-
17 retary of Labor a document describing how the
18 sponsor shall carry out activities as such a large
19 group purchaser consistent with part 2.

20 (b) ELIGIBLE LARGE GROUP PURCHASER.—

21 (1) IN GENERAL.—In this subpart, each of the
22 following is an eligible large group purchaser:

23 (A) NEW LARGE EMPLOYER.—An employer
24 that—

1 (i) is a new large employer (as defined
2 in subsection (e)(2)) as of the date of an
3 election under subsection (a)(1), and

4 (ii) is not an excluded employer de-
5 scribed in paragraph (2).

6 (B) PLAN SPONSOR OF A MULTIEMPLOYER
7 PLAN.—A plan sponsor described in section
8 3(16)(B)(iii) of Employee Retirement Income
9 Security Act of 1974, but only with respect to
10 a group health plan that is a multiemployer
11 plan (as defined in subsection (e)(3)) main-
12 tained by the sponsor and only if—

13 (i) such plan offered health benefits
14 as of September 1, 1993, and

15 (ii) as of both September 1, 1993, and
16 January 1, 1996, such plan covers more
17 than 1,000 full-time employees in the Unit-
18 ed States, or the plan is maintained by one
19 or more affiliates of the same labor organi-
20 zation, or one or more affiliates of labor
21 organizations representing employees in
22 the same industry, covering more than
23 1,000 employees.

1 (2) EXCLUDED EMPLOYERS.—For purposes of
2 this section, any of the following are excluded em-
3 ployers described in this paragraph:

4 (A) An employer whose primary business is
5 employee leasing.

6 (B) The Federal government (other than
7 the United States Postal Service).

8 (c) INDIVIDUALS ELIGIBLE TO ENROLL IN EXPERI-
9 ENCE-RATED PLANS.—For purposes of part 1 of subtitle
10 A, subject to subsection (d)—

11 (1) FULL-TIME EMPLOYEES OF LARGE EMPLOY-
12 ERS.—Each eligible individual who is a full-time em-
13 ployee (as defined in section 1901(b)(2)(C)) of—

14 (A) a current large employer, or

15 (B) a new large employer that has an elec-
16 tion in effect as a large group purchaser,
17 is eligible to enroll in an experience-rated plan of-
18 fered by such purchaser.

19 (2) MULTIEMPLOYER PURCHASERS.—

20 (A) PARTICIPANTS.—Each participant and
21 beneficiary (as defined in subparagraph (B))
22 under a multiemployer plan, with respect to
23 which an eligible purchaser of the plan de-
24 scribed in subsection (b)(1)(B) has an election
25 in effect as a large group purchaser, is eligible

1 to enroll in an experience-rated plan offered by
2 such purchaser.

3 (B) PARTICIPANT AND BENEFICIARY DE-
4 FINED.—In subparagraph (A), the terms “par-
5 ticipant” and “beneficiary” have the meaning
6 given such terms in section 3 of the Employee
7 Retirement Income Security Act of 1974.

8 (3) INELIGIBLE TO ENROLL IN COMMUNITY-
9 RATED PLAN.—Except as provided in section 1013,
10 an experience-rated individual is not eligible to enroll
11 under a community-rated plan.

12 (d) EXCLUSION OF CERTAIN INDIVIDUALS.—In ac-
13 cordance with rules of the Board, the following individuals
14 shall not be treated as experience-rated individuals:

15 (1) AFDC recipients.

16 (2) SSI recipients.

17 (3) Individuals who are described in section
18 1004(b) (relating to veterans, military personnel,
19 and Indians) and who elect an applicable health plan
20 described in such section.

21 (4) Employees who are part-time, seasonal or
22 temporary workers (as defined by the Board), other
23 than such workers who are treated as experience-
24 rated individuals pursuant to a collective bargaining
25 agreement (as defined by the Secretary of Labor).

1 (5) Electing migrant and seasonal agricultural
2 workers (described in section 1005(b)(4)).

3 (e) ADDITIONAL DEFINITIONS.—As used in this sub-
4 title:

5 (1) GROUP HEALTH PLAN.—The term “group
6 health plan” means an employee welfare benefit plan
7 (as defined in section 3(1) of the Employee Retirement
8 Income Security Act of 1974) providing medical
9 care (as defined in section 213(d) of the Internal
10 Revenue Code of 1986) to participants or bene-
11 ficiaries (as defined in section 3 of the Employee Re-
12 tirement Income Security Act of 1974) directly or
13 through insurance, reimbursement, or otherwise.

14 (2) LARGE EMPLOYER.—The term “large em-
15 ployer” means an employer with more than 1000
16 full-time employees in the United States. Such term
17 includes the United States Postal Service. A large
18 group purchaser shall offer a choice of health plans
19 to qualified employees in accordance with section
20 1403 and meet the enrollment requirements de-
21 scribed in such section.

22 (3) SMALL EMPLOYER.—The term “small em-
23 ployer” means an employer with 500 or less full-
24 time employees. A small employer shall offer a
25 choice of health plan to qualified employees in ac-

1 cordance with section 1403 and meet the enrollment
2 requirements described in such section. A small em-
3 ployer under this subtitle is a community-rated em-
4 ployer described in title I and title VI of this Act.

5 (4) DUAL CHOICE EMPLOYER.—

6 (A) IN GENERAL.—The term “dual choice
7 employer” means an employer with more than
8 500 but less than 1000 full-time employees.

9 (B) ELECTION.—A dual choice employer
10 may elect to be considered as either a small em-
11 ployer or a large employer for purposes of this
12 Act. The status of the employer as a small em-
13 ployer or a large employer after such an elec-
14 tion shall remain in effect for a period of not
15 less than 3 years. A dual choice employer elect-
16 ing to be a large employer shall not be eligible
17 for discounts under title VI.

18 (5) EMPLOYER SPONSORED HEALTH PLAN.—

19 The term “employer sponsored health plan” means
20 a group health plan with an enrollment of at least
21 500 individuals that is established and maintained
22 by a large employer. The health plan may be oper-
23 ated as a fee-for-service plan (as described in section
24 1211(b)(2)(A)) or as a network plan (as described in
25 section 1514(c)(4)). The employer shall retain the

1 insurance risk and meet requirements specified by
2 the Secretary of Labor for such plans in accordance
3 with section 1406. The Secretary shall ensure that
4 employer sponsored health plans meet the require-
5 ments of this paragraph.

6 (6) **MULTIEMPLOYER PLAN.**—The term “multi-
7 employer plan” has the meaning given such term in
8 section 3(37) of the Employee Retirement Income
9 Security Act of 1974, and includes any plan that is
10 treated as such a plan under title I of such Act.

11 **SEC. 1402. ELECTION OF LARGE GROUP PURCHASERS.**

12 (a) **IN GENERAL.**—Not later than 6 months after the
13 date of enactment of this Act, the Secretary of Labor shall
14 promulgate regulations for the election of new large em-
15 ployers and multiemployer plans as large group pur-
16 chasers and for the termination of such elections of multi-
17 employer plans.

18 (b) **DUAL CHOICE EMPLOYERS.**—If the number of
19 full-time employees of a dual choice employer changes dur-
20 ing the coverage year such that the employer has fewer
21 than 500 or more than 1000 employees, the status of such
22 employer shall be retained only throughout that year. The
23 employer shall notify the Secretary of Labor of change in
24 employer status in such a manner as the Secretary shall
25 prescribe.

1 **SEC. 1403. EMPLOYEE ENROLLMENT REQUIREMENTS.**

2 (a) ESTABLISHMENT OF EMPLOYER ENROLLMENT
3 FUNCTION.—

4 (1) IN GENERAL.—Each employer shall make
5 available enrollment in at least three health plans,
6 one of which shall be a fee-for-service plan, to each
7 eligible employee of such employer.

8 (2) ASSURANCE OF ENROLLMENT.—Each em-
9 ployer shall ensure that each eligible individual is en-
10 rolled in a health plan and receives continuous cov-
11 erage pursuant to regulations promulgated by the
12 Secretary of Labor and consistent with the appro-
13 priate provisions of subtitle F. The methods and
14 procedures prescribed in such regulations shall en-
15 sure the enrollment of such individuals at the time
16 such individuals first become eligible individuals with
17 respect to the employer.

18 (3) INFORMATION.—The Secretary shall pro-
19 mulgate regulations regarding the provision of infor-
20 mation to employees by employers to effectuate en-
21 rollment under this section.

22 (4) CONSTRUCTION.—Nothing in this section
23 shall be construed to prevent an employer from com-
24 plying with this subsection through the offering of
25 plans provided by a single carrier.

1 (5) SMALL EMPLOYERS.—Each small employer
2 shall offer, at the age-adjusted community rate in
3 the area, at least three State-certified health plans,
4 one of which shall be a fee-for-service plan, and shall
5 join a consumer purchasing cooperative. A small em-
6 ployer may satisfy the requirement that it offer at
7 least three health plans by joining a consumer pur-
8 chasing cooperative.

9 (b) FORWARDING OF ENROLLMENT INFORMATION.—

10 (1) INFORMATION REGARDING PLANS.—An em-
11 ployer must provide each employee of such employer
12 (including any part-time or seasonal employee) with
13 information regarding all qualified health plans of-
14 fered in the health care coverage area in which the
15 employer is located and, if the employee resides in
16 another health care coverage area, information re-
17 garding how to obtain information on qualified
18 health plans offered to residents of such other health
19 care coverage area.

20 (2) INFORMATION REGARDING EMPLOYEES.—
21 An employer must forward the name and address
22 (and any other necessary identifying information
23 specified by the Secretary) of each eligible em-
24 ployee—

1 (A) to the qualified health plan in which
2 such employee is enrolled, or

3 (B) to the cooperative (if any) through
4 which such enrollment is made.

5 (c) PAYROLL DEDUCTION.—The employer, upon au-
6 thorization by the employee, shall provide for the deduc-
7 tion, from the employee’s wages or other compensation,
8 of the premium amount due (less any employer contribu-
9 tion) to the plan or purchasing cooperative in accordance
10 with section 6209. This subsection shall only apply to
11 plans and purchasing cooperatives made available by the
12 employer.

13 (d) NO REQUIREMENT TO ENROLL IN EMPLOYER-
14 PROVIDED PLAN.—An eligible employee of a community-
15 rated employer may elect not to enroll in a health plan
16 offered by an employer under this section. In addition to
17 such plans, such an employee may enroll in a health plan
18 offered through a purchasing cooperative of the employers
19 choosing, in an association health plan (as described in
20 section 1508) or through a plan offered by the Federal
21 Employees Health Benefits Program.

22 **SEC. 1404. RESPONSIBILITIES AND AUTHORITY OF EM-**
23 **PLOYER PURCHASERS.**

24 (a) SELECTION OF PLANS BY MAJORITY OF EMPLOY-
25 EES.—Each employer shall make the selections of health

1 plans under this subsection on an annual basis. In making
2 each such selection, a employer shall comply with any se-
3 lection made by at least 50 percent of the eligible employ-
4 ees of the employer. The Secretary of Labor shall pre-
5 scribe rules which shall govern the manner in which em-
6 ployees may make such a selection.

7 (b) SPECIFIC REQUIREMENTS OF LARGER GROUP
8 PURCHASERS.—

9 (1) CONTRACTS WITH PLANS.—Each large
10 group purchaser may—

11 (A) negotiate with a State-certified health
12 plan to enter into a contract with the plan for
13 the enrollment of such individuals under the
14 plan; or

15 (B) offer to individuals an appropriate em-
16 ployer sponsored health plan (as defined in sec-
17 tion 1401(e)(5));

18 or offer a combination of the plans described in this
19 paragraph.

20 (2) TERMS OF CONTRACTS WITH STATE-CER-
21 TIFIED HEALTH PLANS.—Contracts under this sec-
22 tion between a large group purchaser and a State-
23 certified health plan may contain such provisions
24 (not inconsistent with the requirements of this title)
25 as the large group purchaser and plan may provide,

1 except that in no case does such contract remove the
2 obligation of the large group purchaser to provide
3 for health benefits to large group purchaser eligible
4 individuals consistent with this part.

5 (3) PLAN AND INFORMATION REQUIRE-
6 MENTS.—

7 (A) IN GENERAL.—A large group pur-
8 chaser shall provide a written submission to the
9 Secretary of Labor (in such form as the Sec-
10 retary may require) detailing how the large
11 group purchaser will carry out its activities
12 under this part.

13 (B) ANNUAL INFORMATION.—An employer
14 group purchaser shall provide to the Secretary
15 of Labor each year, in such form and manner
16 as the Secretary may require, such information
17 as the Secretary may require in order to mon-
18 itor the compliance of the purchaser with the
19 requirements of this part.

20 (4) MANAGEMENT OF FUNDS.—

21 (A) MANAGEMENT OF FUNDS.—The man-
22 agement of funds by an large group purchaser
23 shall be subject to the applicable fiduciary re-
24 quirements of part 4 of subtitle B of title I of
25 the Employee Retirement Income Security Act

1 of 1974, together with the applicable enforce-
2 ment provisions of part 5 of subtitle B of title
3 I of such Act.

4 (B) MANAGEMENT OF FINANCES AND
5 RECORDS; ACCOUNTING SYSTEM.—Each large
6 group purchaser shall comply with standards
7 relating to the management of finances and
8 records and accounting systems as the Sec-
9 retary of Labor shall specify.

10 (c) LARGE GROUP PURCHASER TRANSITION.—Each
11 large group purchaser must provide coverage—

12 (1) as of the first day of any month in which
13 an individual first becomes a large group sponsor eli-
14 gible individual, and

15 (2) through the end of the month in the case
16 of a large group sponsor eligible individual who loses
17 such eligibility during the month unless covered
18 under paragraph (1).

19 (d) EMPLOYEE SHARE.—The premiums charged by
20 a large group purchaser to an employee for enrollment in
21 a plan offered by such a purchaser (not taking into ac-
22 count any employer premium payment under section
23 6131) shall vary only by class of family enrollment (as
24 specified under section 6131) and by geographic area. The
25 Secretary of Labor shall promulgate regulations regarding

1 the designation of geographic area by large group pur-
2 chasers. Such regulations shall provide for such exceptions
3 to the requirements under this section with respect to a
4 sponsor described in section 1401(b)(1)(B), as may be ap-
5 propriate.

6 **SEC. 1405. DEVELOPMENT OF LARGE EMPLOYER GROUP**
7 **PURCHASERS.**

8 (a) IN GENERAL.—Nothing in this title shall be con-
9 strued as prohibiting 2 or more large employers from
10 forming a purchasing group with respect to the employees
11 of such employer or employers. Such entities shall comply
12 with the requirements applicable to health plans offered
13 by large group purchasers under this subtitle.

14 (b) NO USE OF INDIVIDUAL AND COMMUNITY-RATED
15 EMPLOYER PURCHASING COOPERATIVES.—A large em-
16 ployer shall be ineligible to purchase health insurance
17 through an individual and community-rated employer pur-
18 chasing cooperative.

19 **SEC. 1406. TIMING AND TERMINATION OF EMPLOYER ELEC-**
20 **TIONS.**

21 (a) REGULATIONS.—Not later than 6 months after
22 the date of enactment of this Act, the Secretary of Labor
23 shall promulgate regulations for employer elections.

24 (b) ELECTIVE TERMINATION.—A large group spon-
25 sor (other than a large employer) may terminate an elec-

1 tion under this part by filing with the National Health
2 Board and the Secretary of Labor a notice of intent to
3 terminate.

4 (c) EFFECTIVE DATE OF TERMINATION.—In the
5 case of a termination of an election under this section,
6 in accordance with rules established by the Secretary of
7 Labor—

8 (1) subject to section 6022(a)(1), the termi-
9 nation shall take effect as of the effective date of en-
10 rollments in experience-rated plans made during the
11 next open enrollment period (as provided in section
12 1403), and

13 (2) the enrollment of eligible individuals in ex-
14 perience-rated plans of the sponsor shall be termi-
15 nated as of such date and such individuals shall be
16 enrolled in other applicable health plans effective on
17 such date.

18 (d) NOTICE TO BOARD.—If an election with respect
19 to a large group sponsor is terminated pursuant to sub-
20 section (b), the Secretary of Labor shall notify the Na-
21 tional Health Board of the termination of the election.

1 **PART 2—REQUIREMENTS FOR HEALTH PLANS**
2 **OFFERED BY LARGE GROUP PURCHASERS**
3 **SEC. 1411. ESTABLISHMENT OF STANDARDS APPLICABLE**
4 **TO EMPLOYER SPONSORED PLANS.**

5 (a) IN GENERAL.—The Secretary of Labor shall de-
6 velop and publish standards applicable to employer spon-
7 sored plans (as defined in section 1401(e)(5)) offered by
8 large group purchasers relating to the requirements de-
9 scribed in subsection (b). The Secretary shall develop and
10 publish such standards by not later than the date that
11 is 6 months after the date of enactment of this Act. Such
12 standards shall be the certified health plan standards ap-
13 plicable to employer sponsored plans under this part.

14 (b) REQUIREMENTS SPECIFIED.—

15 (1) IN GENERAL.—The requirements referred
16 to in subsection (a) are applicable plan requirements
17 specified in subtitle F.

18 (2) OTHER REQUIREMENTS.—The standards
19 referred to in subsection (a) shall include stand-
20 ards—

21 (A) relating to financial solvency, reserve
22 and guaranty fund requirements, as the Sec-
23 retary of Labor shall specify, except that such
24 standards shall be consistent with the applicable
25 rules under part 4 of title I of the Employee
26 Retirement Income Security Act of 1974;

1 (B) relating to the payments of premiums;

2 and

3 (C) relating to claims grievance proce-

4 dures, in accordance with subtitle C of title V.

5 **SEC. 1412. CORRECTIVE ACTIONS FOR HEALTH PLANS OF-**

6 **FERED BY LARGE EMPLOYERS.**

7 (a) IN GENERAL.—The plan sponsor of each large
8 employer plan shall determine semiannually whether the
9 requirements of this part are met. In any case in which
10 the plan sponsor determines that there is reason to believe
11 that there is or will be a failure to meet such requirements,
12 or the Secretary of Labor makes such a determination and
13 so notifies the plan sponsor, the plan sponsor shall, within
14 90 days after making such determination or receiving such
15 notification, notify such Secretary (in such form and man-
16 ner as such Secretary may prescribe by regulation) of a
17 description of the corrective actions (if any) that the plan
18 sponsor has taken or plans to take in response to such
19 recommendations. The plan sponsor shall thereafter report
20 to such Secretary, in such form and frequency as such
21 Secretary may specify to the plan sponsor, regarding cor-
22 rective action taken by the plan sponsor until such require-
23 ments are met. Such Secretary may make a determination
24 that a large employer plan has ceased to be a large em-
25 ployer plan only if such Secretary is satisfied that the nec-

1 essary corrective action cannot reasonably be expected to
2 occur on a timely basis necessary to avoid failure to pro-
3 vide benefits for which the plan is obligated.

4 (b) DISQUALIFIED OR TERMINATION OF PLAN.—

5 (1) IN GENERAL.—In any case in which the
6 plan sponsor of a large employer plan determines
7 that there is reason to believe that the plan will
8 cease to be a large employer sponsored health plan
9 or will terminate, the plan sponsor shall so inform
10 the Secretary of Labor, shall develop a plan for
11 winding up the affairs of the plan in connection with
12 such disqualification or termination in a manner
13 which will result in timely payment of all benefits for
14 which the plan is obligated, and shall submit such
15 plan in writing to such Secretary. Actions required
16 under this subparagraph shall be taken in such form
17 and manner as may be prescribed in regulations
18 jointly prescribed by such Secretary.

19 (2) ACTIONS REQUIRED IN CONNECTION WITH
20 DISQUALIFICATION OR TERMINATION.—

21 (A) IN GENERAL.—In any case in which—

22 (i) the Secretary of Labor has been
23 notified under paragraph (1) of a failure of
24 a large employer sponsored health plan to
25 meet the requirements of this part and has

1 not been notified by the plan sponsor that
2 corrective action has restored compliance
3 with such requirements, and

4 (ii) such Secretary determines that
5 the continuing failure to meet such re-
6 quirements can be reasonably expected to
7 result in a continuing failure to pay bene-
8 fits for which the plan is obligated,

9 the plan sponsor and the large employer shall
10 comply with the requirements of subparagraph
11 (B) or (C), as applicable.

12 (B) ACTIONS BY PLAN SPONSOR.—Upon a
13 determination by the Secretary of Labor under
14 subparagraph (A)(ii), the plan sponsor shall, at
15 the direction of such Secretary, terminate the
16 plan and, in the course of the termination, take
17 such actions as such Secretary may require as
18 necessary to ensure that the affairs of the plan
19 will be, to the maximum extent possible, wound
20 up in a manner which will result in timely pay-
21 ment of all benefits for which the plan is obli-
22 gated.

23 (C) ACTIONS BY LARGE EMPLOYER.—
24 Upon a determination by the Secretary of
25 Labor under subparagraph (A)(ii), the large

1 employer shall provide for such contingency cov-
2 erage for all eligible employees of the employer
3 in accordance with regulations which shall be
4 prescribed by such Secretary. Such regulations
5 may provide for temporary coverage of such
6 employees under a plan provided by a purchas-
7 ing group in the appropriate area, a plan pro-
8 vided under chapter 89 of title 5, United States
9 Code, or other appropriate means established in
10 such regulations.

11 **SEC. 1413. DISCLOSURE AND RESERVE REQUIREMENTS**
12 **FOR LARGE EMPLOYER PURCHASER HEALTH**
13 **PLANS.**

14 (a) IN GENERAL.—The Secretary of Labor shall en-
15 sure that each large group purchaser health plan which
16 is an employer sponsored health plan maintains plan as-
17 sets in trust as provided in section 403 of the Employee
18 Retirement Income Security Act of 1974—

19 (1) without any exemption under section
20 403(b)(4) of such Act, and

21 (2) in amounts which the Secretary determines
22 are sufficient to provide at any time for payment to
23 health care providers of all outstanding balances
24 owed by the plan at such time and consistent with
25 standards for State certified health plans.

1 The requirements of the preceding sentence may be met
2 through letters of credit, bonds, or other appropriate secu-
3 rity to the extent provided in regulations of the Secretary.

4 (b) DISCLOSURE.—Each employer sponsored health
5 plan shall notify the Secretary at such time as the finan-
6 cial reserve requirements of this section are not being met.
7 The Secretary may assess a civil money penalty of not
8 more than \$100,000 against any large group purchaser
9 for any failure to provide such notification in such form
10 and manner and within such time periods as the Secretary
11 may prescribe by regulation.

12 **SEC. 1414. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
13 **VENT LARGE EMPLOYER PURCHASED**
14 **HEALTH PLANS.**

15 (a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
16 INSOLVENT PLANS.—Whenever the Secretary of Labor
17 determines that a large employer sponsored health plan
18 will be unable to provide benefits when due or is otherwise
19 in a financially hazardous condition as defined in regula-
20 tions of the Secretary, the Secretary shall, upon notice to
21 the plan, apply to the appropriate United States district
22 court for appointment of the Secretary as trustee to ad-
23 minister the plan for the duration of the insolvency. The
24 plan may appear as a party and other interested persons
25 may intervene in the proceedings at the discretion of the

1 court. The court shall appoint the Secretary trustee if the
2 court determines that the trusteeship is necessary to pro-
3 tect the interests of the enrolled individuals or health care
4 providers or to avoid any unreasonable deterioration of the
5 financial condition of the plan or any unreasonable in-
6 crease in the liability of the large group purchaser Health
7 Plan Insolvency Fund. The trusteeship of the Secretary
8 shall continue until the conditions described in the first
9 sentence of this subsection are remedied or the plan is ter-
10 minated.

11 (b) POWERS AS TRUSTEE.—The Secretary of Labor,
12 upon appointment as trustee under subsection (a), shall
13 have the power—

14 (1) to do any act authorized by the plan, this
15 Act, or other applicable provisions of law to be done
16 by the plan administrator or any trustee of the plan,

17 (2) to require the transfer of all (or any part)
18 of the assets and records of the plan to the Sec-
19 retary as trustee,

20 (3) to invest any assets of the plan which the
21 Secretary holds in accordance with the provisions of
22 the plan, regulations of the Secretary, and applicable
23 provisions of law,

24 (4) to do such other acts as the Secretary de-
25 termines to be necessary to continue operation of the

1 plan without increasing the potential liability of the
2 large group purchaser Health Plan Insolvency Fund,
3 if such acts may be done under the provisions of the
4 plan,

5 (5) to require the large group purchaser, the
6 plan administrator, any contributing employer, and
7 any employee organization representing covered indi-
8 viduals to furnish any information with respect to
9 the plan which the Secretary as trustee may reason-
10 ably need in order to administer the plan,

11 (6) to collect for the plan any amounts due the
12 plan and to recover reasonable expenses of the trust-
13 eeship,

14 (7) to commence, prosecute, or defend on behalf
15 of the plan any suit or proceeding involving the plan,

16 (8) to issue, publish, or file such notices, state-
17 ments, and reports as may be required under regula-
18 tions of the Secretary or by any order of the court,

19 (9) to terminate the plan and liquidate the plan
20 assets in accordance with applicable provisions of
21 this Act and other provisions of law, to restore the
22 plan to the responsibility of the large group pur-
23 chaser, or to continue the trusteeship,

1 (10) to provide for the enrollment of individuals
2 covered under the plan in an appropriate health
3 plan, and

4 (11) to do such other acts as may be necessary
5 to comply with this Act or any order of the court
6 and to protect the interests of enrolled individuals
7 and health care providers.

8 (c) NOTICE OF APPOINTMENT.—As soon as prac-
9 ticable after the Secretary’s appointment as trustee, the
10 Secretary shall give notice of such appointment to—

11 (1) the plan administrator,

12 (2) each enrolled individual,

13 (3) each employer who may be liable for con-
14 tributions to the plan, and

15 (4) each employee organization which, for pur-
16 poses of collective bargaining, represents enrolled in-
17 dividuals.

18 (d) ADDITIONAL DUTIES.—Except to the extent in-
19 consistent with the provisions of this Act or part 4 of sub-
20 title B of title I of the Employee Retirement Income Secu-
21 rity Act of 1974, or as may be otherwise ordered by the
22 court, the Secretary of Labor, upon appointment as trust-
23 ee under this section, shall be subject to the same duties
24 as those of a trustee under section 704 of title 11, United

1 States Code, and shall have the duties of a fiduciary for
2 purposes of such part 4.

3 (e) OTHER PROCEEDINGS.—An application by the
4 Secretary of Labor under this subsection may be filed not-
5 withstanding the pendency in the same or any other court
6 of any bankruptcy, mortgage foreclosure, or equity receiv-
7 ership proceeding, or any proceeding to reorganize, con-
8 serve, or liquidate such plan or its property, or any pro-
9 ceeding to enforce a lien against property of the plan.

10 (f) JURISDICTION OF COURT.—

11 (1) IN GENERAL.—Upon the filing of an appli-
12 cation for the appointment as trustee or the issuance
13 of a decree under this subsection, the court to which
14 the application is made shall have exclusive jurisdic-
15 tion of the plan involved and its property wherever
16 located with the powers, to the extent consistent
17 with the purposes of this subsection, of a court of
18 the United States having jurisdiction over cases
19 under chapter 11 of title 11, United States Code.
20 Pending an adjudication under this section such
21 court shall stay, and upon appointment by it of the
22 Secretary of Labor as trustee, such court shall con-
23 tinue the stay of, any pending mortgage foreclosure,
24 equity receivership, or other proceeding to reorga-
25 nize, conserve, or liquidate the plan, the large group

1 purchaser, or property of such plan or purchaser,
2 and any other suit against any receiver, conservator,
3 or trustee of the plan, the purchaser, or property of
4 the plan or purchaser. Pending such adjudication
5 and upon the appointment by it of the Secretary as
6 trustee, the court may stay any proceeding to en-
7 force a lien against property of the plan or the large
8 group purchaser or any other suit against the plan
9 or the purchaser.

10 (2) VENUE.—An action under this subsection
11 may be brought in the judicial district where the
12 plan administrator resides or does business or where
13 any asset of the plan is situated. A district court in
14 which such action is brought may issue process with
15 respect to such action in any other judicial district.

16 (g) PERSONNEL.—In accordance with regulations of
17 the Secretary of Labor, the Secretary shall appoint, retain,
18 and reasonably compensate accountants, actuaries, and
19 other professional service personnel as may be necessary
20 in connection with the Secretary’s service as trustee under
21 this section.

22 **Subtitle F—Health Plans**

23 **SEC. 1500. HEALTH PLAN DEFINED.**

24 (a) IN GENERAL.—In this Act, the term “health
25 plan” means a plan that provides the comprehensive bene-

1 fit package and meets the requirements of this Act appli-
2 cable to health plans.

3 (b) STATE-CERTIFIED HEALTH PLAN.—In this Act,
4 the term “State-certified health plan” means a health plan
5 that has been certified by a State under section 1504 (or,
6 in the case in which the Board is exercising certification
7 authority under this title, that has been certified by the
8 Board).

9 (c) DOMICILIARY STATE.—For purposes this section,
10 the State which has certified a cooperative is the State
11 in which the cooperative is domiciled.

12 **PART 1—REQUIREMENTS FOR HEALTH PLANS**

13 **SEC. 1501. CERTIFIED HEALTH PLAN.**

14 (a) IN GENERAL.—To be certified under this title a
15 health plan must meet the applicable standards under sec-
16 tion 1503 for a certified health plan.

17 (b) SPECIAL RULES FOR LARGE GROUP PUR-
18 CHASERS.—Employer sponsored health plans offered by
19 large group purchasers shall meet applicable standards in
20 accordance with subtitle E.

21 (c) CONSTRUCTION.—Whenever in this title a re-
22 quirement or standard is imposed on a health plan, the
23 requirement or standard is deemed to have been imposed
24 on the insurer or health plan sponsor of the plan in rela-
25 tion to that plan.

1 **SEC. 1502. APPLICATION OF REQUIREMENTS.**

2 No plan shall be treated under this Act as a health
3 plan—

4 (1) unless the plan is an employer sponsored
5 health plan or a State-certified plan; or

6 (2) on and after the effective date of a finding
7 by the applicable regulatory authority that the plan
8 has failed to comply with such applicable require-
9 ments.

10 **SEC. 1503. ESTABLISHMENT OF STANDARDS.**

11 In order for a health plan to be eligible to be certified
12 as a health plan by a State, the health plan shall meet
13 the requirements of this Act, as described in regulations
14 promulgated by the Board or the Secretary, including
15 standards requiring that the plan shall—

16 (1) provide for the effective delivery of covered
17 services throughout each designated service area for
18 which it is certified;

19 (2) provide for coverage of the comprehensive
20 benefits package described in subtitle B;

21 (3) provide for the collection and reporting of
22 data;

23 (4) not discriminate in enrollment or benefits;

24 (5) establish community-rated premiums for the
25 comprehensive benefits;

1 (6) meet financial solvency and financial man-
2 agement standards promulgated by the Board;

3 (7) provide for effective grievance procedures;

4 (8) demonstrate an ability to ensure that enroll-
5 ees have adequate access to providers of health care;

6 (9) meet information, disclosure and marketing
7 requirements;

8 (10) meet requirements for open enrollment,
9 availability, and renewability;

10 (11) meet requirements with respect to rural
11 and underserved areas;

12 (12) meet requirements with respect to partici-
13 pation in a payment adjustment program;

14 (13) meet quality standards;

15 (14) enter into agreements with cooperatives;

16 and

17 (15) meet other applicable requirements of this
18 Act pursuant to the Board or to regulations promul-
19 gated by the Secretary.

20 **SEC. 1504. CERTIFICATION AND REVOCATION OF HEALTH**
21 **PLAN CERTIFICATION.**

22 (a) CERTIFICATION.—A participating State shall—

23 (1) certify each health plan, review the contin-
24 ued compliance of each plan with the certification
25 requirements and recertify each plan not less fre-

1 quently than once during every 3-year period if the
2 State determines that the plan continues to meet the
3 criteria for certification, including demonstrating
4 that the policies of the plan have not discriminated
5 on the basis of any of the categories described in
6 section 1914; and

7 (2) review enrollee disenrollment from health
8 plans in order to determine whether there is a pat-
9 tern of disenrollment that does not reflect the dis-
10 tribution of such plans' reenrolling members with re-
11 spect to age, income, health condition, prior utiliza-
12 tion of health services, place of residence and other
13 potential risk characteristics.

14 Evidence of any of the disenrollment patterns described
15 in paragraph (2) may be cause for the denial of a certifi-
16 cation or for the application of one or more interim sanc-
17 tions described in section 1505.

18 (b) REVOCATION.—The State may revoke a plan's
19 certification as a certified health plan for any health care
20 coverage area or refuse to recertify a plan only upon a
21 determination by the State that the health plan no longer
22 meets the requirements of this section, pursuant to proce-
23 dures established by the Board.

1 **SEC. 1505. MONITORING.**

2 A participating State shall monitor the performance
3 of each State-certified health plan to ensure that it contin-
4 ues to meet the criteria for certification. If during such
5 monitoring the State determined that a health plan fails
6 to deliver care of adequate quality, either with respect to
7 the overall enrollment population or the vulnerable popu-
8 lation, fails to meet applicable standards relating to finan-
9 cial solvency and stability, or fails to meet any other cri-
10 teria for certification or recertification, the State shall im-
11 pose sanctions on the plan. Such sanctions may include
12 fines and the limitation or prohibition of further enroll-
13 ment until such time as the plan develops and complies
14 with a corrective action plan.

15 **SEC. 1506. ASSOCIATION HEALTH PLANS.**

16 (a) APPLICATION.—This section shall apply to any
17 association health plan that is in operation on June 1,
18 1994 and that meets the requirements for being consid-
19 ered an multiple employer welfare arrangement under sec-
20 tion 3(40) of the Employee Retirement Income Security
21 Act of 1974 (29 U.S.C. 1002(40)).

22 (b) APPLICATION OF STANDARDS.—An association
23 health plan shall meet the requirements of a State-cer-
24 tified community-rated health plan.

25 (c) REQUIREMENTS.—The sponsoring entity of the
26 association health plan—

1 (1) shall be organized and maintained in good
2 faith, with appropriate bylaws that specifically state
3 the purpose, as a trade association, industry associa-
4 tion, professional association, chamber of commerce,
5 a religious organization, or a public entity associa-
6 tion and that the entity has been established and
7 maintained for substantial purposes other than to
8 provide the health care required under this section;
9 and

10 (2) is and has been in operation (together with
11 its immediate predecessor, if any) for a continuous
12 period of not less than 3 years and receives the ac-
13 tive support of its membership.

14 (d) TREATMENT OF EXISTING ENTITIES.—Any ar-
15 rangement that, as of June 1, 1994, has been in effect
16 for not less than 18 months and with respect to which
17 there is a pending application with the State insurance
18 commissioner for a certificate of operation as a health
19 plan, shall be treated for purposes of this subtitle as a
20 qualified health plan (if such plan otherwise meets the re-
21 quirements of this Act) unless the State can demonstrate
22 that—

23 (1) fraudulent or material misrepresentations
24 have been made by the sponsor in the application;

1 (2) the plan that is the subject of the applica-
2 tion, on its face, fails to meet the requirements for
3 a complete application; or

4 (3) a financial impairment exists with respect
5 to the applicant that is sufficient to demonstrate the
6 applicant's inability to continue its operations.

7 (e) TREATMENT OF MULTIPLE EMPLOYER WELFARE
8 ARRANGEMENTS.—

9 (1) MEWAs.—The Secretary of Labor shall
10 promulgate regulations that prohibit the insuring of
11 employees under a multiple employer welfare ar-
12 rangement as defined under section 3(40) of the
13 Employee Retirement Income Security Act of 1974
14 (29 U.S.C. 1002(40)) unless the arrangement meets
15 the standards for an association health plan under
16 subtitle F or is certified by a State or a consumer
17 purchasing cooperative in accordance with subtitle
18 D.

19 (2) REPEAL OF ERISA PROVISIONS.—

20 (A) Paragraph (40) of section 3 of such
21 Act (29 U.S.C. 1002(40)) is repealed.

22 (B) Paragraph 6 of section 514(b) of such
23 Act (29 U.S.C. 1144(b)(6)) is repealed.

1 **SEC. 1507. SPECIFIED STANDARD BENEFITS; SUPPLE-**
2 **MENTAL BENEFITS AND COST-SHARING POLI-**
3 **CIES.**

4 (a) STANDARD BENEFITS AND OTHER REQUIRE-
5 MENTS.—A State shall not accept the certification of a
6 health plan as a certified health plan unless the plan pro-
7 vides the comprehensive benefits package required under
8 this Act.

9 (b) TREATMENT OF SUPPLEMENTARY HEALTH BEN-
10 EFITS.—

11 (1) IN GENERAL.—Subsection (a) shall not be
12 construed as preventing a health plan, carrier, or in-
13 surer from offering (in a manner that is separate
14 from the offering of health plans) supplemental in-
15 surance policies, pursuant to the State certification
16 plan and regulations promulgated by the Board.

17 (2) NO DUPLICATIVE HEALTH BENEFITS.—A
18 health plan or any other carrier or insurer may not
19 offer any policy for supplementary health benefits
20 under paragraph (1) that duplicates the comprehen-
21 sive benefits or is linked in any manner to the plan's
22 comprehensive benefits package.

23 (3) REGULATION OF SUPPLEMENTAL PLANS.—
24 The Secretary shall provide appropriate rules for the
25 regulation of supplemental benefit policies and plans,

1 including rules providing for the guaranteed issue
2 and the community rating of supplemental policies.

3 (c) TREATMENT OF COST-SHARING POLICIES.—

4 (1) RULES FOR OFFERING OF POLICIES.—A
5 cost sharing policy may be offered to an individual
6 only if—

7 (A) the policy is offered by the certified
8 health plan in which the individual is enrolled;

9 (B) the certified health plan offers the pol-
10 icy to all individuals enrolled in the plan;

11 (C) the plan offers each such individual a
12 choice of a policy that provides standard cov-
13 erage and a policy that provides maximum cov-
14 erage (in accordance with standards established
15 by the Board); and

16 (D) the policy is offered only during the
17 annual open enrollment period for community-
18 rated health plans (described in section 1516).

19 (2) PROHIBITION OF COVERAGE OF
20 COPAYMENTS.—Each cost sharing policy may not
21 provide any benefits relating to any copayments es-
22 tablished under subtitle B.

23 (3) EQUIVALENT COVERAGE FOR ALL SERV-
24 ICES.—Each cost sharing policy must provide cov-
25 erage for items and services in the comprehensive

1 benefit package to the same extent as the policy pro-
2 vides coverage for all items and services in the pack-
3 age.

4 (4) REQUIREMENTS FOR PRICING.—

5 (A) IN GENERAL.—The price of any cost
6 sharing policy shall—

7 (i) be the same for each individual to
8 whom the policy is offered;

9 (ii) take into account any expected in-
10 crease in utilization resulting from the pur-
11 chase of the policy by individuals enrolled
12 in the community-rated health plan; and

13 (iii) not result in a loss-ratio of less
14 than 90 percent.

15 (B) LOSS-RATIO DEFINED.—In subpara-
16 graph (A)(iii), a “loss-ratio” is the ratio of the
17 premium returned to the consumer in payout
18 relative to the total premium collected.

19 **SEC. 1508. COLLECTION, PROVISION OF STANDARDIZED IN-**
20 **FORMATION, AND CONFIDENTIALITY.**

21 Each health plan must provide information required
22 in accordance with subtitles A and B of title V.

23 **SEC. 1509. PROHIBITION OF DISCRIMINATION.**

24 (a) IN GENERAL.—Each health plan shall comply
25 with the antidiscrimination requirements of section 1914.

1 (b) ANTIDISCRIMINATION.—

2 (1) IN GENERAL.—No health plan may dis-
3 criminate on the basis of—

4 (A) the method through which a family
5 seeks enrollment under the plan; or

6 (B) the provider's status as a member of
7 a health care profession for the purposes of se-
8 lecting among providers of health services for
9 participation in a provider network, provided
10 that the State authorizes members of that pro-
11 fession to render the services in question and
12 that such services are covered in the com-
13 prehensive benefits package described in sub-
14 title B.

15 (2) RULE OF CONSTRUCTION.—Nothing in
16 paragraph (1)(B) shall be construed as requiring
17 any health plan to—

18 (A) include in a network any individual
19 provider;

20 (B) establish any defined ratio of different
21 categories of health professionals;

22 (C) maintain any specific reimbursement
23 methodology other than that which is estab-
24 lished in other provisions of this Act; and

1 (D) establish any specific utilization review
2 or internal quality standards other than that re-
3 quired in other provisions of this Act.

4 **SEC. 1510. QUALITY ASSURANCE STANDARDS.**

5 (a) IN GENERAL.—Each health plan shall comply
6 with the plan performance standards in accordance with
7 subtitle A of title V. Each health plan shall establish pro-
8 cedures, including ongoing quality improvement proce-
9 dures, to ensure that the health care services provided to
10 enrollees under the plan will be provided under reasonable
11 standards of quality of care consistent with prevailing pro-
12 fessionally recognized standards of medical practice and
13 the quality standards established under subtitle A of title
14 V.

15 (b) INTERNAL QUALITY ASSURANCE PROGRAM.—
16 Each health plan shall establish, and communicate to its
17 enrollees and its providers, an ongoing internal program,
18 including periodic reporting, to monitor and evaluate the
19 quality and cost effectiveness of its health care services,
20 pursuant to standards established by the National Quality
21 Council.

22 **SEC. 1511. COMMUNITY-RATING.**

23 (a) IN GENERAL.—The Secretary shall promulgate
24 regulations for community rating as modified by age. Such
25 regulations pertaining to adjustments in the community

1 rate for age shall terminate on December 31, 1998, except
2 that the Board at any time may make a recommendation
3 to Congress to maintain a form of modified community
4 rating during the transition.

5 (b) **MARKETING FEES.**—Notwithstanding this sec-
6 tion, a health plan may impose a marketing fee for individ-
7 uals enrolling in a plan through an agent. Such fees shall
8 be a uniform percentage of the premium established under
9 section 6102(a)(1). In no case shall a plan impose a mar-
10 keting fee for individuals enrolled through a cooperative
11 or through a direct enrollment process established pursu-
12 ant to section 1660.

13 **SEC. 1512. FINANCIAL SOLVENCY REQUIREMENTS AND**
14 **CONSUMER PROTECTION AGAINST PRO-**
15 **VIDER CLAIMS.**

16 (a) **SOLVENCY PROTECTION.**—Each health plan shall
17 meet financial solvency requirements to assure protection
18 of enrollees with respect to potential insolvency. Health
19 plans must provide a financial plan and meet capital re-
20 quirements established by the Board under section 1651.
21 Health plans may utilize reinsurance, provide risk sharing,
22 and other appropriate measures established by the Board.

23 (b) **PROTECTION AGAINST PROVIDER CLAIMS.**—In
24 the case of a failure of a health plan to make payments
25 with respect to the comprehensive benefits for any reason,

1 an individual who is enrolled under the plan is not liable
2 to any health care provider with respect to the provision
3 of health services within such set of benefits for payments
4 in excess of the amount for which the enrollee would have
5 been liable if the plan were to have made payments in a
6 timely manner.

7 **SEC. 1513. GRIEVANCE MECHANISMS.**

8 A health plan shall establish grievance procedures
9 that enrollees may utilize in pursuing complaints in ac-
10 cordance with subtitle C of title V.

11 **SEC. 1514. ACCESS TO CARE.**

12 (a) POINT-OF-SERVICE OPTION.—Each health plan
13 that is a low-cost sharing plan (as described in section
14 1131) shall offer enrollees the opportunity to obtain cov-
15 erage for out-of-network items and services, except that
16 such point-of-service option must be offered, and priced
17 separately from the benefits offered through the plan's
18 network. A health plan providing coverage to an enrollee
19 for out-of-network items and services may charge an alter-
20 native premium and require alternative cost-sharing to
21 take into account such coverage, consistent with regula-
22 tions promulgated by the Secretary.

23 (b) TREATMENT OF COST-SHARING.—Each health
24 plan, in providing benefits in the comprehensive benefit
25 package shall include in its payments to providers such

1 additional reimbursement as may be necessary to reflect
2 cost sharing reductions to which individuals are entitled
3 under section 1281.

4 (c) DEFINITIONS.—

5 (1) IN-NETWORK ITEMS AND SERVICES.—For
6 purposes of this Act, the term “in-network”, when
7 used with respect to items or services described in
8 this subtitle, means items or services provided to an
9 individual enrolled under a health plan by a health
10 care provider who is a member of a provider network
11 of the plan (as defined in paragraph (3)).

12 (2) OUT-OF-NETWORK ITEMS AND SERVICES.—
13 For purposes of this Act, the term “out-of network”,
14 when used with respect to items or services de-
15 scribed in this subtitle, means items or services pro-
16 vided to an individual enrolled under a health plan
17 by a health care provider who is not a member of
18 a provider network of the plan (as defined in para-
19 graph (3)).

20 (3) PROVIDER NETWORK DEFINED.—A “pro-
21 vider network” means, with respect to a health plan,
22 providers who have entered into an agreement with
23 the plan under which such providers are obligated to
24 provide items and services in the comprehensive ben-
25 efit package to individuals enrolled in the plan, or

1 have an agreement to provide services on a fee-for-
2 service basis.

3 (4) NETWORK PLAN DEFINED.—For purposes
4 of this Act, a “network plan” means a health plan
5 that utilizes a provider network described in para-
6 graph (3) and that meets the requirements of sec-
7 tion 1523(c).

8 (d) RELATION TO DETENTION.—A health plan is not
9 required to provide any reimbursement to any detention
10 facility for services performed in that facility for detainees
11 in the facility.

12 **SEC. 1515. INFORMATION AND MARKETING STANDARDS.**

13 (a) IN GENERAL.—Each health plan shall provide in-
14 formation in accordance with sections 1205 and 1603(e),
15 other applicable information requirements of this Act and
16 rules promulgated by the Board.

17 (b) MARKETING METHODS; ADVERTISING MATE-
18 RIALS.—A health plan may utilize direct marketing, agen-
19 cy, or other arrangements to distribute health plan infor-
20 mation, subject to applicable State fair marketing prac-
21 tices laws and standards established by the State, includ-
22 ing standards to prevent selective marketing. All advertis-
23 ing, promotional materials, and other communications
24 with health plan members and the general public must be
25 factually accurate and responsive to the needs of served

1 populations. A health plan may not distribute marketing
2 materials to an area smaller than the entire designated
3 service area of the plan.

4 (c) PAYMENT OF AGENT COMMISSIONS.—A health
5 plan—

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

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

13 (d) MATERIALS IN APPROPRIATE LANGUAGES.—In
14 the case of a health care coverage area that includes a
15 significant number or proportion of residents with limited
16 English proficiency, the State shall provide all materials
17 under this Act at an appropriate reading level and in the
18 native languages of such residents, as appropriate.

19 **SEC. 1516. ENROLLMENT; AVAILABILITY, AND RENEWABIL-**
20 **ITY.**

21 (a) ENROLLMENT REQUIREMENTS.—Each health
22 plan shall establish an enrollment process consistent with
23 this paragraph. To be certified as a health plan, the plan
24 shall accept the enrollment of every eligible individual who
25 seeks such enrollment (including individuals enrolling di-

1 rectly with the plan or through a cooperative) and comply
2 with all rules and procedures regarding enrollment estab-
3 lished by the State and by the Board. No plan may engage
4 in any practice that has the effect of attracting or limiting
5 enrollees on the basis of personal characteristics, such as
6 occupation or affiliation with any person or entity, or
7 those characteristics described in section 1914.

8 (b) NO LIMITS ON COVERAGE; NO PRE-EXISTING
9 CONDITION LIMITS.—A health plan may not—

10 (1) terminate, restrict, or limit coverage for the
11 comprehensive benefit package in any portion of the
12 plan's service area, except as provided in this sec-
13 tion;

14 (2) cancel coverage for any community rate eli-
15 gible individual until that individual is enrolled in
16 another applicable health plan;

17 (3) exclude any eligible individual from coverage
18 because of existing medical conditions or genetic pre-
19 disposition to medical conditions;

20 (4) impose waiting periods before coverage be-
21 gins; or

22 (5) impose a rider that serves to exclude cov-
23 erage of particular eligible individuals.

24 (c) RENEWABILITY; LIMITATION ON TERMI-
25 NATION.—Coverage of eligible individuals, except as pro-

1 vided in this section, under a health plan in a health care
2 coverage area shall be renewed at the option of such eligi-
3 ble individuals, and coverage may not be terminated ex-
4 cept after notice and in accordance with subsection (g).

5 (d) CAPACITY LIMITATIONS.—

6 (1) IN GENERAL.—With the approval of the ap-
7 plicable regulatory authority, a health plan may limit
8 enrollment because of the plan’s capacity to deliver
9 services or to maintain financial stability. If such a
10 limitation is imposed, the limitation may not be im-
11 posed on a basis referred to in subsection (a).

12 (2) RESTRICTIONS.—If such a limitation is im-
13 posed—

14 (A) the plan may only enroll individuals
15 under the plan consistent with priorities estab-
16 lished by the State consistent with paragraph
17 (3); and

18 (B) the plan may not discriminate based
19 on the method through which a family seeks en-
20 rollment under the plan.

21 (3) STATE OVERSIGHT.—Each State shall, in
22 accordance with rules promulgated by the Board, es-
23 tablish procedures and methods to assure equal op-
24 portunity of enrollment for all families, regardless of

1 when during the open enrollment period or the
2 method by which the enrollment has been sought.

3 (e) TREATMENT OF NETWORK PLANS.—

4 (1) GEOGRAPHIC LIMITATIONS.—A health plan
5 which is a network plan as defined in section
6 1514(c)(4) may deny enrollment under the plan to
7 an eligible individual who is located outside a service
8 area of the plan, but only if such denial is applied
9 uniformly.

10 (2) SERVICE AREAS.—The State shall establish
11 standards, consistent with guidelines promulgated by
12 the Secretary, for the designation by network plans
13 of service areas in order to prevent discrimination in
14 violation of section 1914.

15 (f) TERMINATION OF PLANS.—A health plan may
16 elect not to renew or make available a health plan in a
17 health care coverage area, or not to utilize a particular
18 type of delivery system in a health care coverage area, but
19 only if the health plan—

20 (1) elects not to renew all of its health plans in
21 such health care coverage area or not to use the de-
22 livery system in such health care coverage area; and

23 (2) provides notice to the State and each indi-
24 vidual covered under the plan of such termination at

1 least 180 days before the date of expiration of either
2 the plan or use of the delivery system.

3 In such case, a health plan may not provide for the issu-
4 ance of any health plan in such health care coverage area,
5 or to utilize such delivery system in that health care cov-
6 erage area during a 5-year period beginning on the date
7 of the termination of the last plan not so renewed. For
8 purposes of this paragraph the term “delivery system”
9 means an open-network, closed network, or nonnetwork
10 health care delivery system.

11 **SEC. 1517. ADMINISTRATIVE PROVISIONS.**

12 (a) CAPABILITY.—Each health plan shall dem-
13 onstrate to the certifying authority the capability to ad-
14 minister the plan.

15 (b) UTILIZATION MANAGEMENT.—Each health plan
16 shall demonstrate to the certifying authority, through
17 written management procedures, an appropriate utiliza-
18 tion management process. The Secretary shall establish
19 guidelines under this subsection for utilization manage-
20 ment.

21 **SEC. 1518. INFORMATION REGARDING A PATIENT’S RIGHT**
22 **TO SELF-DETERMINATION IN HEALTH CARE**
23 **SERVICES.**

24 Each health plan shall provide written information to
25 each individual enrolling in such plan of such individual’s

1 right under State law (whether statutory or as recognized
2 by the courts of the State) to make decisions concerning
3 medical care, including the right to accept or refuse medi-
4 cal treatment and the right to formulate advance direc-
5 tives (as defined in section 1866(f)(3) of the Social Secu-
6 rity Act (42 U.S.C. 1395cc(f)(3))), and the written poli-
7 cies of the qualified health plan with respect to such right.

8 **SEC. 1519. RURAL AND MEDICALLY UNDERSERVED AREAS.**

9 (a) IN GENERAL.—If, in accordance with appropriate
10 rules established by the Secretary, a State determines that
11 there is inadequate access in the provision of health serv-
12 ices by health plans in any area of a State, the State may
13 authorize—

14 (1) a health plan to be the only health plan in
15 the area; or

16 (2) two or more health plans to take joint ac-
17 tion to develop and implement a program.

18 (b) MEDICALLY UNDERSERVED AREA DEFINED.—
19 For purposes of this subtitle the term “medically under-
20 served area” means an urban or rural area designated by
21 the Board as an area with a shortage of health profes-
22 sionals or of health services or facilities.

23 **SEC. 1520. PAYMENT ADJUSTMENTS.**

24 Each health plan shall participate in any risk adjust-
25 ment, reinsurance, or other premium adjustment program

1 implemented by the State in accordance with section 1641.
2 Provisions of this section concerning risk adjustment and
3 reinsurance shall not apply to health plans offered by large
4 group purchasers.

5 **SEC. 1521. PREEMPTION OF CERTAIN STATE LAWS RELAT-**
6 **ING TO HEALTH PLANS.**

7 (a) LAWS RESTRICTING PLANS OTHER THAN FEE-
8 FOR-SERVICE PLANS.—Except as may otherwise be pro-
9 vided in this section, no State law shall apply to any serv-
10 ices provided under a health plan that is not a fee-for-
11 service plan (or a fee-for-service component of a plan) if
12 such law has the effect of prohibiting or otherwise restrict-
13 ing plans from—

14 (1) limiting the number and type of health care
15 providers who participate in the plan;

16 (2) requiring enrollees to obtain health services
17 (other than emergency services) from participating
18 providers or from providers authorized by the plan;

19 (3) requiring enrollees to obtain a referral for
20 treatment by a specialized physician or health insti-
21 tution;

22 (4) establishing different payment rates for par-
23 ticipating providers and providers outside the plan;

24 (5) creating incentives to encourage the use of
25 participating providers; or

1 (6) requiring the use of single-source suppliers
2 for pharmacy, non-serviced medical equipment, and
3 other health products and services.

4 (b) PREEMPTION OF STATE CORPORATE PRACTICE
5 ACTS.—Any State law related to the corporate practice
6 of medicine and to provider ownership of health plans or
7 other providers shall not apply to arrangements between
8 health plans that are not fee-for-service plans and their
9 participating providers.

10 **SEC. 1522. CONTRACTS WITH CONSUMER PURCHASING CO-**
11 **OPERATIVES.**

12 (a) CONTRACTS WITH COOPERATIVES.—A certified
13 health plan provided by a carrier shall enter into contracts
14 with each cooperative in the designated service area served
15 by the plan seeking such a contract.

16 (b) PRICING.—No health plan shall offer a rate to
17 a cooperative that is more than the filed per-capita com-
18 munity rate (as described in section 6000(a)(1)).

19 **SEC. 1523. HEALTH PLAN ARRANGEMENTS WITH PROVID-**
20 **ERS.**

21 (a) PROVIDER VERIFICATION.—Plans shall ensure
22 that all health care providers reimbursed by the plan are
23 authorized under State law to provide applicable services.
24 Each health plan shall—

1 (1) verify the credentials of practitioners and
2 facilities;

3 (2) ensure that all providers participating in the
4 plan meet applicable State licensing and certification
5 standards;

6 (3) ensure that each health care provider par-
7 ticipating in the plan annually discloses information
8 regarding operations, ownership, finances, and
9 workforce necessary to evaluate the providers com-
10 pliance with this Act;

11 (4) oversee the quality and performance of par-
12 ticipating providers, consistent with section 1510;
13 and

14 (5) investigate and resolve consumer complaints
15 against participating providers.

16 (b) REQUIREMENTS FOR NONNETWORK PLANS.—

17 Each health plan must enter into such agreements or have
18 such other arrangements as may be necessary with an ap-
19 propriate mix, number, and distribution of qualified health
20 professionals to ensure the provision of all services covered
21 by the comprehensive benefit package to eligible individ-
22 uals enrolled in the plan.

23 (c) REQUIREMENTS FOR NETWORK PLANS.—A

24 health plan that requires coinsurance for an out-of-net-

1 work item or service shall comply with the following re-
2 quirements:

3 (1) AGREEMENTS.—Each health plan must
4 enter into such agreements or have such other ar-
5 rangements as may be necessary with an appropriate
6 mix, number, and distribution of qualified health
7 professionals to ensure the provision of all services
8 covered by the comprehensive benefit package to eli-
9 gible individuals enrolled in the plan.

10 (2) GATEKEEPER.—With respect to each health
11 plan that utilizes a gatekeeper or similar process to
12 approve health care services prior to or following the
13 provision of such services, such gatekeepers shall in-
14 clude specialists or a care coordinator from an inter-
15 disciplinary team if medically necessary or appro-
16 priate given the nature, severity, or complexity of
17 each patient’s chronic disease, disorder, or other
18 health condition.

19 (3) CONTINUED CARE.—Each health plan shall
20 develop a process to ensure the access of enrollees
21 to—

22 (A) obstetrician-gynecologists for medically
23 necessary or appropriate primary care without
24 gatekeeper approval prior to each visit, and

1 (B) relevant specialists for the continued
2 care of patient-enrollees with chronic diseases,
3 disorders, or health conditions without gate-
4 keeper approval prior to each visit, when the
5 continued care is medically indicated.

6 (4) ELIGIBLE CENTERS OF SPECIALIZED
7 TREATMENT EXPERTISE.—

8 (A) IN GENERAL.—Each health plan shall
9 provide access through agreements (as defined
10 in subparagraph (B)) to eligible centers of spe-
11 cialized treatment expertise (as defined in sub-
12 paragraphs (C) and (D)), including centers out-
13 side the health care coverage area or State, to
14 ensure that enrollees receive the specialized
15 treatment expertise of such centers when medi-
16 cally indicated. For children such specialized
17 treatment expertise shall specifically be in pedi-
18 atrics. A health plan shall be deemed to be in
19 accordance with this paragraph if the agree-
20 ment of such plan provides that, with respect to
21 health conditions within the specialized treat-
22 ment expertise of the center involved, the plan
23 will, at the enrollees request—

24 (i) refer medical cases involving such
25 conditions to such center;

1 (ii) inform plan members of the avail-
2 ability of referral care; and

3 (iii) establish an appeal mechanism in
4 which plan participants may challenge de-
5 nials of referrals to such center or may re-
6 quest that their specialized care be pro-
7 vided at an alternative center as described
8 in subparagraph (E).

9 (B) AGREEMENTS.—An agreement be-
10 tween a health plan and a center of specialized
11 treatment expertise shall—

12 (i) be a written provider participation
13 agreement with the center; or

14 (ii) be a written agreement under
15 which the plan shall make payment to the
16 center such that services provided will be
17 reimbursable at the plan's normal rate for
18 equivalent services or, with respect to a
19 plan that does not pay providers on a fee-
20 for-service basis, based on payment meth-
21 odologies and rates used under the applica-
22 ble methodology and rates or the most
23 closely applicable Medicare payment meth-
24 odologies under such program as the Sec-
25 retary may specify in regulations.

1 (C) SPECIALIZED TREATMENT EXPER-
2 TISE.—For purposes of this subtitle, the term
3 “specialized treatment expertise”, with respect
4 to the treatment of a health condition by an eli-
5 gible center, means expertise in diagnosing and
6 treating unusual diseases or conditions, diag-
7 nosing and treating diseases or conditions
8 which are unusually difficult to diagnose or
9 treat, and providing other specialized health
10 care.

11 (D) ELIGIBLE CENTERS.—Eligible centers
12 under this paragraph shall be designated to di-
13 agnose and provide care for patients with speci-
14 fied categories of conditions and diseases. Such
15 centers may include academic health centers
16 and teaching hospitals, and other designated
17 centers and systems of advanced care that meet
18 strict objective criteria established by the Sec-
19 retary including—

20 (i) specialized credentials for caring
21 for patients with the specified categories of
22 conditions and diseases;

23 (ii) staff with experience in caring for
24 a significant number of patients with the

1 specified categories of conditions and dis-
2 eases; and

3 (iii) excellent measured outcomes in
4 the diagnosis and treatment of patients
5 with the specified categories of conditions
6 and diseases.

7 (E) ACCESS TO ALTERNATIVE CENTERS.—

8 (i) IN GENERAL.—Patients in need of
9 specialized treatment expertise may re-
10 quest that specialized care be provided at
11 an alternative center. As used in this sub-
12 paragraph, the term “alternative center”
13 means a center of specialized treatment ex-
14 pertise with which the health plan of the
15 patient does not have a written agreement
16 as described in subparagraph (B). Plans
17 shall have a procedure for making deci-
18 sions regarding such requests and have an
19 appeals process for patients who are re-
20 fused coverage at an alternative center for
21 specialized treatment.

22 (ii) REIMBURSEMENT.—Care provided
23 at an alternative center shall be reim-
24 bursed by the health plan at the plan’s
25 normal rate for equivalent services or, with

1 respect to a plan that does not pay provid-
2 ers on a fee-for-service basis, based on pay-
3 ment methodologies and rates used under
4 the applicable methodology and rates or
5 the most closely applicable Medicare pay-
6 ment methodologies under such program
7 as the Secretary may specify in regula-
8 tions.

9 (F) LIMITATION.—A State may not estab-
10 lish rules or policies that require or encourage
11 health plans to give preference to centers of
12 specialized treatment expertise within the State
13 or within the health care coverage area. A
14 health plan shall not prohibit an academic
15 health center, teaching hospital, or other center
16 for specialized care with which it contracts from
17 contracting with one or more other plans.

18 (d) EMERGENCY AND URGENT CARE SERVICES.—

19 (1) IN GENERAL.—Each health plan must cover
20 emergency and urgent care services provided to en-
21 rollees, without regard to whether or not the pro-
22 vider furnishing such services has a contractual (or
23 other) arrangement with the plan to provide items or
24 services to enrollees of the plan and in the case of

1 emergency services without regard to prior author-
2 ization.

3 (2) PAYMENT AMOUNTS.—In the case of emer-
4 gency and urgent care provided to an enrollee out-
5 side of a health plan’s service area, the payment
6 amounts of the plan shall be based on the applicable
7 fee schedule described in subsection (e).

8 (e) APPLICATION OF FEE SCHEDULE.—

9 (1) IN GENERAL.—Subject to paragraphs (2)
10 and (3), each qualified health plan that provides for
11 payment for services on a fee-for-service basis and
12 has not established an agreement or contractual ar-
13 rangement with providers specifying a basis for pay-
14 ment shall make such payment to such providers
15 under a fee schedule established by the plan.

16 (2) RULE OF CONSTRUCTION.—Nothing in the
17 paragraph (1) shall be construed to prevent a health
18 plan from providing for a different basis or level of
19 payment than the fee schedule established under
20 such paragraph as part of a contractual agreement
21 with participating providers under the plan.

22 (3) REDUCTION FOR PROVIDERS VOLUNTARILY
23 REDUCING CHARGES.—If a provider under a health
24 plan voluntarily agrees to reduce the amount
25 charged to an individual enrolled under the plan, the

1 plan shall reduce the amount otherwise determined
2 under the fee schedule applicable under paragraph
3 (1) by the proportion of the reduction in such
4 amount charged.

5 (4) REDUCTION FOR NONCOMPLYING PLAN.—
6 Each community-rated health plan that is a non-
7 complying plan shall provide for reductions in pay-
8 ments under the fee schedule to providers that are
9 not participating providers in accordance with sec-
10 tion 6012(b).

11 (f) PROHIBITION AGAINST BALANCE BILLING; RE-
12 QUIREMENT OF DIRECT BILLING.—

13 (1) PROHIBITION OF BALANCE BILLING.—A
14 provider may not charge or collect from an enrollee
15 a fee in excess of the applicable payment amount
16 under the applicable fee schedule under subsection
17 (e), and the health plan and its enrollees are not le-
18 gally responsible for payment of any amount in ex-
19 cess of such applicable payment amount for items
20 and services covered under the comprehensive bene-
21 fits package.

22 (2) DIRECT BILLING.—

23 (A) IN GENERAL.—A provider may not
24 charge or collect from an enrollee amounts that
25 are payable by the health plan (including any

1 cost sharing reduction assistance payable by the
2 plan) and shall submit charges to such plan in
3 accordance with any applicable requirements of
4 subtitle B of title V (relating to health informa-
5 tion systems).

6 (B) PROHIBITION.—An individual or entity
7 that performs ancillary health services, such as
8 clinical laboratory services or other services as
9 defined by the Secretary, may not present or
10 cause to be presented, a claim, bill, or demand
11 for payment to any person other than the indi-
12 vidual receiving such services, or to the health
13 plan of the individual, except that the Secretary
14 may by regulation establish appropriate excep-
15 tions to the requirement of this subparagraph.

16 (3) COVERAGE UNDER AGREEMENTS WITH
17 PLANS.—The agreements or other arrangements en-
18 tered into under section 1514(c)(2) between a health
19 plan and the health care providers providing the
20 comprehensive benefit package to individuals en-
21 rolled with the plan shall prohibit a provider from
22 engaging in balance billing described in paragraph
23 (1).

24 (4) RULE OF CONSTRUCTION.—Nothing in this
25 Act shall be construed to—

1 (A) require or force an individual to re-
2 ceive health care solely through the individual's
3 health plan; or

4 (B) prohibit any individual from privately
5 contracting with any health care provider and
6 paying for the treatment or service provided by
7 such provider on a cash basis or any other basis
8 as agreed to between the individual and the
9 provider.

10 (g) IMPOSITION OF PARTICIPATING PROVIDER AS-
11 SESSMENT IN CASE OF A NONCOMPLYING PLAN.—Each
12 community-rated health plan shall provide that if the plan
13 is a noncomplying plan for a year under section 6012, pay-
14 ments to participating providers shall be reduced by the
15 applicable network reduction percentage under such sec-
16 tion.

17 (h) PROVIDERS OUTSIDE AREA.—A State may not
18 limit the ability of any plan to contract with a provider
19 of health services located outside of the geographic bound-
20 aries of a health care coverage area or the State, so long
21 as the provider is authorized under State law to provide
22 such services.

23 **SEC. 1524. HEALTH SECURITY CARDS.**

24 Each health plan shall issue a health security card
25 to each individual enrolled in such plan in accordance with

1 subtitle B of title V and regulations promulgated by the
2 Board.

3 **SEC. 1525. UTILIZATION MANAGEMENT PROTOCOLS AND**
4 **PHYSICIAN INCENTIVE PLANS.**

5 (a) **REQUIRING CONSUMER DISCLOSURE.**—Each
6 health plan shall disclose to enrollees (and prospective en-
7 rollees) and providers the protocols and financial incen-
8 tives used by the plan, including utilization management
9 protocols and physician incentive plans (as defined in sub-
10 section (b)), for controlling utilization and costs.

11 (b) **UTILIZATION MANAGEMENT.**—Each health plan
12 shall provide that all treatment assessment and placement
13 decisions, or review of such decisions, shall be made by
14 personnel—

15 (1) licensed, certified or otherwise credentialed
16 by the State in the field for which the assessment
17 or treatment is sought; and

18 (2) qualified to review utilization of the specific
19 treatment delivered.

20 (c) **PHYSICIAN INCENTIVE PLAN DEFINED.**—As used
21 in this section, the term “physician incentive plan” means
22 any compensation arrangement between a health plan, a
23 utilization management organization or other organization
24 and a physician or physician group that may directly or
25 indirectly have the effect of reducing or limiting services

1 provided with respect to individuals enrolled with the orga-
2 nization.

3 (d) LIMITATIONS ON PHYSICIAN INCENTIVE
4 PLANS.—A health plan, or any provider or group of pro-
5 viders with whom the health plan contracts, may not oper-
6 ate a physician incentive plan (as defined in subsection
7 (c)) unless the following requirements are complied with:

8 (1) The physician incentive plan provides that
9 no specific payment may be made directly or indi-
10 rectly under the plan to a physician or physician
11 group or utilization management organization as an
12 inducement to reduce or limit medically necessary or
13 appropriate services provided to individuals enrolled
14 with the organization.

15 (2) If the health plan places a physician or phy-
16 sician group at financial risk for services not pro-
17 vided by the physician or physician group, the physi-
18 cian incentive plan shall provide stop-loss protection
19 for the physician or physician group that is adequate
20 and appropriate, based on standards developed by
21 the Board that take into account the number of phy-
22 sicians placed at such financial risk in the group or
23 under the plan and the number of individuals en-
24 rolled with the organization who receive services
25 from the physician or the physician group.

1 (3) The health plan and any physician or physi-
2 cian group with whom the health plan contracts
3 shall provide the Board with descriptive information
4 regarding the physician incentive plan, sufficient to
5 permit the Board to determine whether the plan is
6 in compliance with the requirements of this sub-
7 section.

8 **PART 2—REQUIREMENTS RELATING TO**
9 **ESSENTIAL COMMUNITY PROVIDERS**

10 **SEC. 1531. HEALTH PLAN REQUIREMENT.**

11 (a) IN GENERAL.—Each health plan shall, with re-
12 spect to each electing essential community provider (as de-
13 fined in subsection (d), other than a provider of school
14 health services) located within the plan’s service area, ei-
15 ther—

16 (1) enter into a written provider participation
17 agreement (described in subsection (b)) with the
18 provider, or

19 (2) enter into a written agreement under which
20 the plan shall make payment to the provider in ac-
21 cordance with subsection (c).

22 (b) PARTICIPATION AGREEMENT.—A participation
23 agreement between a health plan and an electing essential
24 community provider under this subsection shall provide
25 that the health plan agrees to treat the provider in accord-

1 ance with terms and conditions at least as favorable as
2 those that are applicable to other providers participating
3 in the health plan with respect to each of the following:

4 (1) The scope of services for which payment is
5 made by the plan to the provider.

6 (2) The rate of payment for covered care and
7 services.

8 (3) The availability of financial incentives to
9 participating providers.

10 (4) Limitations on financial risk provided to
11 other participating providers.

12 (5) Assignment of enrollees to participating
13 providers.

14 (6) Access by the provider's patients to provid-
15 ers in medical specialties or subspecialties participat-
16 ing in the plan.

17 (c) PAYMENTS FOR PROVIDERS WITHOUT PARTICI-
18 PATION AGREEMENTS.—

19 (1) IN GENERAL.—Payment in accordance with
20 this subsection is payment based, as elected by the
21 electing essential community provider, either—

22 (A) on the fee schedule developed by the
23 State; or

24 (B) on payment methodologies and rates
25 used under the applicable Medicare payment

1 methodology and rates (or the most closely ap-
2 plicable methodology under such program as
3 the Secretary of Health and Human Services
4 specifies in regulations).

5 (2) SPECIAL RULE FOR FEDERALLY QUALIFIED
6 HEALTH CENTERS.—With respect to each federally
7 qualified health center (as such term is defined in
8 section 1861(aa) of the Social Security Act) that is
9 an essential community provider, a health plan shall
10 make payments based on the reasonable cost rates
11 applicable under section 1833(a)(3) of the Social Se-
12 curity Act, except that the federally qualified health
13 center may accept other payment amounts.

14 (3) NO APPLICATION OF GATE-KEEPER LIMITA-
15 TIONS.—Payment in accordance with this subsection
16 may be subject to utilization review, but may not be
17 subject to otherwise applicable gate-keeper require-
18 ments under the plan.

19 (d) ELECTION.—

20 (1) IN GENERAL.—In this part, the term “elect-
21 ing essential community provider” means, with re-
22 spect to a health plan, an essential community pro-
23 vider that elects this subpart to apply to the health
24 plan.

1 (2) FORM OF ELECTION.—An election under
2 this subsection shall be made in a form and manner
3 specified by the Secretary, and shall include notice
4 to the health plan involved. Such an election may be
5 made annually with respect to a health plan, except
6 that the plan and provider may agree to make such
7 an election on a more frequent basis.

8 (e) SPECIAL RULE FOR PROVIDERS OF SCHOOL
9 HEALTH SERVICES.—A health plan shall pay, to each pro-
10 vider of school health services located in the plan's service
11 area an amount determined by the Secretary for such
12 services furnished to enrollees of the plan.

13 **SEC. 1532. RECOMMENDATION ON CONTINUATION OF RE-**
14 **QUIREMENT.**

15 (a) STUDIES.—In order to prepare recommendations
16 under subsection (b), the Secretary shall conduct studies
17 regarding essential community providers, including studies
18 that assess—

19 (1) the definition of essential community pro-
20 vider,

21 (2) the sufficiency of the funding levels for pro-
22 viders, including the special rule for federally quali-
23 fied health centers under section 1531(c)(2), for
24 both covered and uncovered benefits under this Act,

1 (3) the effects of contracting requirements re-
2 relating to such providers on such providers, health
3 plans, and enrollees,

4 (4) the impact of the payment rules for such
5 providers, and

6 (5) the impact of national health reform on
7 such providers.

8 (b) RECOMMENDATIONS TO CONGRESS.—The Sec-
9 retary shall submit to Congress, by not later than March
10 1, 2001, specific recommendations respecting whether,
11 and to what extent, section 1531 should continue to apply
12 to some or all essential community providers. Such rec-
13 ommendations may include a description of the particular
14 types of such providers and circumstances under which
15 such section should continue to apply.

16 **Subtitle G—Federal** 17 **Responsibilities**

18 **PART 1—NATIONAL HEALTH BOARD**

19 **Subpart A—Establishment of National Health Board**

20 **SEC. 1601. CREATION OF NATIONAL HEALTH BOARD; MEM-** 21 **BERSHIP.**

22 (a) IN GENERAL.—There is hereby created in the Ex-
23 ecutive Branch a National Health Board.

1 (b) COMPOSITION.—The Board is composed of 9
2 members appointed by the President, by and with the ad-
3 vice and consent of the Senate.

4 (c) CHAIR.—The President shall designate one of the
5 members as chair. The chair serves a term concurrent
6 with that of the President. The chair may serve a maxi-
7 mum of 3 terms. The chair shall serve as the chief execu-
8 tive officer of the Board.

9 (d) TERMS.—

10 (1) IN GENERAL.—Except as provided in para-
11 graphs (2) and (4), the term of each member of the
12 Board, except the chair, is 4 years and begins when
13 the term of the predecessor of that member ends.

14 (2) INITIAL TERMS.—The initial terms of the
15 members of the Board (other than the chair) first
16 taking office after the date of the enactment of this
17 Act, shall expire as designated by the President,
18 three at the end of one year, three at the end of two
19 years, and three at the end of three years.

20 (3) REAPPOINTMENT.—A member (other than
21 the chair) may be reappointed for one additional
22 term.

23 (4) CONTINUATION IN OFFICE.—Upon the expi-
24 ration of a term of office, a member shall continue
25 to serve until a successor is appointed and qualified.

1 (e) VACANCIES.—

2 (1) IN GENERAL.—Whenever a vacancy shall
3 occur, other than by expiration of term, a successor
4 shall be appointed by the President, by and with the
5 consent of the Senate, to fill such vacancy, and is
6 appointed for the remainder of the term of the pred-
7 ecessor.

8 (2) NO IMPAIRMENT OF FUNCTION.—A vacancy
9 in the membership of the Board does not impair the
10 authority of the remaining members to exercise all
11 of the powers of the Board.

12 (3) ACTING CHAIR.—The Board may designate
13 a Member to act as chair during any period in which
14 there is no chair designated by the President.

15 (f) MEETINGS; QUORUM.—

16 (1) MEETINGS.—At meetings of the Board the
17 chair shall preside, and in the absence of the chair,
18 the Board shall elect a member to act as chair pro
19 tempore.

20 (2) QUORUM.—Four members of the Board
21 shall constitute a quorum thereof.

22 **SEC. 1602. QUALIFICATIONS OF BOARD MEMBERS.**

23 (a) CITIZENSHIP.—Each member of the Board shall
24 be a citizen of the United States.

1 (b) BASIS OF SELECTION.—Board members will be
2 selected on the basis of their experience and expertise in
3 relevant subjects, including the practice of medicine, nurs-
4 ing, or other clinical practices, health care financing and
5 delivery, state health systems, consumer protection, busi-
6 ness, law, and delivery of care to vulnerable populations,
7 including children, individuals with disabilities, and indi-
8 viduals in rural and urban underserved areas.

9 (c) EXCLUSIVE EMPLOYMENT.—During the term of
10 appointment, Board members shall serve as employees of
11 the Federal Government and shall hold no other employ-
12 ment.

13 (d) PROHIBITION OF CONFLICT OF INTEREST.—A
14 member of the Board may not have a pecuniary interest
15 in or hold an official relation to any health care plan,
16 health care provider, insurance company, pharmaceutical
17 company, medical equipment company, or other affected
18 industry. Before entering upon the duties as a member
19 of the Board, the member shall certify under oath compli-
20 ance with this requirement.

21 (e) POST-EMPLOYMENT RESTRICTIONS.—After leav-
22 ing the Board, former members are subject to post-em-
23 ployment restrictions applicable to comparable Federal
24 employees.

1 (f) COMPENSATION OF BOARD MEMBERS.—Each
2 member of the Board (other than the chair) shall receive
3 an annual salary at the annual rate payable from time
4 to time for level IV of the Executive Schedule. The chair
5 of the Board, during the period of service as chair, shall
6 receive an annual salary at the annual rate payable from
7 time to time for level III of the Executive Schedule.

8 **SEC. 1603. GENERAL DUTIES AND RESPONSIBILITIES.**

9 (a) COMPREHENSIVE BENEFIT PACKAGE.—

10 (1) INTERPRETATION.—The Board shall inter-
11 pret the comprehensive benefit package, adjust the
12 delivery of preventive services under section 1153,
13 and take such steps as may be necessary to assure
14 that the comprehensive benefit package is available
15 on a uniform national basis to all eligible individuals.

16 (2) FISCAL ANALYSIS BY NATIONAL HEALTH
17 BOARD.—

18 (A) IN GENERAL.—Not later than 6
19 months prior to the effective date of this Act,
20 the National Health Board, in cooperation with
21 the Congressional Budget Office, shall under-
22 take and conclude a fiscal analysis of—

23 (i) the cost of the comprehensive ben-
24 efits package under section 1101;

1 (ii) the ability of the health care sys-
2 tem's cost containment mechanisms, as de-
3 fined in this Act, to control health care
4 spending and Federal health expenditures
5 based on current economic projections; and

6 (iii) the impact of new health care fi-
7 nancial obligations under this Act on the
8 Federal budget deficit, in current economic
9 terms, and the source of any projected
10 spending increases, including those de-
11 scribed in clauses (i) and (ii), provider re-
12 imbursement rates, and administrative ex-
13 penses.

14 (B) SUBMISSION OR REPORT.—The Board
15 shall prepare and submit a preliminary analysis
16 under this paragraph not later than January 1,
17 1997, and submit a final report not later than
18 July 1, 1997, and July 1 of each year there-
19 after.

20 (C) REQUIREMENT OF REPORT.—In a re-
21 port submitted under this paragraph, the Board
22 shall specify the source and amount of any Fed-
23 eral budget deficit increases in order that Con-
24 gress may more adequately assess other sources
25 of funding or spending reductions that may be

1 appropriate to maintain the benefit package
2 without adjustments.

3 (D) REPORT.—Based on the fiscal analysis
4 contained in a report under this paragraph, if
5 the Board concludes that the Federal govern-
6 ment’s obligation to contribute to the health
7 care system (through the provision of subsidies
8 to employers and families) will result in pre-
9 viously unprojected increases in the Federal
10 budget deficit, the Board shall report and make
11 corrective recommendations to the President
12 and the Congress.

13 (3) REPORT AND RECOMMENDATIONS.—

14 (A) IN GENERAL.—If determined to be
15 necessary by the Board, in consultation with
16 the Congressional Budget Office, to prevent sig-
17 nificant Federal deficit increases attributable to
18 the provisions of this Act (or subsequent
19 amendments to this Act), the Board shall in-
20 clude in the reports under paragraph (2)(B),
21 adjustments in specific aspects of the com-
22 prehensive benefits package (such as scope of
23 benefits, co-payments, deductibles, and phase-
24 in’s for additional benefits) to achieve savings

1 consistent with the findings in a report under
2 paragraph (2).

3 (B) NO BOARD ADJUSTMENTS.—If the re-
4 port of the Board under paragraph (2) contains
5 no adjustments in the benefit package, the ben-
6 efit package described in section 1101 shall be-
7 come effective, except that the President may
8 take action under section 9100(e)(4) as the
9 President determines appropriate.

10 (C) BOARD ADJUSTMENTS.—If the report
11 of the Board under paragraph (2) contains ad-
12 justments in the benefit package, the adjust-
13 ments shall apply unless a joint resolution dis-
14 approving the adjustments is passed by Con-
15 gress within 45 legislative days of the date of
16 the submission of the report. The provisions of
17 section 6006(d) shall apply to Congressional
18 consideration of a joint resolution considered
19 under this paragraph.

20 (D) AUTHORITY OF PRESIDENT.—The re-
21 quirements of this section shall not be limited
22 in any way by section 9100(e)(4) or any other
23 provision of this Act.

24 (4) SCOPE OF RECOMMENDATIONS.—The
25 Board may make adjustments in the services covered

1 under the benefit package, including any periodicity
2 tables; copayment, deductible, and out-of-pocket re-
3 quirements; and phase-in schedules for additional
4 health benefits. The Board may not require co-pay-
5 ments for preventive health services, but may re-
6 classify services described in section 1101 as preven-
7 tive services.

8 (5) RECOMMENDATIONS.—The Board may rec-
9 ommend to the President and the Congress appro-
10 priate revisions to such package. Such recommenda-
11 tions may reflect changes in technology, health care
12 needs, health care costs, and methods of service de-
13 livery.

14 (b) ADMINISTRATION OF COST CONTAINMENT PRO-
15 VISIONS.—The Board shall oversee the cost containment
16 requirements of subtitle A of title VI and certify compli-
17 ance with such requirements.

18 (c) COVERAGE AND FAMILIES.—The Board shall de-
19 velop and implement standards relating to the eligibility
20 of individuals for coverage in applicable health plans under
21 subtitle A of title I and may provide such additional excep-
22 tions and special rules relating to the treatment of family
23 members under section 1012 as the Board finds appro-
24 priate.

1 (d) QUALITY MANAGEMENT AND IMPROVEMENT.—
2 The Board shall establish and have ultimate responsibility
3 for a performance-based system of quality management
4 and improvement as required by section 5001.

5 (e) INFORMATION SYSTEM AND INFORMATION RE-
6 LATED FUNCTIONS.—

7 (1) IN GENERAL.—The Board shall—

8 (A) develop and implement standards to
9 establish a national health information system
10 to measure quality as required by section 5101;

11 (B) provide model format and content re-
12 quirements for summary plan descriptions; and

13 (C) provide model format and content re-
14 quirements for comparative plan brochures
15 under section 1205.

16 (2) INFORMATION RELATED FUNCTIONS.—

17 (A) DESIGNATION.—The Board shall pro-
18 vide for the use of entities in the national
19 health data network to perform information re-
20 lated functions under this section with respect
21 to employers, States, contracting entities, and
22 consumer purchasing cooperatives.

23 (B) FUNCTIONS.—The functions referred
24 to in subparagraph (A) shall include—

- 1 (i) receipt of information submitted by
2 employers under section 1702,
3 (ii) from the information received,
4 transmittal to States, and
5 (iii) such other functions as the Board
6 specifies.

7 (f) PARTICIPATING STATE REQUIREMENTS.—Con-
8 sistent with the provisions of subtitle C, the Board shall—

- 9 (1) establish requirements for participating
10 States,
11 (2) monitor State compliance with those re-
12 quirements,
13 (3) provide technical assistance, and
14 in a manner that ensures access to the comprehensive ben-
15 efit package for all eligible individuals.

16 (g) DEVELOPMENT OF PREMIUM CLASS FACTORS.—
17 The Board shall establish premium class factors under
18 subpart D of this part.

19 (h) DEVELOPMENT OF REINSURANCE AND RISK-AD-
20 JUSTMENT METHODOLOGY.—The Board shall develop a
21 methodology for the reinsurance and risk-adjustment of
22 premium payments to community-rated health plans in ac-
23 cordance with subpart E of this part.

24 (i) FINANCIAL REQUIREMENTS.—The Board shall es-
25 tablish minimum capital requirements and requirements

1 for guaranty funds and financial reporting and auditing
2 standards under subpart F of this part.

3 (j) STANDARDS FOR HEALTH PLAN GRIEVANCE
4 PROCEDURES.—The Board shall establish standards for
5 health plan grievance procedures that are used by enroll-
6 ees in pursuing complaints.

7 (k) NATIONAL OPEN ENROLLMENT PERIODS.—The
8 Board shall specify those periods which shall include a na-
9 tional, uniform open enrollment period, in which eligible
10 individuals may change the applicable health plan in which
11 they enrolled.

12 (l) FIDUCIARY REQUIREMENTS.—The Board shall, in
13 consultation with the Secretary of Labor, develop and pro-
14 mulgate fiduciary requirements for the management of
15 funds by States, plans, cooperatives, and employers.

16 **SEC. 1604. ANNUAL REPORT.**

17 (a) IN GENERAL.—The Board shall prepare and send
18 to the President and Congress an annual report address-
19 ing the overall implementation of the new health care sys-
20 tem.

21 (b) MATTERS TO BE INCLUDED.—The Board shall
22 include in each annual report under this section the follow-
23 ing:

24 (1) Information on Federal and State imple-
25 mentation.

1 (2) Data related to quality improvement.

2 (3) Recommendations or changes in the admin-
3 istration, regulation and laws related to health care
4 and coverage.

5 (4) A full account of all actions taken during
6 the previous year.

7 **SEC. 1605. POWERS.**

8 (a) STAFF; CONTRACT AUTHORITY.—The Board
9 shall have authority, subject to the provisions of the civil-
10 service laws and chapter 51 and subchapter III of chapter
11 53 of title 5, United States Code, to appoint such officers
12 and employees as are necessary to carry out its functions.
13 To the extent provided in advance in appropriations Acts,
14 the Board may contract with any person (including an
15 agency of the Federal Government) for studies and analy-
16 sis as required to execute its functions. Any employee of
17 the Executive Branch may be detailed to the Board to as-
18 sist the Board in carrying out its duties.

19 (b) ESTABLISHMENT OF ADVISORY COMMITTEES.—
20 The Board may establish advisory committees, including
21 committees to advise the Board on the health care needs
22 of disadvantaged and vulnerable populations, including
23 children and individuals with physical, cognitive and other
24 mental disabilities.

1 (c) ACCESS TO INFORMATION.—The Board may se-
2 cure directly from any department or agency of the United
3 States information necessary to enable it to carry out its
4 functions, to the extent such information is otherwise
5 available to a department or agency of the United States.
6 Upon request of the chair, the head of that department
7 or agency shall furnish that information to the Board.

8 (d) DELEGATION OF AUTHORITY.—Except as other-
9 wise provided in this Act, the Board may delegate any
10 function to such officers and employees as the Board may
11 designate and may authorize such successive redelegations
12 of such functions with the Board as the Board deems to
13 be necessary or appropriate. No delegation of functions
14 by the Board shall relieve the Board of responsibility for
15 the administration of such functions.

16 (e) RULEMAKING.—The National Health Board is
17 authorized to establish such rules as may be necessary to
18 carry out this Act.

19 **SEC. 1606. FUNDING.**

20 (a) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to the Board such sums
22 as may be necessary for fiscal years 1994, 1995, 1996,
23 1997, and 1998.

24 (b) SUBMISSION OF BUDGET.—Under the procedures
25 of chapter 11 of title 31, United States Code, the budget

1 for the Board for a fiscal year shall be reviewed by the
2 Director of the Office of Management and Budget and
3 submitted to the Congress as part of the President's sub-
4 mission of the Budget of the United States for the fiscal
5 year.

6 **Subpart B—Responsibilities Relating to Review and**
7 **Approval of State Systems**

8 **SEC. 1611. FEDERAL REVIEW AND ACTION ON STATE SYS-**
9 **TEMS.**

10 (a) APPROVAL OF STATE SYSTEMS BY NATIONAL
11 BOARD.—

12 (1) IN GENERAL.—The National Health Board
13 shall approve a State health care system for which
14 a document is submitted under section 1200(b) un-
15 less the Board finds that the system (as set forth in
16 the document) does not (or will not) provide for the
17 State meeting the responsibilities for participating
18 States under this Act.

19 (2) REGULATIONS.—The Board shall issue reg-
20 ulations, not later than July 1, 1995, prescribing the
21 requirements for State health care systems under
22 subtitle C, except that in the case of a document
23 submitted under section 1200(b) before the date of
24 issuance of such regulations, the Board shall take

1 action on such document notwithstanding the fact
2 that such regulations have not been issued.

3 (3) NO APPROVAL PERMITTED FOR YEARS
4 PRIOR TO 1996.—The Board may not approve a
5 State health care system under this subpart for any
6 year prior to 1996.

7 (b) REVIEW OF COMPLETENESS OF DOCUMENTS.—

8 (1) IN GENERAL.—If a State submits a docu-
9 ment under subsection (a)(1), the Board shall notify
10 the State, not later than 7 working days after the
11 date of submission, whether or not the document is
12 complete and provides the Board with sufficient in-
13 formation to approve or disapprove the document.

14 (2) ADDITIONAL INFORMATION ON INCOMPLETE
15 DOCUMENT.—If the Board notifies a State that the
16 State's document is not complete, the State shall be
17 provided such additional period (not to exceed 45
18 days) as the Board may by regulation establish in
19 which to submit such additional information as the
20 Board may require. Not later than 7 working days
21 after the State submits the additional information,
22 the Board shall notify the State respecting the com-
23 pleteness of the document.

24 (c) ACTION ON COMPLETED DOCUMENTS.—

1 (1) IN GENERAL.—The Board shall make a de-
2 termination (and notify the State) on whether the
3 State’s document provides for implementation of a
4 State system that meets the applicable requirements
5 of subtitle C—

6 (A) in the case of a State that did not re-
7 quire the additional period described in sub-
8 section (b)(2) to file a complete document, not
9 later than 90 days after notifying a State under
10 subsection (b) that the State’s document is
11 complete, or

12 (B) in the case of a State that required the
13 additional period described in subsection (b)(2)
14 to file a complete document, not later than 90
15 days after notifying a State under subsection
16 (b) that the State’s document is complete.

17 (2) REVIEW OF COVERAGE AREA.—The Board
18 shall review State designation of health care cov-
19 erage area boundaries to determine whether such
20 boundaries comply with sections 1202 and 1914,
21 and in particular, the requirements of such sections
22 concerning non-discrimination in the establishment
23 of coverage area boundaries.

24 (3) PLANS DEEMED APPROVED.—If the Board
25 does not meet the applicable deadline for making a

1 determination and providing notice under paragraph
2 (1) with respect to a State's document, the Board
3 shall be deemed to have approved the State's docu-
4 ment for purposes of this Act.

5 (d) OPPORTUNITY TO RESPOND TO REJECTED DOC-
6 UMENT.—

7 (1) IN GENERAL.—If (within the applicable
8 deadline under subsection (c)(1)) the Board notifies
9 a State that its document does not provide for im-
10 plementation of a State system that meets the appli-
11 cable requirements of subtitle C, the Board shall
12 provide the State with a period of 30 days in which
13 to submit such additional information and assur-
14 ances as the Board may require.

15 (2) DEADLINE FOR RESPONSE.—Not later than
16 30 days after receiving such additional information
17 and assurances, the Board shall make a determina-
18 tion (and notify the State) on whether the State's
19 document provides for implementation of a State
20 system that meets the applicable requirements of
21 subtitle C.

22 (3) PLAN DEEMED APPROVED.—If the Board
23 does not meet the deadline established under para-
24 graph (2) with respect to a State, the Board shall

1 be deemed to have approved the State's document
2 for purposes of this Act.

3 (e) APPROVAL OF PREVIOUSLY TERMINATED
4 STATES.—If the Board has approved a State system
5 under this part for a year but subsequently terminated
6 the approval of the system under section 1612(b)(2), the
7 Board shall approve the system for a succeeding year if
8 the State—

9 (1) demonstrates to the satisfaction of the
10 Board that the failure that formed the basis for the
11 termination no longer exists, and

12 (2) provides reasonable assurances that the
13 types of actions (or inactions) which formed the
14 basis for such termination will not recur.

15 (f) REVISIONS TO STATE SYSTEM.—

16 (1) SUBMISSION.—A State may revise a system
17 approved for a year under this section, except that
18 such revision shall not take effect unless the State
19 has submitted to the Board a document describing
20 such revision and the Board has approved such revision.
21

22 (2) ACTIONS ON AMENDMENTS.—Not later than
23 60 days after a document is submitted under paragraph (1), the Board shall make a determination
24 (and notify the State) on whether the implementa-
25

1 tion of the State system, as proposed to be revised,
2 meets the applicable requirements of subtitle C. If
3 the Board fails to meet the requirement of the pre-
4 ceding sentence, the Board shall be deemed to have
5 approved the implementation of the State system as
6 proposed to be revised.

7 (3) REJECTION OF AMENDMENTS.—Subsection
8 (d) shall apply to an amendment submitted under
9 this subsection in the same manner as it applies to
10 a completed document submitted under subsection
11 (b).

12 (g) NOTIFICATION OF NON-PARTICIPATING
13 STATES.—If a State fails to submit a document for a
14 State system by the deadline referred to in section 1200,
15 or such a document is not approved under subsection (c),
16 the Board shall immediately notify the Secretary of Health
17 and Human Services of the State's failure for purposes
18 of applying subpart C in that State.

19 **SEC. 1612. FAILURE OF PARTICIPATING STATES TO MEET**
20 **CONDITIONS FOR COMPLIANCE.**

21 (a) IN GENERAL.—In the case of a participating
22 State, if the Board determines that the operation of the
23 State system under subtitle C fails to meet the applicable
24 requirements of this Act, sanctions shall apply against the
25 State in accordance with subsection (b).

1 (b) TYPE OF SANCTION APPLICABLE.—The sanctions
2 applicable under this part are as follows:

3 (1) If the Board determines that the State's
4 failure does not substantially jeopardize the ability
5 of eligible individuals in the State to obtain coverage
6 for the comprehensive benefit package the Board
7 shall notify the Secretary who shall reduce payment
8 with respect to the State in accordance with section
9 1613.

10 (2) If the Board determines that the failure
11 substantially jeopardizes the ability of eligible indi-
12 viduals in the State to obtain coverage for the com-
13 prehensive benefit package—

14 (A) the Board shall terminate its approval
15 of the State system; and

16 (B) the Board shall notify the Secretary of
17 Health and Human Services, who shall assume
18 the responsibilities described in section 1622.

19 (c) TERMINATION OF SANCTION.—

20 (1) COMPLIANCE BY STATE.—A State against
21 which a sanction is imposed may submit information
22 at any time to the Board to demonstrate that the
23 failure that led to the imposition of the sanction has
24 been corrected.

1 (2) TERMINATION OF SANCTION.—If the Board
2 determines that the failure that led to the imposition
3 of a sanction has been corrected in the case of the
4 sanction described in subsection (b)(1)(A), the
5 Board shall notify the Secretary of Health and
6 Human Services.

7 (d) PROTECTION OF ACCESS TO BENEFITS.—The
8 Board and the Secretary of Health and Human Services
9 shall exercise authority to take actions under this section
10 with respect to a State only in a manner that assures the
11 continuous coverage of eligible individuals enrolled in com-
12 munity-rated health plans.

13 **SEC. 1613. REDUCTION IN PAYMENTS FOR HEALTH PRO-**
14 **GRAMS BY SECRETARY OF HEALTH AND**
15 **HUMAN SERVICES.**

16 (a) IN GENERAL.—Upon receiving notice from the
17 Board under section 1612(b)(1)(B), the Secretary of
18 Health and Human Services shall reduce the amount of
19 any of the payments described in subsection (b) that would
20 otherwise be made to individuals and entities in the State
21 by such amount as the Secretary determines to be appro-
22 priate.

23 (b) PAYMENTS DESCRIBED.—The payments de-
24 scribed in this subsection are as follows:

1 (1) Payments to academic health centers in the
2 State under subtitle B of title III.

3 (2) Payments to individuals and entities in the
4 State for health research activities under section 301
5 and title IV of the Public Health Service Act.

6 (3) Payments to hospitals in the State under
7 part 4 of subtitle E of title III (relating to payments
8 to hospitals serving vulnerable populations)

9 **SEC. 1614. REVIEW OF FEDERAL DETERMINATIONS.**

10 Any State affected by a determination by the Board
11 under this subpart may appeal such determination in ac-
12 cordance with section 5231.

13 **SEC. 1615. FEDERAL SUPPORT FOR STATE IMPLEMENTA-**
14 **TION.**

15 (a) PLANNING GRANTS.—

16 (1) IN GENERAL.—Not later than 90 days after
17 the date of the enactment of this Act, the Secretary
18 shall make available to each State a planning grant
19 to assist a State in the development of a health care
20 system to become a participating State under sub-
21 title C.

22 (2) FORMULA.—The Secretary shall establish a
23 formula for the distribution of funds made available
24 under this subsection.

1 (3) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated
3 \$50,000,000 in each of fiscal years 1995 and 1996
4 for grants under this subsection.

5 (b) GRANTS FOR START-UP SUPPORT.—

6 (1) IN GENERAL.—The Secretary shall make
7 available to States, upon their enacting enabling leg-
8 islation to become participating States, grants to as-
9 sist in the establishment of consumer purchasing co-
10 operatives.

11 (2) FORMULA.—The Secretary shall establish a
12 formula for the distribution of funds made available
13 under this subsection.

14 (3) STATE MATCHING FUNDS REQUIRED.—
15 Funds are payable to a State under this subsection
16 only if the State provides assurances, satisfactory to
17 the Secretary, that amounts of State funds (at least
18 equal to the amount made available under this sub-
19 section) are expended for the purposes described in
20 paragraph (1).

21 (4) AUTHORIZATION OF APPROPRIATIONS.—

22 There are authorized to be appropriated
23 \$313,000,000 for fiscal year 1996, \$625,000,000 for
24 fiscal year 1997, and \$313,000,000 for fiscal year
25 1998 for grants under this subsection.

1 Secretary shall take such steps as are necessary to ensure
2 that the comprehensive benefit package is provided to eli-
3 gible individuals in the State during the year.

4 (c) ESTABLISHMENT OF GUARANTY FUND.—

5 (1) ESTABLISHMENT.—The Secretary must en-
6 sure that there is a guaranty fund that meets the re-
7 quirements established by the Board under section
8 1652, in order to provide financial protection to
9 health care providers and others in the case of a fail-
10 ure of a community-rated health plan under a health
11 care system established and operated by the Sec-
12 retary under this section.

13 (2) ASSESSMENTS TO PROVIDE GUARANTY
14 FUNDS.—In the case of a failure of one or more
15 community-rated health plans, the Secretary may re-
16 quire each community-rated health plan to pay an
17 assessment to the Secretary in an amount not to ex-
18 ceed 2 percent of the premiums of such plans paid
19 by or on behalf of community rate eligible individ-
20 uals during a year for so long as necessary to gen-
21 erate sufficient revenue to cover any outstanding
22 claims against the failed plan.

1 **SEC. 1623. IMPOSITION OF SURCHARGE ON PREMIUMS**
2 **UNDER FEDERALLY-OPERATED SYSTEM.**

3 (a) IN GENERAL.—If this subpart applies to a State
4 for a calendar year, the premiums charged by community-
5 rated health plans in the State shall be equal to premiums
6 that would otherwise be charged, increased by 15 percent.
7 Such 15 percent increase shall be used to reimburse the
8 Secretary for any administrative or other expenses in-
9 curred as a result of establishing and operating the sys-
10 tem.

11 (b) TREATMENT OF SURCHARGE AS PART OF PRE-
12 MIUM.—For purposes of determining the compliance of a
13 State for which this subpart applies in a year with the
14 requirements for budgeting under subtitle A of title VI
15 for the year, the 15 percent increase described in sub-
16 section (a) shall be treated as part of the premium for
17 payment to a State.

18 **SEC. 1624. RETURN TO STATE OPERATION.**

19 (a) APPLICATION PROCESS.—After the establishment
20 and operation of a system by the Secretary in a State
21 under section 1622, the State may at any time apply to
22 the Board for the approval of a State system in accord-
23 ance with the procedures described in section 1611.

24 (b) TIMING.—If the Board approves the system of a
25 State for which the Secretary has operated during a year,
26 the Secretary shall terminate the operation of the system,

1 **Subpart E—Risk Adjustment and Reinsurance**

2 **Methodology for Payment of Plans**

3 **SEC. 1641. DEVELOPMENT OF A RISK ADJUSTMENT AND RE-**
4 **INSURANCE METHODOLOGY.**

5 (a) DEVELOPMENT.—

6 (1) INITIAL DEVELOPMENT.—Not later than
7 April 1, 1995, the Board shall develop a risk adjust-
8 ment and reinsurance methodology in accordance
9 with this subpart.

10 (2) IMPROVEMENTS.—The Board shall make
11 such improvements in such methodology as may be
12 appropriate to achieve the purposes described in sub-
13 section (b)(1).

14 (b) RISK ADJUSTMENT METHODOLOGY.—

15 (1) PURPOSES.—Such risk adjustment meth-
16 odology shall provide for the adjustment of payments
17 to community-rated health plans for the purposes
18 of—

19 (A) assuring that payments to such plans
20 reflect the expected relative utilization and ex-
21 penditures for such services by each plan's en-
22 rollees compared to the average utilization and
23 expenditures for community rate eligible indi-
24 viduals, and

25 (B) protecting health plans that enroll a
26 disproportionate share of community rate eligi-

1 ble individuals with respect to whom expected
2 utilization of health care services (included in
3 the comprehensive benefit package) and ex-
4 pected health care expenditures for such serv-
5 ices are greater than the average level of such
6 utilization and expenditures for community rate
7 eligible individuals.

8 (2) FACTORS TO BE CONSIDERED.—In develop-
9 ing such risk adjustment methodology, the Board
10 shall take into account the following factors:

11 (A) Demographic characteristics.

12 (B) Health status, including prior use of
13 health services.

14 (C) Geographic area of residence.

15 (D) Socio-economic status.

16 (E) Subject to paragraph (5), (i) the pro-
17 portion of enrollees who are SSI recipients and
18 (ii) the proportion of enrollees who are AFDC
19 recipients.

20 (F) Any other factors determined by the
21 Board to be material to the purposes described
22 in paragraph (1).

23 (3) ZERO SUM.—The risk adjustment methodol-
24 ogy shall assure that the total payments to health
25 plans after application of the methodology are the

1 same as the amount of payments that would have
2 been made without application of the methodology.

3 (4) TREATMENT OF SSI/AFDC ADJUSTMENT.—
4 The Board is not required to apply the factor de-
5 scribed in clause (i) or (ii) of paragraph (2)(E) if
6 the Board determines that the application of the
7 other risk adjustment factors described in paragraph
8 (2) is sufficient to adjust premiums to take into ac-
9 count the enrollment in plans of AFDC recipients
10 and SSI recipients.

11 (5) SPECIAL CONSIDERATION FOR MENTAL ILL-
12 NESS AND MENTAL RETARDATION.—In developing
13 the methodology under this section, the Board shall
14 give consideration to the unique problems of adjust-
15 ing payments to health plans with respect to individ-
16 uals with mental illness and mental retardation.

17 (6) SPECIAL CONSIDERATION FOR VETERANS,
18 MILITARY, AND INDIAN HEALTH PLANS.—In devel-
19 oping the methodology under this section, the Board
20 shall give consideration to the special enrollment and
21 funding provisions relating to plans described in sec-
22 tion 1004(b).

23 (7) ADJUSTMENT TO ACCOUNT FOR USE OF ES-
24 TIMATES.—If the total payments made to all com-
25 munity-rated health plans in a year under section

1 1239 exceeds, or is less than, the total of such pay-
2 ments estimated by the State in the application of
3 the methodology under this subsection, because of a
4 difference between—

5 (A) the State's estimate of the distribution
6 of enrolled families in different risk categories
7 (assumed in the application of risk factors
8 under this subsection in making payments to
9 community-rated health plans), and

10 (B) the actual distribution of such enrolled
11 families in such categories,

12 the methodology under this subsection shall provide
13 for an adjustment in the application of such meth-
14 odology in the second succeeding year in a manner
15 that would reduce, or increase, respectively, by the
16 amount of such excess (or deficit) the total of such
17 payments made to all such plans.

18 (c) MANDATORY REINSURANCE.—

19 (1) IN GENERAL.—The methodology developed
20 under this section shall include a system of manda-
21 tory reinsurance as a component of the risk adjust-
22 ment methodology.

23 (2) REQUIREMENT IN CERTAIN CASES.—The
24 Board shall reduce or eliminate such a system of re-
25 insurance at such time as the Board determines that

1 an adequate prospective payment adjustment for
2 health status has been developed and is ready for
3 implementation.

4 (3) REINSURANCE SYSTEM.—The Board, in de-
5 veloping the methodology for a mandatory reinsur-
6 ance system under this subsection, shall—

7 (A) provide for health plans to make pay-
8 ments to state-established reinsurance programs
9 for the purpose of eliminating incentives for
10 plans to discriminate against individuals on the
11 basis of their expected utilization of health serv-
12 ices; and

13 (B) specify the manner of creation, struc-
14 ture, and operation of the system in each State,
15 including—

16 (i) the manner (which may be pro-
17 spective or retrospective) in which health
18 plans make payments to the system, and

19 (ii) the type and level of reinsurance
20 coverage provided by the system.

21 (d) CONFIDENTIALITY OF INFORMATION.—The
22 methodology shall be developed in a manner consistent
23 with privacy standards promulgated under section
24 5120(a). In developing such standards, the Board shall
25 take into account any potential need of States for certain

1 individually identifiable health information in order to
2 carry out risk-adjustment and reinsurance activities under
3 this Act, but only to the minimum extent necessary to
4 carry out such activities and with protections provided to
5 minimize the identification of the individuals to whom the
6 information relates.

7 (e) STATE EXPERIMENTATION.—The Board is au-
8 thorized to undertake experimentation with alternative re-
9 insurance and risk adjustments methods in one or more
10 different States, with the approval of the States adopting
11 such experiments, to determine the most appropriate
12 method to be used on a national basis.

13 (f) STATE-SPECIFIC ADJUSTERS.—States may, with
14 the approval of the Board, add such risk adjusters to the
15 national risk adjustment and reinsurance methodology
16 that reflect State specific patters of disease or population
17 characteristics.

18 **SEC. 1642. INCENTIVES TO ENROLL DISADVANTAGED**
19 **GROUPS.**

20 The Board shall establish standards under which
21 States may provide (under section 1203) for an additional
22 adjustment in the risk-adjustment methodology developed
23 under section 1641 in order to provide a financial incen-
24 tive for community-rated health plans to enroll individuals

1 who are members of disadvantaged groups or populations
2 vulnerable to discrimination due to their health status.

3 **SEC. 1643. RESEARCH AND DEMONSTRATIONS.**

4 The Secretary shall conduct and support research
5 and demonstration projects to develop and improve, on a
6 continuing basis, the risk adjustment and reinsurance
7 methodology under this subpart.

8 **SEC. 1644. TECHNICAL ASSISTANCE TO STATES.**

9 The Board shall provide technical assistance to
10 States in implementing the methodology developed under
11 this subpart.

12 **Subpart F—Responsibilities for Financial**
13 **Requirements**

14 **SEC. 1651. CAPITAL STANDARDS FOR COMMUNITY-RATED**
15 **PLANS.**

16 (a) IN GENERAL.—The Board shall establish, in con-
17 sultation with the States, minimum capital requirements
18 for carriers, for purposes of section 1512.

19 (b) \$500,000 MINIMUM.—Subject to subsection (c),
20 under such requirements there shall be not less than
21 \$500,000 of capital maintained for each carrier.

22 (c) ADDITIONAL CAPITAL REQUIREMENTS.—The
23 Board shall establish standards that provide for additional
24 capital. The amount of such additional capital required

1 shall reflect factors likely to affect the financial stability
2 of a carrier, including the following:

3 (1) Projected plan enrollment and number of
4 providers participating in plans of the carrier.

5 (2) Market share and strength of competition.

6 (3) Extent and nature of risk-sharing with par-
7 ticipating providers and the financial stability of
8 risk-sharing providers.

9 (4) Prior performance of the carrier, risk his-
10 tory, and liquidity of assets.

11 (d) COMMUNITY- AND PROVIDER-BASED PLANS.—

12 (1) IN GENERAL.—States shall consider alter-
13 native financial instruments and methods for
14 community- and provider-based plans (as defined in
15 paragraph (2)) to meet the capital and solvency
16 standards developed in accordance with this section.
17 Provisions made for such plans shall ensure the fis-
18 cal integrity and financial solvency of such plans.

19 (2) ELIGIBLE PLANS.—Plans eligible for special
20 consideration by States must be public or not-for-
21 profit entities that are owned, or in which a majority
22 share of the plan's investment is held by—

23 (A) health care providers who practice in
24 the plan;

1 (B) individuals who live in the area, or
2 not-for-profit organizations located in the area
3 serviced by the plan;

4 (C) a combination of individuals and orga-
5 nizations described in subparagraphs (A) and
6 (B); or

7 (D) organizations located outside the serv-
8 ice area which provide for control over local op-
9 erations by individuals described in subpara-
10 graphs (A) or (B).

11 (e) DEVELOPMENT OF STANDARDS BY NAIC.—The
12 Board may request the National Association of Insurance
13 Commissioners to develop model standards for the addi-
14 tional capital requirements described in subsection (c) and
15 to present such standards to the Board not later than July
16 1, 1995. The Board may accept such standards as the
17 standards to be applied under subsection (c) or modify the
18 standards in any manner it finds appropriate.

19 **SEC. 1652. STANDARD FOR GUARANTY FUNDS.**

20 (a) IN GENERAL.—In consultation with the States,
21 the Board shall establish standards for guaranty funds es-
22 tablished by States.

23 (b) GUARANTY FUND STANDARDS.—The standards
24 established under subsection (a) for a guaranty fund shall
25 include the following:

1 (1) Each fund must have a method to generate
2 sufficient resources to pay health providers and oth-
3 ers in the case of a failure of a health plan in order
4 to meet obligations with respect to—

5 (A) services rendered by the health plan
6 for the comprehensive benefit package, includ-
7 ing any supplemental coverage for cost sharing
8 provided by the health plan, and

9 (B) services rendered prior to health plan
10 insolvency and services to patients after the in-
11 solvency but prior to their enrollment in other
12 health plans.

13 (2) The fund is liable for all claims against the
14 plan by health care providers with respect to their
15 provision of items and services covered under the
16 comprehensive benefit package to enrollees of the
17 failed plan. Such claims, in full, shall take priority
18 over all other claims. The fund also is liable, to the
19 extent and in the manner provided in accordance
20 with rules established by the Board, for other
21 claims, including other claims of such providers and
22 the claims of contractors, employees, governments,
23 or any other claimants.

1 (3) The fund stands as a creditor for any pay-
2 ments owed the plan to the extent of the payments
3 made by the fund for obligations of the plan.

4 (4) The fund has authority to borrow against
5 future assessments in order to meet the obligations
6 of failed plans participating in the fund.

7 **Subpart G—Open Enrollment**

8 **SEC. 1660. PERIODS OF AUTHORIZED CHANGES IN ENROLL-**
9 **MENT.**

10 (a) ANNUAL OPEN ENROLLMENT PERIOD.—

11 (1) IN GENERAL.—For purposes of section
12 1211 and section 1502(a)(1), in order to encourage
13 periodic family choice in the selection of health
14 plans, the National Health Board shall specify a
15 uniform, national annual open enrollment period
16 during which all eligible individuals are permitted
17 the opportunity to change enrollment among the
18 health plans offered to them under this Act.

19 (2) EFFECTIVENESS OF CHANGE OF ENROLL-
20 MENT.—Except as the National Health Board may
21 provide, changes in enrollment during an annual
22 open enrollment period under paragraph (1) shall
23 take effect as of the first date of the following year.

1 (b) ADDITIONAL PERIODS OF AUTHORIZED
2 CHANGES IN ENROLLMENT.—The National Health Board
3 also shall specify—

4 (1) such other periods and occurrences (includ-
5 ing the insolvency of carriers or large group pur-
6 chasers, changes in residence, and appropriate
7 changes in employment) for which an individual is
8 authorized to change enrollment in health plans, and

9 (2) when such change of enrollment becomes ef-
10 fective.

11 (c) DIRECT ENROLLMENT.—

12 (1) IN GENERAL.—The Board shall establish
13 methods and procedures for the direct enrollment of
14 individuals in the health plans of their choice.

15 (2) ENROLLMENT PROCESSES.—The Board
16 shall provide standards for State to ensure the broad
17 availability of enrollment forms, including direct en-
18 rollment through the mail, and other such processes
19 as the Board may designate.

20 (3) NO MARKETING FEE.—Individuals enrolling
21 in plans through the processes described in para-
22 graph (2) shall be eligible for the community-rated
23 premium (described in section 6000) filed by the
24 health plan selected by the individual, without incur-
25 ring a marketing fee, a surcharge or any other pay-

1 ment that represents an addition to the community-
2 rated premium, whether such charge is imposed by
3 the health plan, an agent of the plan, or any other
4 entity.

5 (d) DISENROLLMENT FOR CAUSE.—

6 (1) IN GENERAL.—In addition to the annual
7 open enrollment period held under subsection (a),
8 the Board shall establish procedures by which eligi-
9 ble individuals enrolled in a plan may disenroll from
10 the plan for good cause (as defined by Board) at any
11 time during a year and enroll in another plan. Such
12 procedures shall be implemented by participating
13 States in a manner that ensures continuity of cov-
14 erage for the comprehensive benefit package for such
15 individuals during the year.

16 (2) DISENROLLMENT FOR CAUSE.—

17 (A) IN GENERAL.—In addition to the peri-
18 ods of authorized change in enrollment under
19 paragraph (1), the National Health Board shall
20 define good cause and establish procedures
21 under which eligible individuals enrolled in a
22 health plan provided by a carrier may disenroll
23 from the plan for good cause at any time dur-
24 ing a year and enroll in another applicable
25 health plan.

1 (B) ASSURING CONTINUITY OF COV-
2 ERAGE.—The procedures under this paragraph
3 shall be implemented in a manner that ensures
4 continuity of coverage for the comprehensive
5 benefit package for individuals changing enroll-
6 ment during the year.

7 (C) ADDITIONAL REMEDIES.—The Board
8 may provide rules under which an individual
9 who changes enrollment from a plan for good
10 cause due to a pattern of underservice under a
11 plan, the carrier providing the health plan is
12 liable, to the subsequent health plan in which
13 the individual is enrolled, for excess costs (as
14 identified in accordance with such rules) during
15 a reasonable period of the anticipated duration
16 of enrollment with the original health plan.

17 (e) CHANGE OF ENROLLMENT.—In this section and
18 subtitle E, the term “change of enrollment” includes, with
19 respect to an individual—

20 (1) a change in the health plan in which the in-
21 dividual is enrolled,

22 (2) a change in the type of family enrollment,
23 and

24 (3) the enrollment of the individual at the time
25 the individual first becomes an eligible individual.

1 (f) PROVIDER-BASED ENROLLMENT MECHANISMS.—

2 The Board shall promulgate rules regarding the establish-
3 ment by States of provider-based enrollment mechanisms
4 for individuals seeking care who are not enrolled in a
5 health plan. Such rules shall include provisions requiring
6 health plans to pay providers for care delivered to individ-
7 uals prior to the individual's enrollment in the plan.

8 (g) COORDINATION OF ENROLLMENT ACTIVITIES.—

9 Each State shall coordinate its activities, including plan
10 enrollment and disenrollment activities, with other States
11 in a manner specified by the National Health Board that
12 ensures continuous, nonduplicative coverage of commu-
13 nity-rated and experience-rated individuals in health plans
14 and that minimizes administrative procedures and paper-
15 work.

16 **SEC. 1661. DISTRIBUTION OF COMPARATIVE INFORMATION.**

17 The Board shall specify a period of time prior to open
18 enrollment during which States must provide for the dis-
19 tribution to community-rate eligible individuals enrollment
20 materials and comparative information on health plans.

1 **PART 2—RESPONSIBILITIES OF DEPARTMENT OF**
2 **HEALTH AND HUMAN SERVICES**
3 **Subpart A—General Responsibilities**

4 **SEC. 1671. GENERAL RESPONSIBILITIES OF SECRETARY OF**
5 **HEALTH AND HUMAN SERVICES.**

6 (a) IN GENERAL.—Except as otherwise specifically
7 provided under this Act (or with respect to administration
8 of provisions in the Internal Revenue Code of 1986 or in
9 the Employee Retirement Income Security Act of 1974),
10 the Secretary of Health and Human Services shall admin-
11 ister and implement all of the provisions of this Act, except
12 those duties delegated to the National Health Board, any
13 other executive agency, or to any State.

14 (b) FINANCIAL MANAGEMENT STANDARDS.—The
15 Secretary, in consultation with the Secretaries of Labor
16 and the Treasury, shall establish, for purposes of section
17 1512, standards relating to the management of finances,
18 maintenance of records, accounting practices, auditing
19 procedures, and financial reporting for States, consumer
20 purchasing cooperatives and health plans. Such standards
21 shall take into account current Federal laws and regula-
22 tions relating to fiduciary responsibilities and financial
23 management of funds.

24 (c) AUDITING STATE PERFORMANCE.—The Sec-
25 retary shall perform periodic financial and other audits of
26 States to assure that such States are carrying out their

1 responsibilities under this Act consistent with this Act.
2 Such audits shall include audits of State performance in
3 the areas of—

4 (1) assuring enrollment of all community rate
5 eligible individuals in health plans,

6 (2) management of premium and cost sharing
7 discounts and reductions provided;

8 (3) financial management (including the finan-
9 cial activities of cooperatives and State-designated
10 contracting entities); and

11 (4) assuring enforcement of the antidiscrimina-
12 tion provisions of this Act.

13 (d) STANDARDS FOR UTILIZATION MANAGEMENT
14 PROGRAMS.—

15 (1) IN GENERAL.—Not later than 12 months
16 after the date of enactment of this Act, the Sec-
17 retary, in consultation with interested parties which
18 may include one or more accrediting organizations,
19 shall promulgate uniform Federal standards for uti-
20 lization management programs, to include the activi-
21 ties described in section 1210(b).

22 (2) COMPLIANCE.—States shall ensure compli-
23 ance with the Federal standards established under
24 paragraph (1), consistent with their role in certify-
25 ing health plans.

1 (3) REVIEW AND UPDATE.—The Secretary shall
2 periodically review and update utilization manage-
3 ment standards to reflect appropriate policies and
4 practices in health care delivery.

5 **SEC. 1672. MEDICAL TECHNOLOGY IMPACT STUDY.**

6 (a) ASSESSMENT OF THE COMPREHENSIVE IMPACT
7 OF MEDICAL TECHNOLOGIES.—

8 (1) IN GENERAL.—The Secretary, acting
9 through the Administrator of the Agency for Health
10 Care Policy and Research (hereafter referred to in
11 this section as the “Administrator”), shall undertake
12 an interdisciplinary study (to be known as the “Med-
13 ical Technology Impact Study”) to assess the overall
14 economic costs, economic benefits, and effect on pa-
15 tient outcomes of medical technologies used in treat-
16 ing each of a list of target diseases and conditions.
17 The Secretary shall submit the report of the Admin-
18 istrator to Congress (in accordance with subsection
19 (c)) concerning the results of the study and may
20 provide any recommendations determined to be nec-
21 essary to ensure the availability, access, and appro-
22 priate use of medical technologies to improve the
23 quality of health care in the United States.

24 (2) PURPOSE.—The purpose of the study under
25 paragraph (1) is to assess the impact of old, new

1 and emerging medical technologies on health care
2 costs, social costs, and patient outcomes, and to
3 identify the factors, including government and pri-
4 vate payor reimbursement policies, that impede or
5 encourage innovation that improves patient out-
6 comes. Congress intends that the study complement
7 the technology assessment, outcomes research, and
8 guideline development activities authorized under
9 title IX of the Public Health Service Act by provid-
10 ing a comprehensive context for understanding the
11 economic and social factors related to the develop-
12 ment and use of medical technologies.

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

14 (A) ECONOMIC BENEFITS.—The term eco-
15 nomic benefits may include, based on available
16 data—

17 (i) reductions in the economic costs of
18 disease;

19 (ii) increases in employment attrib-
20 utable to the medical technology industry;

21 (iii) increases in Federal and State
22 tax revenues attributable to the medical
23 technology industry and its employees;

1 (iv) improvements in the balance of
2 trade deficit attributable to the medical
3 technology industry; and

4 (v) other benefits that are determined
5 by the Advisory Committee to be relevant
6 to assessing the impact of medical tech-
7 nology.

8 (B) ECONOMIC COSTS.—The term “eco-
9 nomic costs” may include, based on available
10 data—

11 (i) the financial costs to the health
12 care system of diagnosing and treating dis-
13 ease, including the costs of nontreatment
14 and palliative care;

15 (ii) the financial costs to employers
16 resulting from worker illness, including the
17 costs of productivity losses and worker ab-
18 senteeism;

19 (iii) the financial costs to families re-
20 sulting from illness of a family member, in-
21 cluding costs associated with loss of in-
22 come, hiring of caretakers, and long term
23 and hospice care;

24 (iv) the financial costs to government
25 of illness, including reductions in income

1 tax revenues attributable to worker illness
2 and worker related injuries and increases
3 in transfer payments, including unemploy-
4 ment, disability, welfare, and survivor ben-
5 efit payments, made to individuals and
6 families on account of illness; and

7 (v) other costs that are determined by
8 the Advisory Committee to be relevant to
9 assessing the impact of medical technology.

10 (C) PATIENT OUTCOMES.—The term “pa-
11 tient outcomes” may include—

12 (i) changes in clinical outcomes, in-
13 cluding stabilization of patients with pro-
14 gressive disease or health conditions, re-
15 sulting from the use of safe and effective
16 medical technology in prevention, diag-
17 nosis, or treatment;

18 (ii) changes in mortality, morbidity,
19 and health service use, including stabiliza-
20 tion of patients with progressive diseases;

21 (iii) changes in quality of life, includ-
22 ing ability to perform activities of daily liv-
23 ing, ability to return to work, relief from
24 discomfort or pain, alleviation of fatigue,

1 and improved mental functioning and well-
2 being; and

3 (iv) other outcomes that are deter-
4 mined by the advisory committee to be rel-
5 evant to assessing the impact of medical
6 technology.

7 (D) MEDICAL TECHNOLOGIES.—The term
8 “medical technologies” includes drugs, biologics
9 (including vaccines), medical devices, drug de-
10 livery systems, and surgical services and other
11 procedures for preventing, diagnosing, and
12 treating diseases or health conditions.

13 (E) MEDICAL TECHNOLOGY INDUSTRY.—
14 The term “medical technology industry” in-
15 cludes the biotechnology, pharmaceutical, and
16 medical device industries, and such other indus-
17 tries that invent, develop, or market medical
18 technologies.

19 (b) ADVISORY COMMITTEE.—

20 (1) IN GENERAL.—The Administrator shall es-
21 tablish an Advisory Committee to assist the Agency
22 in preparing the reports required under subsection
23 (c). Except as provided in paragraph (3), no member
24 of the advisory committee shall be an employee of
25 the Federal Government.

1 (2) MEMBERSHIP.—The Advisory Committee
2 shall be balanced in its representation of interested
3 parties and shall be composed of at least two indi-
4 viduals appointed by the President of the Institute
5 of Medicine and two individuals from each of the fol-
6 lowing categories:

7 (A) Experts in medical technology assess-
8 ment.

9 (B) Experts in objective measures of im-
10 proved patient outcomes, such as clinical out-
11 comes, mortality, morbidity, and health service
12 use.

13 (C) Experts in subjective measures of im-
14 proved patient outcomes, such as quality of life.

15 (D) Experts in quantifying the economic
16 costs of disease to the health care system, in-
17 cluding public and private payers.

18 (E) Experts in quantifying the economic
19 impact of the medical technology industry.

20 (F) Experts in health statistics and epide-
21 miology.

22 (G) Physicians and other health care pro-
23 viders.

24 (H) Officers or employees of health plans
25 and other health care payers.

1 (I) Experts in the ethical implications of
2 health care.

3 (J) Experts in private sector financial mar-
4 ket investment in the medical technology indus-
5 try.

6 (K) Consumers and members of patient
7 advocacy groups.

8 (L) Health professional organizations.

9 (M) Officers or employees of biotechnology
10 companies.

11 (N) Officers or employees of medical device
12 companies.

13 (O) Officers or employees of pharma-
14 ceutical companies.

15 (3) EX OFFICIO.—The following individuals or
16 their designees shall serve as ex officio members of
17 the Advisory Committee:

18 (A) The Director of the National Institutes
19 of Health.

20 (B) The Commissioner of Food and Drugs.

21 (C) The Director of the Centers for Dis-
22 ease Control and Prevention.

23 (D) The Administrator of the Health Care
24 Financing Administration.

1 (E) The Under Secretary of Commerce for
2 Technology.

3 (F) The Director of the Congressional Of-
4 fice of Technology Assessment.

5 (c) INTERDISCIPLINARY STUDY AND REPORT.—

6 (1) IN GENERAL.—The Administrator, in con-
7 sultation with the Advisory Committee established
8 under subsection (b), shall determine which diseases
9 or conditions should be studied in the Medical Tech-
10 nology Impact Study. In carrying out the medical
11 technology assessment required under this sub-
12 section, the Administrator shall consider various fac-
13 tors, including those outlined in section 904(b)(2) of
14 the Public Health Service Act and government and
15 private payor reimbursement policies that impede or
16 encourage innovation that improves patient out-
17 comes. The diseases or conditions studied in such
18 Study shall be those considered to be high priority
19 according to the following criteria:

20 (A) Aggregate economic costs to the
21 United States.

22 (B) Overall importance to public health.

23 (C) Potential for improvements in patient
24 outcomes.

1 (D) Significant changes expected in man-
2 agement of the condition.

3 (E) Other criteria identified by the Advi-
4 sory Committee.

5 (2) DESIGN.—The Administrator, in consulta-
6 tion with the Advisory Committee established under
7 subsection (b), and the Institute of Medicine pursu-
8 ant to paragraph (3), shall develop a design, based
9 on the list of target diseases and conditions, for un-
10 dertaking the Medical Technology Impact Study.

11 (3) CONTRACT.—The Secretary shall request
12 the Institute of Medicine of the National Academy
13 of Sciences to enter into a contract to review the
14 Study design and report to the Administrator con-
15 cerning any recommendations for revising such de-
16 sign, in the interest of assuring that it reflects the
17 best available scientific methodologies.

18 (4) PUBLICATION.—The Administrator shall
19 publish the study design and list of target diseases
20 and conditions, the recommendations of the Institute
21 of Medicine, and the response of the Administrator
22 to such recommendations in the Federal Register for
23 a 60-day period for public comment. Any such com-
24 ments shall be considered by the Administrator in

1 completing the proposed study design for submission
2 to the Secretary.

3 (5) DESIGN REPORT.—The Secretary shall re-
4 port to Congress concerning the proposed design of
5 the Medical Technology Impact Study, together with
6 recommendations for appropriations necessary to
7 carry out the Study.

8 (6) GRANTS AND CONTRACTS.—Beginning in
9 the first fiscal year for which Congress appropriates
10 funds consistent with paragraph (5), and ending on
11 September 30 of that year, the Administrator shall
12 enter into grants and contracts with appropriate en-
13 tities to conduct any investigations and analyses that
14 may be required to carry out the design of the Medi-
15 cal Technology Impact Study.

16 (7) REPORT ON FINDINGS.—The Administrator,
17 in consultation with the Advisory Committee, shall
18 develop a draft comprehensive report concerning the
19 findings of the Study, shall make copies of the draft
20 report available to the public and publish a notice in
21 the Federal Register providing for a 60-day period
22 of public comment. Any such comments shall be con-
23 sidered by the Administrator in completing and sub-
24 mitting the final report to the Secretary.

1 (8) FINAL REPORT.—Not later than 3 years
2 after the date of enactment of this section, the Sec-
3 retary shall submit the report of the Administrator
4 to Congress, and may include any recommendations
5 determined necessary to assure the availability, ac-
6 cess and appropriate use of medical technologies to
7 improve the quality of health care in the United
8 States.

9 (d) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section.

12 **SEC. 1673. ASSISTANCE WITH FAMILY COLLECTIONS.**

13 The Secretary shall provide States with such tech-
14 nical and other assistance as may promote the efficient
15 collection of other amounts owed by families under this
16 Act. Such assistance may include the assessment of civil
17 monetary penalties, not to exceed \$5,000 or three times
18 the amount of the liability owed, whichever is greater, in
19 the case of repeated failure to pay (as specified in rules
20 of the Secretary).

21 **SEC. 1674. ADVISORY OPINIONS.**

22 (a) IN GENERAL.—Community- and provider-based
23 plans and individuals and organizations seeking to estab-
24 lish such plans shall be eligible to receive advisory opinions
25 from appropriate Federal entities, including opinions con-

1 cerning whether their arrangement complies with Federal
2 self-referral, fraud and abuse, and anti-trust laws.

3 (b) REGULATIONS.—The Secretary shall issue regula-
4 tions setting forth the procedures for obtaining advisory
5 opinions described in subsection (a).

6 (c) TIMING OF OPINIONS.—Advisory opinions shall
7 be issued not later than 90 days after receipt of a request
8 for such opinions from a plan.

9 (d) FEES.—Applicants shall pay a fee, the amount
10 of which to be determined by the Secretary, to cover the
11 costs of providing the opinion.

12 **SEC. 1675. REPORTS.**

13 (a) DENTAL CARE.—The Secretary shall undertake
14 studies to determine—

15 (1) the costs of providing—

16 (A) preventive dental care to all adults;

17 (B) restorative dental care to all adults;

18 and

19 (C) preventive dental care to adults with
20 developmental, cognitive, and other mental dis-
21 abilities; and

22 (2) the best oral health care practice and the
23 cost or savings of providing such care prior to 2001.

24 The Secretary shall report to the National Health

1 Board and the Congress not later than September 1,
2 1995 concerning such study.

3 (b) IN VITRO FERTILIZATION.—The Secretary shall
4 undertake a study to determine the costs of providing cov-
5 erage for in vitro fertilization in the comprehensive bene-
6 fits package. The Secretary shall report to the National
7 Health Board and the Congress not later than September
8 1, 1995 concerning such study.

9 **Subpart B—Certification of Essential Community**
10 **Providers**

11 **SEC. 1681. CERTIFICATION.**

12 For purposes of this Act, the Secretary shall certify
13 as an “essential community provider” any health care pro-
14 vider or organization that—

15 (1) is within any of the categories of providers
16 and organizations specified in section 1682(a), or

17 (2) meets the standards for certification under
18 section 1683(a).

19 **SEC. 1682. CATEGORIES OF PROVIDERS AUTOMATICALLY**
20 **CERTIFIED.**

21 (a) IN GENERAL.—The categories of providers and
22 organizations, including subrecipients, specified in this
23 subsection are as follows:

24 (1) Covered entities as defined in section
25 340B(a)(4) of the Public Health Service Act (42

1 U.S.C. 256b(a)(4)), except that subsections
2 (a)(4)(L)(iii) and (a)(7) of such section shall not
3 apply.

4 (2) School health services centers under title III
5 of this Act.

6 (3)(A) Nonprofit hospitals meeting the criteria
7 for public hospitals which are eligible entities under
8 section 340B of the Public Health Service Act, ex-
9 cept that subsection (a)(4)(L)(iii) of such section
10 shall not apply.

11 (B) Nonprofit hospitals with a minimum of 200
12 beds, located in urban areas where—

13 (i) the cumulative total of its services pro-
14 vided to individuals who are entitled to benefits
15 under title XVIII of the Social Security Act or
16 under a State plan under title XIX of such Act
17 equals a minimum of 65 percent; and

18 (ii) a minimum of 20 percent of its services
19 are provided to individuals eligible for assist-
20 ance under such title XIX;

21 (C) A Medicare dependent small rural hospital
22 under section 1886(d)(8)(iii) of the Social Security
23 Act.

24 (D) Children's hospitals meeting comparable
25 criteria determined appropriate by the Secretary.

1 (4) Public and private, nonprofit mental health
2 and substance abuse providers receiving funds under
3 title V or XIX of the Public Health Service Act.

4 (5) Runaway homeless youth centers or transi-
5 tional living programs for homeless youth providing
6 health services under the Runaway Homeless Youth
7 Act of 1974 (42 U.S.C. 5701 et seq.).

8 (6) Public or nonprofit maternal and child
9 health providers that receive funding under title V of
10 the Social Security Act.

11 (7) Rural health clinics as defined under section
12 1861(aa)(2) of the Social Security Act.

13 (b) STUDY OF FEDERALLY CERTIFIED RURAL
14 HEALTH CLINICS.—The Secretary shall conduct an eval-
15 uation of the Rural Health Clinics program as defined in
16 section 1861(aa)(2) of the Social Security Act to examine
17 the causes of the growth in the program and the charac-
18 teristics of providers certified as rural health clinics and
19 the characteristics of the population served by rural health
20 clinics to ensure that the program meets the needs of rural
21 underserved communities. The Secretary shall report the
22 findings of such evaluation, together with any rec-
23 ommended changes in the rural health clinics program, to
24 the Congress not later than January 1, 1996.

1 **SEC. 1683. STANDARDS FOR ADDITIONAL PROVIDERS.**

2 (a) STANDARDS.—The Secretary shall publish stand-
3 ards for the certification of additional categories of health
4 care providers and organizations as essential community
5 providers, including the categories described in subsection
6 (b). Such a health care provider or organization shall not
7 be certified unless the Secretary determines, under such
8 standards, that health plans operating in the area served
9 by the applicant would not otherwise be able to assure ade-
10 quate access to items and services included in the com-
11 prehensive benefit package if such a provider was not so
12 certified.

13 (b) CATEGORIES TO BE INCLUDED.—The categories
14 described in this subsection are as follows:

15 (1) CERTAIN HEALTH PROFESSIONALS.—A
16 health professional who—

17 (A) for at least 20 hours per week—

18 (i) is located in an area (or areas)
19 designated as a health professional short-
20 age area (under section 332 of the Public
21 Health Service Act) or serves a population
22 (or populations) designated as a medically
23 underserved population (under section 330
24 of the Public Health Service Act); or

1 (ii)(I) is located or provides services in
2 a neighborhood or community whose resi-
3 dents are at risk of underservice; and

4 (II) is available to patients at such lo-
5 cation on evenings and weekends; and

6 (B) if the health professional is a physi-
7 cian—

8 (i) is licensed to practice in the juris-
9 diction; and

10 (ii) is either—

11 (I) granted privileges to practice
12 at one or more hospitals; or

13 (II) has a consultation and refer-
14 ral arrangement with one or more
15 physicians who are granted privileges
16 to practice at one or more hospitals.

17 (2) INSTITUTIONAL PROVIDERS.—Public and
18 private nonprofit hospitals and other public and non-
19 profit institutional health care providers, including
20 family planning clinics, located in health professional
21 shortage areas (as defined under section 332 of the
22 Public Health Service Act) or providing health serv-
23 ices to medically underserved populations (as defined
24 under title III of this Act).

1 (3) OTHER PROVIDERS.—Other public and pri-
2 vate nonprofit agencies and organizations that—

3 (A) are located in such an area or provid-
4 ing health services to such a population, and

5 (B) provide health care and services essen-
6 tial to residents of such an area or such popu-
7 lations.

8 **SEC. 1684. CERTIFICATION PROCESS; REVIEW; TERMI-**
9 **NATION OF CERTIFICATIONS.**

10 (a) CERTIFICATION PROCESS.—

11 (1) PUBLICATION OF PROCEDURES.—The Sec-
12 retary shall publish, not later than 6 months after
13 the date of the enactment of this Act, the procedures
14 to be used by health care professionals, providers,
15 agencies, and organizations seeking certification
16 under this subpart, including the form and manner
17 in which an application for such certification is to be
18 made.

19 (2) TIMELY DETERMINATION.—The Secretary
20 shall make a determination upon such an application
21 not later than 60 days (or 15 days in the case of
22 a certification for an entity described in section
23 1682) after the date the complete application has
24 been submitted. The determination on an application
25 for certification of an entity described in section

1 1682 shall only involve the verification that the en-
2 tity is an entity described in such section.

3 (b) REVIEW OF CERTIFICATIONS.—The Secretary
4 shall periodically review whether professionals, providers,
5 agencies, and organizations certified under this subpart
6 continue to meet the requirements for such certification.

7 (c) TERMINATION OR DENIAL OF CERTIFICATION.—

8 (1) PRELIMINARY FINDING.—If the Secretary
9 preliminarily finds that an entity seeking certifi-
10 cation under this section does not meet the require-
11 ments for such certification or such an entity cer-
12 tified under this subpart fails to continue to meet
13 the requirements for such certification, the Secretary
14 shall notify the entity of such preliminary finding
15 and permit the entity an opportunity, under subtitle
16 C of title V, to rebut such findings.

17 (2) FINAL DETERMINATION.—If, after such op-
18 portunity, the Secretary continues to find that such
19 an entity continues to fail to meet such require-
20 ments, the Secretary shall terminate the certification
21 and shall notify the entity, the State, large group
22 purchasers, of such termination and the effective
23 date of the termination.

1 **SEC. 1685. NOTIFICATION OF PARTICIPATING STATES.**

2 (a) IN GENERAL.—Not less often than annually the
3 Secretary shall notify each participating State of essential
4 community providers that have been certified under this
5 subpart.

6 (b) CONTENTS.—Such notice shall include sufficient
7 information to permit each State to notify health plans
8 of the identity of each entity certified as an essential com-
9 munity provider, including—

10 (1) the location of the provider within each
11 plan’s service area,

12 (2) the health services furnished by the pro-
13 vider, and

14 (3) other information necessary for health plans
15 to carry out part 3 of subtitle E.

16 **SEC. 1686. DEFINITIONS.**

17 As used in subpart:

18 (1) SUBRECIPIENT.—The term “subrecipient”
19 means, with respect to a recipient of a grant under
20 a particular authority, an entity that—

21 (A) is receiving funding from such a grant
22 under a contract with the principal recipient of
23 such a grant, and

24 (B) meets the requirements established to
25 be a recipient of such a grant.

1 (2) HEALTH PROFESSIONAL.—The term
2 “health professional” means a physician, nurse,
3 nurse practitioner, certified nurse midwife, physician
4 assistant, psychologist, dentist, pharmacist, chiro-
5 practor, clinical social worker, and other health care
6 professional recognized by the Secretary.

7 (3) CHILDREN’S HOSPITAL.—The term “chil-
8 dren’s hospital” means those hospitals whose inpa-
9 tients are certified by the Secretary or the State to
10 be predominantly under the age of 18.

11 **Subpart C—Workplace Wellness Programs**

12 **SEC. 1687. WORKPLACE WELLNESS PROGRAM.**

13 (a) IN GENERAL.—The Secretary shall perform re-
14 sponsibilities required under this Act with respect to the
15 development of certification criteria and other duties re-
16 quired under this Act relating to workplace wellness pro-
17 grams.

18 (b) APPLICATION OF SECTION.—Employers main-
19 taining qualified worksite health promotion programs
20 meeting the requirements of subsection (d) shall be enti-
21 tled to the worksite health promotion rebate specified in
22 subsection (c).

23 (c) WORKSITE HEALTH PROMOTION REBATE.—Em-
24 ployers maintaining a qualified worksite health promotion
25 programs shall be paid a rebate by the State in an amount

1 determined using the methodology developed by the Sec-
2 retary.

3 (d) REQUIREMENTS FOR QUALIFIED WORKSITE
4 HEALTH PROMOTION PROGRAMS.—

5 (1) ESTABLISHMENT OF LEVELS.—The Sec-
6 retary shall establish not less than two levels of
7 qualified worksite health promotion programs and
8 determine the program elements (or combination of
9 program elements) necessary for an employer to
10 qualify at each level. In establishing such levels, the
11 Secretary shall take into consideration the special
12 characteristics of small businesses (as defined in sec-
13 tion 6123(c)) and incorporate provisions providing
14 small businesses the opportunity to qualify at all lev-
15 els.

16 (2) PROGRAM ELEMENTS.—Program elements
17 that the Secretary should consider for inclusion in
18 qualified worksite health promotion programs are
19 the following:

20 (A) Education, screening, counseling, fol-
21 low-up, treatment or referral programs to re-
22 duce lifestyle and other modifiable risk factors
23 such as cholesterol, inactivity, nutrition and
24 weight management, HIV, sexually transmitted
25 diseases, cancer prevention, or smoking.

1 (B) Education, screening, counseling, fol-
2 low-up, monitoring or referral for chronic health
3 risks or problems such as high blood pressure
4 or diabetes.

5 (C) Promotion of exercise and fitness
6 through education or the provision of exercise
7 facilities at the worksite, adjoining the worksite,
8 or at a proximate location with transportation
9 provided from the worksite.

10 (D) Employee assistance programs that
11 provide counseling and assistance with respect
12 to other areas of personal concern that may ad-
13 versely affect job performance such as sub-
14 stance abuse, stress or parenting.

15 (E) Workplace health and safety education
16 and prevention programs that go beyond those
17 required by law.

18 (F) Prenatal counseling and education.

19 (G) Consumer education regarding health
20 care services including programs on the devel-
21 opment of living wills.

22 (3) MINIMUM PARTICIPATION RATES.—The
23 Secretary shall have the authority to establish mini-
24 mum employee participation rates as a condition of

1 employer qualification under a qualified worksite
2 health promotion program.

3 (4) GUIDELINES.—The Secretary shall develop
4 guidelines to ensure that employers who sponsor
5 qualified worksite health promotion program do not
6 discriminate among employees as to either eligibility
7 for participation or program benefits.

8 (5) APPLICATION.—The Secretary shall develop
9 an application form and supporting material to be
10 used by employers to certify that they qualify for
11 one of the worksite health promotion program levels
12 established by the Secretary.

13 **SEC. 1688. WELLNESS DISCOUNT METHODOLOGY.**

14 (a) REQUIREMENT.—The Secretary shall develop a
15 methodology consistent with subsection (b) in order to en-
16 sure that—

17 (1) families entitled to a wellness discount by
18 virtue of employment of a family member by an em-
19 ployer maintaining a qualified worksite health pro-
20 motion program under section 1687(d) receive a
21 credit toward their family share of premium (as de-
22 fined in section 6101(b)(1)) equal to the wellness
23 discount specified by the plan in which the family
24 elects to enroll; and

1 (2) employers maintaining qualified programs
2 receive a rebate annually, based on the average
3 worksite health promotion discount in the health
4 care coverage area, weighted by the enrollment of
5 employees of all employers offering certified wellness
6 programs in the area.

7 (b) METHODOLOGY.—The methodology developed by
8 the Secretary under subsection (a) shall—

9 (1) ensure that each family enrolled in a com-
10 munity-rated plan that offers a wellness discount re-
11 ceives the discount provided by the plan chosen by
12 the family regardless of whether the family has en-
13 rolled in the plan through a consumer purchasing
14 cooperative directly or through the plan, or through
15 some other means;

16 (2) ensure that a separate rebate is computed
17 for each worksite health promotion program level es-
18 tablished by the Secretary under section 1687; and

19 (3) ensure that any wellness discount offered by
20 health plans are not taken into account in the
21 Board's determination of plan and area compliance
22 with the per-capita premium targets described in
23 subtitle A of title VI of this Act.

1 **PART 3—SPECIFIC RESPONSIBILITIES OF**

2 **SECRETARY OF LABOR**

3 **SEC. 1691. RESPONSIBILITIES OF SECRETARY OF LABOR.**

4 (a) IN GENERAL.—The Secretary of Labor is respon-
5 sible—

6 (1) under subtitle E, for the enforcement of re-
7 quirements applicable to community-rated employers
8 (including requirements relating to payment of pre-
9 miums) and the administration of large group pur-
10 chasers;

11 (2) under subtitle E, with respect to elections
12 by eligible purchasers to become large group pur-
13 chasers and the termination of such elections;

14 (3) for the temporary assumption of the oper-
15 ation of self-insured employer sponsored health plans
16 that are insolvent;

17 (4) for carrying out any other responsibilities
18 assigned to the Secretary under this Act; and

19 (5) for administering title I of the Employee
20 Retirement Income Security Act of 1974 as it re-
21 lates to group health plans maintained by large
22 group purchasers.

23 (b) AGREEMENTS WITH STATES.—The Secretary of
24 Labor may enter into agreements with States in order to
25 enforce responsibilities of employers and large group pur-
26 chasers, and requirements of employer sponsored health

1 plans, under subtitle B of title I of the Employee Retirement
2 Income Security Act of 1974.

3 (c) CONSULTATION WITH BOARD.—In carrying out
4 activities under this Act with respect to large group pur-
5 chasers, employer sponsored health plans, and employers,
6 the Secretary of Labor shall consult with the National
7 Health Board.

8 (d) STUDY ON SEASONAL WORKERS.—Not later than
9 6 months after the date of enactment of this Act, the Sec-
10 retary of Labor, in consultation with the Secretary and
11 such other Federal departments and experts as deter-
12 mined appropriate, shall prepare and submit to the appro-
13 priate committees of Congress, a report concerning the im-
14 pact of requiring employers of seasonal workers to make
15 premium contributions for such workers. The report shall
16 analyze and make recommendations concerning the fiscal
17 and administrative (including paperwork) burdens on em-
18 ployers, employees, and health plans.

19 (e) EMPLOYER-RELATED REQUIREMENTS.—

20 (1) IN GENERAL.—The Secretary of Labor, in
21 consultation with the Secretary, shall be responsible
22 for assuring that employers—

23 (A) make payments of any employer pre-
24 miums (and withhold and make payment of the
25 family share of premiums with respect to quali-

1 fying employees) and provide discounts to em-
2 ployees as required under this Act, including
3 auditing of collection activities with respect to
4 such payments,

5 (B) submit timely reports as required
6 under this Act, and

7 (C) otherwise comply with requirements
8 imposed on employers under this Act.

9 (2) AUDIT AND SIMILAR AUTHORITIES.—The
10 Secretary of Labor—

11 (A) may carry out such audits (directly or
12 through contract) and such investigations of
13 employers and States, consumer purchasing co-
14 operatives and large group purchasers,

15 (B) may exercise such authorities under
16 section 504 of Employee Retirement Income Se-
17 curity Act of 1974 (in relation to activities
18 under this Act),

19 (C) may, with the permission of the Board,
20 provide (through contract or otherwise) for such
21 collection activities (in relation to amounts owed
22 to States, consumer purchasing cooperatives
23 and large group purchasers, and for the benefit
24 of such States, consumer purchasing coopera-
25 tives and large group purchasers), and

1 (D) may impose such civil penalties under
2 section 6210,
3 as may be necessary to carry out such Secretary's
4 responsibilities under this section.

5 (3) AUDITING OF EMPLOYER PAYMENTS.—

6 (A) IN GENERAL.—Each State is respon-
7 sible for auditing the records of community-
8 rated employers to assure that employer pay-
9 ments (including the payment of amounts with-
10 held) were made in the appropriate amount as
11 provided under subpart A of part 2 of subtitle
12 B of title VI.

13 (B) EMPLOYERS WITH EMPLOYEES RESID-
14 ING IN DIFFERENT COMMUNITY-RATING
15 AREAS.—In the case of a community-rated em-
16 ployer which has employees who reside in more
17 than one community-rating area, the Secretary
18 of Labor, in consultation with the Secretary,
19 shall establish a process for the coordination of
20 State auditing activities among the States in-
21 volved.

22 (C) APPEAL.—In the case of an audit con-
23 ducted by a State on an employer under this
24 paragraph, an employer or other State that is
25 aggrieved by the determination in the audit is

1 entitled to review of such audit by the Secretary
2 of Labor in a manner to be provided by such
3 Secretary.

4 (f) **AUTHORITY.**—The Secretary of Labor is author-
5 ized to issue such regulations as may be necessary to carry
6 out section 1704 and responsibilities of the Secretary
7 under this Act (including under title XI).

8 **SEC. 1692. ASSISTANCE WITH EMPLOYER COLLECTIONS.**

9 The Secretary of Labor shall provide States with such
10 technical and other assistance as may promote the effi-
11 cient collection of all amounts owed under this Act by em-
12 ployers. Such assistance may include the assessment of
13 civil monetary penalties, not to exceed \$5,000 or three
14 times the amount of the liability owed, whichever is great-
15 er, in the case of repeated failure to pay (as specified in
16 rules of the Secretary of Labor).

17 **SEC. 1693. PENALTIES FOR FAILURE OF LARGE EMPLOY-**
18 **ERS TO MEET REQUIREMENTS.**

19 (a) **IN GENERAL.**—If the Secretary of Labor finds
20 that a large group purchaser has failed substantially to
21 meet the applicable requirements of subtitle E, the Sec-
22 retary shall impose a civil money penalty of not to exceed
23 \$10,000 for each such violation.

24 (b) **EXCESS INCREASE IN PREMIUM EQUIVALENT.**—
25 If the Secretary of Labor finds that a large group pur-

1 chaser that is a large employer is in violation of the re-
2 quirements of section 6022 (relating to prohibition against
3 excess increase in premium expenditures), the Secretary
4 shall require that the purchaser enter into contracts with
5 all carriers providing community-rated plans in commu-
6 nity-rating areas in which their experience-rated individ-
7 uals reside, under which the purchaser—

8 (1) makes payment to the carriers based on an
9 appropriate community rate (determined by the Sec-
10 retary of Labor based on the final filed per capita
11 premium rate, subject to appropriate risk adjust-
12 ment and not subject to any employer discount), and

13 (2) makes payments to the State of an amount
14 provided under section 6124.

15 **SEC. 1694. APPLICABILITY OF ERISA ENFORCEMENT MECH-**
16 **ANISMS FOR ENFORCEMENT OF CERTAIN RE-**
17 **QUIREMENTS.**

18 The provisions of sections 502 (relating to civil en-
19 forcement), 504 (relating to investigative authority) and
20 506 (relating to criminal enforcement) of the Employee
21 Retirement Income Security Act of 1974 shall apply to
22 enforcement by the Secretary of Labor of the applicable
23 requirements for large group purchasers in the same man-
24 ner and to same extent as such provisions apply to en-
25 forcement of title I of such Act.

1 **PART 4—COLLECTIVE BARGAINING DISPUTE**

2 **RESOLUTION**

3 **SEC. 1695. FINDINGS AND PURPOSE.**

4 (a) FINDING.—Congress finds that—

5 (1) consistent with the intention of this Act to
6 eliminate waste and inefficiency in the health care
7 industry, it is important to avoid costly and disrupt-
8 tive labor disputes; and

9 (2) such disputes are particularly likely to take
10 place during the period of transition to a restruc-
11 tured health care delivery system because of disrupt-
12 tions to established employment relationships result-
13 ing from that restructuring.

14 (b) PURPOSE.—It is the purpose of this part to ex-
15 pand the role of the Federal Mediation and Conciliation
16 Service, acting through the Boards of Inquiry provided for
17 in limited terms under section 8(g) of the National Labor
18 Relations Act (29 U.S.C. 158(g)) and section 213 of the
19 Labor Management Relations Act of 1947 (29 U.S.C.
20 183), to avoid labor disputes by providing for public fact-
21 finding in contract negotiations.

22 **SEC. 1696. APPLICATION LIMITED TO TRANSITION PERIOD.**

23 The provisions of this part are intended to avoid cost-
24 ly and disruptive labor disputes during the period of tran-
25 sition to a restructured health care delivery system, and

1 shall be repealed effective upon the end of calendar year
2 2000.

3 **SEC. 1697. REQUEST FOR APPOINTMENT OF BOARD OF IN-**
4 **QUIRY.**

5 (a) IN GENERAL.—A health care entity (as defined
6 in section 3082(a)) or a labor organization that has been
7 lawfully certified or recognized as the representative of the
8 employees of a health care entity for the purpose of engag-
9 ing in collective bargaining concerning wages, hours and
10 other terms and conditions of employment, may request
11 that the Director of the Federal Mediation and Concilia-
12 tion Service (hereafter referred to in this part as the “Di-
13 rector”) appoint an impartial Health Care Board of In-
14 quiry to investigate the issues involved in a collective bar-
15 gaining dispute between the entity and the labor organiza-
16 tion.

17 (b) TIME FOR REQUEST.—Such request may be made
18 no earlier than 60 days after notice of the existence of
19 a contract dispute has been provided to—

20 (1) the Federal Mediation and Conciliation
21 Service in accordance with clause (A) or (B) of the
22 last sentence of section 8(d) of the Labor Manage-
23 ment Relations Act (29 U.S.C. 158(d)); or

24 (2) where the health care entity is otherwise ex-
25 empt from coverage under such Act, any comparable

1 State or territorial agency established to mediate
2 and conciliate disputes to which notice is required to
3 be given under applicable State law.

4 **SEC. 1698. APPOINTMENT OF BOARD OF INQUIRY.**

5 (a) IN GENERAL.—Except as provided in subsection
6 (b), the Director shall appoint a Health Care Board of
7 Inquiry not later than 10 days after receipt of a request
8 under section 1696. Each such Board shall be composed
9 of such number of individuals as the Director may deem
10 desirable. No member appointed under this section shall
11 have any interest or involvement in the health care institu-
12 tions or the employee organizations involved in the dis-
13 pute.

14 (b) LIMITATION.—With respect to the appointment
15 of a Health Care Board of Inquiry under paragraph (1),
16 if the Director determines that—

17 (1) the health care entity is—

18 (A) otherwise exempt from coverage under
19 the Labor Management Relations Act, as
20 amended (29 U.S.C. 141 et seq.); and

21 (B) subject to State laws containing proce-
22 dures for the resolution of impasses in collective
23 bargaining that are comparable to those that
24 would be followed by a Board of Inquiry under
25 this section; or

1 (2) the parties involved have agreed to proce-
2 dures for the resolution of the impasse in collective
3 bargaining that are comparable to those that would
4 be followed by a Board of Inquiry;
5 the Director may refuse the request for the appointment
6 of such a Board.

7 **SEC. 1699. PUBLIC FACTFINDING.**

8 A Health Care Board of Inquiry appointed under this
9 part shall investigate the issues involved in the dispute and
10 make a written report thereon to the parties and to the
11 Director within 30 days after the establishment of such
12 a Board. The written report shall contain the findings of
13 fact together with the Board's recommendations for set-
14 tling the dispute, with the objective of achieving a prompt,
15 peaceful and just settlement of the dispute. The Board
16 shall arrange for publication of such report within the
17 community served by the health care entity involved.

18 **SEC. 1699A. COMPENSATION OF MEMBERS OF BOARDS OF**
19 **INQUIRY.**

20 (a) EMPLOYEES IF FEDERAL GOVERNMENT.—Mem-
21 bers of any board established under this part who are oth-
22 erwise employed by the Federal Government shall serve
23 without compensation but shall be reimbursed for travel,
24 subsistence, and other necessary expenses incurred by
25 such members in carrying out its duties under this section.

1 (b) OTHER MEMBERS.—Members of any board estab-
2 lished under this section who are not subject to subsection
3 (a) shall receive compensation at a rate prescribed by the
4 Director but not to exceed the daily rate prescribed for
5 GS-128 of the General Schedule under section 5332 of
6 title 5, United States Code, including travel for each day
7 they are engaged in the performance of their duties under
8 this section and shall be entitled to reimbursement for
9 travel, subsistence, and other necessary expenses incurred
10 by them in carrying out their duties under this part.

11 **SEC. 1699B. MAINTENANCE OF STATUS QUO.**

12 After the establishment of a board under section
13 1697, and for 15 days after any such board has issued
14 its report, no change in the status quo in effect prior to
15 the expiration of the contract in the case of negotiations
16 for a contract renewal, or in effect prior to the time the
17 parties began their bargaining in the case of an initial be-
18 ginning negotiation, except by agreement, shall be made
19 by the parties to the controversy.

20 **Subtitle H—Miscellaneous**
21 **Employer Requirements**

22 **SEC. 1701. AUDITING OF RECORDS.**

23 Each community-rated employer shall maintain such
24 records, and provide the State for the area in which the
25 employer maintains the principal place of employment (as

1 specified by the Secretary of Labor) with access to such
2 records, as may be necessary to verify and audit the infor-
3 mation reported under this subtitle.

4 **SEC. 1702. PROHIBITION OF CERTAIN EMPLOYER DISCRIMI-**
5 **NATION.**

6 No employer may discriminate with respect to an em-
7 ployee on the basis of the family status of the employee
8 or on the basis of the class of family enrollment selected
9 with respect to the employee.

10 **SEC. 1703. EVASION OF OBLIGATIONS.**

11 It shall be unlawful for any employer or other person
12 to discharge, fine, suspend, expel, discipline, discriminate
13 or otherwise take adverse action against any employee if
14 a purpose of such action is to interfere with the employee's
15 attainment of status as a qualifying employee, as a full
16 time employee, or as a part-time employee, or if a purpose
17 of such action is to evade or avoid any obligation under
18 this Act.

19 **SEC. 1704. PROHIBITION ON SELF-FUNDING OF COST SHAR-**
20 **ING BENEFITS.**

21 (a) PROHIBITION.—A community-rated employer
22 (and an experience-rated employer with respect to employ-
23 ees who are community rate eligible individuals) may pro-
24 vide benefits to employees that consist of the benefits in-
25 cluded in a cost sharing policy (as defined in section

1 1507(c)) only through a contribution toward the purchase
2 of a cost sharing policy which is funded primarily through
3 insurance.

4 (b) INDIVIDUAL AND EMPLOYER RESPONSIBIL-
5 ITIES.—In the case of an individual who resides in a sin-
6 gle-payer State and an employer with respect to employees
7 who reside in such a State, the responsibilities of such in-
8 dividual and employer under such system shall supersede
9 the obligations of the individual and employer under this
10 subtitle.

11 **SEC. 1705. EMPLOYER RETIREE OBLIGATION.**

12 (a) IN GENERAL.—If an employer was providing, as
13 of October 1, 1993, a threshold payment (specified in sub-
14 section (c)) for a person who was a qualifying retired bene-
15 ficiary (as defined in subsection (b)) as of such date, the
16 employer shall pay, to or on behalf of that beneficiary for
17 each month beginning with January 1998, an amount that
18 is not less than the amount specified in subsection (d),
19 but only if and for so long as the person remains a qualify-
20 ing retired beneficiary.

21 (b) QUALIFYING RETIRED BENEFICIARY.—In this
22 section, the term “qualifying retired beneficiary” means
23 a person who is an eligible retiree or qualified spouse or
24 child (as such terms are defined in subsections (b) and
25 (c) of section 6114).

1 (c) THRESHOLD PAYMENT.—The term “threshold
2 payment” means, for an employer with respect to a health
3 benefit plan providing coverage to a qualifying retired ben-
4 efiary, a payment—

5 (1) for coverage of any item or service described
6 in section 1101, and

7 (2) the amount of which is at least 20 percent
8 of the amount of the premium (or premium equiva-
9 lent) for such coverage with respect to the bene-
10 ficiary (and dependents).

11 (d) AMOUNT.—The amount specified in this sub-
12 section is 20 percent of the weighted average premium for
13 the health care coverage area in which the beneficiary re-
14 sides and for the applicable class of family enrollment.

15 (e) NATURE OF OBLIGATION.—The requirement of
16 this section shall be in addition to any other requirement
17 imposed on an employer under this Act or otherwise.

18 (f) PROTECTION OF COLLECTIVE BARGAINING
19 RIGHTS.—Nothing in this Act (including this section)
20 shall be construed as affecting collective bargaining rights
21 or rights under collective bargaining agreements.

22 **SEC. 1706. RULES GOVERNING LITIGATION INVOLVING RE-**
23 **TIREE HEALTH BENEFITS.**

24 (a) MAINTENANCE OF BENEFITS.—

25 (1) IN GENERAL.—If—

1 (A) retiree health benefits or plan or plan
2 sponsor payments in connection with such bene-
3 fits are to be or have been terminated or re-
4 duced under an employee welfare benefit plan;
5 and

6 (B) an action is brought by any participant
7 or beneficiary to enjoin or otherwise modify
8 such termination or reduction,
9 the court without requirement of any additional
10 showing shall promptly order the plan and plan
11 sponsor to maintain the retiree health benefits and
12 payments at the level in effect immediately before
13 the termination or reduction while the action is
14 pending in any court. No security or other undertak-
15 ing shall be required of any participant or bene-
16 ficiary as a condition for issuance of such relief. An
17 order requiring such maintenance of benefits may be
18 refused or dissolved only upon determination by the
19 court, on the basis of clear and convincing evidence,
20 that the action is clearly without merit.

21 (2) MODIFICATIONS.—Nothing in this section
22 shall preclude a court from modifying the obligation
23 of a plan or plan sponsor to the extent retiree bene-
24 fits are otherwise being paid under section 6208.

1 (b) BURDEN OF PROOF.—In addition to the relief au-
2 thORIZED in subsection (a) or otherwise available, if, in any
3 action described in subsection (a), the terms of the em-
4 ployee welfare benefit plan summary plan description or
5 other materials distributed to employees at the time of a
6 participant's retirement or disability are silent or are am-
7 biguous, either on their face or after consideration of ex-
8 trinsic evidence, as to whether retiree health benefits and
9 payments may be terminated or reduced for a participant
10 and his or her beneficiaries after the participant's retire-
11 ment or disability, then the benefits and payments shall
12 not be terminated or reduced for the participant and his
13 or her beneficiaries unless the plan or plan sponsor estab-
14 lishes by a preponderance of the evidence that the sum-
15 mary plan description and other materials about retiree
16 benefits—

17 (1) were distributed to the participant at least
18 90 days in advance of retirement or disability;

19 (2) did not promise retiree health benefits for
20 the lifetime of the participant and his or her spouse;
21 and

22 (3) clearly and specifically disclosed that the
23 plan allowed such termination or reduction as to the
24 participant after the time of his or her retirement or
25 disability.

1 The disclosure described in paragraph (3) must have been
2 made prominently and in language which can be under-
3 stood by the average plan participant.

4 (c) REPRESENTATION.—Notwithstanding any other
5 provision of law, an employee representative of any retired
6 employee or the employee’s spouse or dependents may—

7 (1) bring an action described in this section on
8 behalf of such employee, spouse, or dependents; or

9 (2) appear in such an action on behalf of such
10 employee, spouse or dependents.

11 (d) RETIREE HEALTH BENEFITS.—For the purposes
12 of this section, the term “retiree health benefits” means
13 health benefits (including coverage) which are provided
14 to—

15 (1) retired or disabled employees who, imme-
16 diately before the termination or reduction, are enti-
17 tled to receive such benefits upon retirement or be-
18 coming disabled; and

19 (2) their spouses and dependents.

20 (e) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to actions relating to terminations
22 or reductions of retiree health benefits which are pending
23 or brought, on or after July 20, 1993.

1 **SEC. 1707. PARTICIPATION IN FEHBP.**

2 (a) IN GENERAL.—A qualifying employee of an
3 American employer (as defined in section 3121(h) of the
4 Internal Revenue Code of 1986) who is employed by such
5 an employer outside the United States may elect to pur-
6 chase coverage through designated health plans participat-
7 ing in FEHBP.

8 (b) VOLUNTARY PARTICIPATION.—Participation by
9 an employee described in subsection (a) shall be at the
10 discretion of such employee, and employer payments on
11 behalf of such employee shall be voluntary.

12 (c) REGULATIONS.—The National Health Board, in
13 consultation with the Office of Personnel Management,
14 shall issue regulations governing the provision and reim-
15 bursement of items and services included in the com-
16 prehensive benefit package, premium payments by employ-
17 ers and employees, and the establishment of separate risk
18 pools for Federal and non-Federal employees abroad.

19 **SEC. 1708. ENFORCEMENT.**

20 In the case of a person that violates a requirement
21 of this subtitle, the Secretary of Labor may impose a civil
22 money penalty, in an amount not to exceed \$10,000, for
23 each violation with respect to each individual.

1 **Subtitle I—General Definitions;**
2 **Miscellaneous Provisions**

3 **PART 1—GENERAL DEFINITIONS**

4 **SEC. 1901. DEFINITIONS RELATING TO EMPLOYMENT AND**
5 **INCOME.**

6 (a) IN GENERAL.—Except as otherwise specifically
7 provided, in this Act the following definitions and rules
8 apply:

9 (1) EMPLOYER, EMPLOYEE, EMPLOYMENT, AND
10 WAGES DEFINED.—Except as provided in this sec-
11 tion—

12 (A) the terms “wages” and “employment”
13 have the meanings given such terms under sec-
14 tion 3121 of the Internal Revenue Code of
15 1986,

16 (B) the term “employee” has the meaning
17 given such term under section 3121 of such
18 Code, subject to the provisions of chapter 25 of
19 such Code, and

20 (C) the term “employer” has the same
21 meaning as the term “employer” as used in
22 such section 3121.

23 (2) EXCEPTIONS.—For purposes of paragraph
24 (1)—

25 (A) EMPLOYMENT.—

1 (i) EMPLOYMENT INCLUDED.—Para-
2 graphs (1), (2), (5), (7) (other than
3 clauses (i) through (iv) of subparagraph
4 (C) and clauses (i) through (v) of subpara-
5 graph (F)), (8), (9), (10), (11), (13), (15),
6 (18), and (19) of section 3121(b) of the
7 Internal Revenue Code of 1986 shall not
8 apply.

9 (ii) EXCLUSION OF INMATES AS EM-
10 PLOYEES.—Employment shall not include
11 services performed in a penal institution by
12 an inmate thereof or in a hospital or other
13 health care institution by a patient thereof.

14 (B) WAGES.—

15 (i) IN GENERAL.—Paragraph (1) of
16 section 3121(a) of the Internal Revenue
17 Code of 1986 shall not apply.

18 (ii) TIPS NOT INCLUDED.—The term
19 “wages” does not include cash tips.

20 (C) EXCLUSION OF CERTAIN FOREIGN EM-
21 PLOYMENT.—The term “employee” does not in-
22 clude an individual with respect to service, if
23 the individual is not a citizen or resident of the
24 United States and the service is performed out-
25 side the United States.

1 (3) AGGREGATION RULES FOR EMPLOYERS.—

2 For purposes of this Act—

3 (A) all employers treated as a single em-
4 ployer under subsection (a) or (b) of section 52
5 of the Internal Revenue Code of 1986 shall be
6 treated as a single employer, and

7 (B) under regulations of the Secretary of
8 Labor, all employees of organizations which are
9 under common control with one or more organi-
10 zations which are exempt from income tax
11 under subtitle A of the Internal Revenue Code
12 of 1986 shall be treated as employed by a single
13 employer.

14 The regulations prescribed under subparagraph (B)
15 shall be based on principles similar to the principles
16 which apply to taxable organizations under subpara-
17 graph (A).

18 (4) EMPLOYER PREMIUM.—The term “employer
19 premium” refers to the premium established and im-
20 posed under part 2 of subtitle B of title VI.

21 (b) QUALIFYING EMPLOYEE; FULL-TIME EMPLOY-
22 MENT.—

23 (1) QUALIFYING EMPLOYEE.—

24 (A) IN GENERAL.—In this Act, the term
25 “qualifying employee” means, with respect to

1 an employer for a month, an employee (other
2 than a covered child, as defined in subpara-
3 graph (C)) who is employed by the employer for
4 at least 40 hours (as determined under para-
5 graph (3)) in the month, subject to the limita-
6 tion set forth in subparagraph (D).

7 (B) NO SPECIAL TREATMENT OF MEDI-
8 CARE BENEFICIARIES, SSI RECIPIENTS, AFDC
9 RECIPIENTS, AND OTHERS.—Subparagraph (A)
10 shall apply regardless of whether or not the em-
11 ployee is a medicare-eligible individual, an SSI
12 recipient, an AFDC recipient, an individual de-
13 scribed in section 1004(b), an eligible individual
14 or is authorized to be so employed.

15 (C) COVERED CHILD DEFINED.—In sub-
16 paragraph (A), the term “covered child” means
17 an eligible individual who is a child and is en-
18 rolled under a health plan as a family member
19 described in section 1011(b)(2)(B).

20 (D) QUALIFYING EMPLOYEES.—As used in
21 this Act—

22 (i) the term qualifying employee shall
23 not include, with respect to an employer
24 for a month, an employee of a nonelecting

1 small employer (as defined in section
2 6220);

3 (ii) the term “nonqualifying em-
4 ployee” means, with respect to an employer
5 for a month, an employee (who otherwise
6 would be a qualifying employee) of a
7 nonelecting small employer;

8 (iii) the term “qualifying employee”
9 shall not include, with respect to an em-
10 ployer for a month, a part-time employee
11 during the first month (four-week period)
12 of such employee’s employment; and

13 (iv) the term “qualifying employee”
14 shall include, with respect to an employer
15 for a month, a part-time employee begin-
16 ning with the second month of such em-
17 ployee’s employment.

18 (2) FULL-TIME EQUIVALENT EMPLOYEES;
19 PART-TIME EMPLOYEES.—

20 (A) IN GENERAL.—For purposes of this
21 Act, a qualifying employee who is employed by
22 an employer—

23 (i) for at least 120 hours in a month,
24 is counted as 1 full-time equivalent em-

1 ployee for the month and shall be deemed
2 to be employed on a full-time basis, or

3 (ii) for at least 40 hours, but less
4 than 120 hours, in a month, is counted as
5 a fraction of a full-time equivalent em-
6 ployee in the month equal to the full-time
7 employment ratio (as defined in subpara-
8 graph (B)) for the employee and shall be
9 deemed to be employed on a part-time
10 basis.

11 (B) FULL-TIME EMPLOYMENT RATIO DE-
12 FINED.—For purposes of this Act, the term
13 “full-time employment ratio” means, with re-
14 spect to a qualifying employee of an employer
15 in a month, the lesser of 1 or the ratio of—

16 (i) the number of hours of employ-
17 ment such employee is employed by such
18 employer for the month (as determined
19 under paragraph (3)), to

20 (ii) 120 hours.

21 (C) FULL-TIME EMPLOYEE.—For purposes
22 of this Act, the term “full-time employee”
23 means, with respect to an employer, an em-
24 ployee who is employed on a full-time basis (as
25 specified in subparagraph (A)) by the employer.

1 (D) PART-TIME EMPLOYEE.—For purposes
2 of this Act, the term “part-time employee”
3 means, with respect to an employer, an em-
4 ployee who is employed on a part-time basis (as
5 specified in subparagraph (A)) by the employer.

6 (E) CONSIDERATION OF INDUSTRY PRAC-
7 TICE.—As provided under rules established by
8 the Board, an employee who is not described in
9 subparagraph (C) or (D) shall be considered to
10 be employed on a full-time or part-time basis by
11 an employer (and to be a full-time or part-time
12 employee of an employer) for a month (or for
13 all months in a 12-month period) if the em-
14 ployee is employed by that employer on a con-
15 tinuing basis that, taking into account the
16 structure or nature of employment in the indus-
17 try, represents full or part-time employment in
18 that industry.

19 (F) INSTITUTIONS OF HIGHER EDU-
20 CATION.—Notwithstanding any other provision
21 in this section—

22 (i)(I) employees of an Institution of
23 higher education (as defined in section
24 1201(a) of the Higher Education Act of
25 1965), or of an elementary or secondary

1 school (as defined in section 1471 of the
2 Elementary and Secondary Education Act
3 of 1965), who are exempt under section 13
4 of the Fair Labor Standards Act, shall be
5 deemed to be full-time employees if they
6 work the hours that constitute full-time
7 employment as defined at such institution;

8 (II) part-time employment shall be
9 considered proportional to such hours for
10 full-time employees; and

11 (III) part-time employees who work at
12 least one-third of the hours that constitute
13 full-time employment as defined at such in-
14 stitution shall be eligible for proportional
15 employer premium contributions; and

16 (ii) regular employees of institutions
17 of higher education or elementary and sec-
18 ondary schools who are not paid during the
19 summer months or other periods of the
20 year, but are assured employment at the
21 end of such periods, shall be eligible for
22 year-round employer premium contribu-
23 tions if such individuals are not eligible to
24 collect unemployment compensation for the
25 periods for which they would receive health

1 care premium contributions from the em-
2 ployer covered by this subsection.

3 (3) HOURS OF EMPLOYMENT.—

4 (A) IN GENERAL.—For purposes of this
5 Act, the Board shall specify the method for
6 computing hours of employment for employees
7 of an employer consistent with this paragraph.
8 The Board shall take into account rules used
9 for purposes of applying the Fair Labor Stand-
10 ards Act.

11 (B) HOURLY WAGE EARNERS.—In the case
12 of an individual who receives compensation (in
13 the form of hourly wages or compensation) for
14 the performance of services, the individual is
15 considered to be “employed” by an employer for
16 an hour if compensation is payable with respect
17 to that hour of employment, without regard to
18 whether or not the employee is actually per-
19 forming services during such hours.

20 (4) TREATMENT OF SALARIED EMPLOYEES AND
21 EMPLOYEES PAID ON CONTINGENT OR BONUS AR-
22 RANGEMENTS.—In the case of an employee who re-
23 ceives compensation on a salaried basis or on the
24 basis of a commission (or other contingent or bonus
25 basis), rather than an hourly wage, the Board shall

1 establish rules for the conversion of the compensa-
2 tion to hours of employment, taking into account the
3 minimum monthly compensation levels for workers
4 employed on a full-time basis under the Fair Labor
5 Standards Act and other factors the Board considers
6 relevant.

7 (c) DEFINITIONS RELATING TO SELF-EMPLOY-
8 MENT.—In this Act:

9 (1) NET EARNINGS FROM SELF-EMPLOY-
10 MENT.—The term “net earnings from self-employ-
11 ment” has the meaning given such term under sec-
12 tion 1402(a) of the Internal Revenue Code of 1986.

13 (2) SELF-EMPLOYED INDIVIDUAL.—The term
14 “self-employed individual” means, for a year, an in-
15 dividual who has net earnings from self-employment
16 for the year.

17 **SEC. 1902. OTHER GENERAL DEFINITIONS.**

18 Except as otherwise specifically provided, in this Act
19 the following definitions apply:

20 (1) AFDC FAMILY.—The term “AFDC family”
21 means a family composed entirely of one or more
22 AFDC recipients.

23 (2) AFDC RECIPIENT.—The term “AFDC re-
24 cipient” means, for a month, an individual who is
25 receiving aid or assistance under any plan of the

1 State approved under title I, X, XIV, or XVI, or
2 part A or part E of title IV, of the Social Security
3 Act for the month.

4 (3) APPLICABLE HEALTH PLAN.—The term
5 “applicable health plan” means, with respect to an
6 eligible individual, the health plan specified pursuant
7 to section 1004 and part 2 of subtitle A.

8 (4) CARRIER.—The term “carrier” means a li-
9 censed insurance company, a hospital or medical
10 service corporation (including an existing Blue Cross
11 or Blue Shield organization, within the meaning of
12 section 833(c)(2) of Internal Revenue Code of
13 1986), a health maintenance organization, or other
14 entity licensed or certified by the State to provide
15 health insurance or health benefits. The Board may
16 issue regulations that provide for affiliated carriers
17 to be treated as a single carrier where appropriate
18 under this Act.

19 (5) CASE MANAGEMENT.—The term “case man-
20 agement” means services that assist individuals in
21 gaining access to needed medical, social, educational,
22 and other services.

23 (6) CITIZEN OF ANOTHER COUNTRY LEGALLY
24 RESIDING IN THE UNITED STATES.—The term “citi-

1 zen of another country legally residing in the United
2 States'' means any of the following:

3 (A) An alien lawfully admitted for perma-
4 nent residence (within the meaning of section
5 101(a)(20) of the Immigration and Nationality
6 Act).

7 (B) An alien granted work authorization
8 by the Immigration and Naturalization Service.

9 (C) An alien permanently residing in the
10 United States under color of law, including (but
11 not limited to) any of the following:

12 (i) An alien who is admitted as a refu-
13 gee under section 207 of the Immigration
14 and Nationality Act.

15 (ii) An alien who is granted asylum
16 under section 208 of such Act.

17 (iii) An alien whose deportation is
18 withheld under section 243(h) of such Act.

19 (iv) An alien who is admitted for tem-
20 porary residence under section 210, 210A,
21 or 245A of such Act.

22 (v) An alien who has been paroled
23 into the United States under section
24 212(d)(5) of such Act for an indefinite pe-
25 riod or who has been granted extended vol-

1 untary departure, temporary protected sta-
2 tus, or deferred enforced departure.

3 (vi) An alien who is the spouse or un-
4 married child under 21 years of age of a
5 citizen of the United States, or the parent
6 of such a citizen if the citizen is over 21
7 years of age, and with respect to whom an
8 application for adjustment to lawful per-
9 manent residence is pending.

10 (vii) An alien within such other classi-
11 fication of aliens permanently residing
12 under color of law for purposes of this Act
13 only as the National Health Board may es-
14 tablish by regulation. Such regulation shall
15 include categories of such aliens who are
16 included in regulations as in effect on the
17 date of the enactment of this Act under
18 title XIX of the Social Security Act and
19 other categories within a public health pri-
20 ority.

21 (7) COMBINATION COST SHARING PLAN.—The
22 term “combination cost sharing plan” means a
23 health plan that provides combination cost sharing
24 schedule (consistent with section 1134).

1 (8) COMMUNITY-RATED EMPLOYER.—The term
2 “community-rated employer” means, with respect to
3 an employee, an employer that is not an experience-
4 rated employer with respect to such employee.

5 (9) COMMUNITY-RATED PLAN.—The term
6 “community-rated plan” means a health plan cer-
7 tified by a State under section 1503 that is provided
8 to community-rated individuals.

9 (10) COMMUNITY RATE ELIGIBLE INDIVID-
10 UAL.—The term “community rate eligible individ-
11 ual” means an eligible individual with respect to
12 whom a community-rated plan is an applicable
13 health plan.

14 (11) COMPREHENSIVE BENEFIT PACKAGE.—
15 The term “comprehensive benefit package” means
16 the package of health benefits provided under sub-
17 title B.

18 (12) CONSUMER PRICE INDEX; CPI.—The terms
19 “consumer price index” and “CPI” mean the
20 Consumer Price Index for all urban consumers (U.S.
21 city average), as published by the Bureau of Labor
22 Statistics.

23 (13) COST SHARING POLICY.—The term “cost
24 sharing policy” means a health insurance policy or
25 health benefit plan offered to an community rate eli-

1 gible individual which provides coverage for
2 deductibles, coinsurance, and copayments imposed as
3 part of the comprehensive benefit package under
4 subtitle B, whether imposed under a higher cost
5 sharing plan or with respect to out-of-network pro-
6 viders.

7 (14) COVERED WAGES DEFINED.—In this sec-
8 tion, the term “covered wages” means wages paid an
9 employee of an employer during a month in which
10 the employee was a qualifying employee of the em-
11 ployer.

12 (15) DIAGNOSABLE MENTAL DISORDER AND
13 DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The
14 terms “diagnosable mental disorder” and
15 “diagnosable substance abuse disorder” mean a dis-
16 order that—

17 (A) is listed in the Diagnostic and Statis-
18 tical Manual of Mental Disorders, Fourth Edi-
19 tion, Revised or a revised version of such man-
20 ual (except V Codes for Conditions Not Attrib-
21 utable to a Mental Disorder That Are a Focus
22 of Attention or Treatment);

23 (B) is the equivalent of a disorder de-
24 scribed in subparagraph (A), but is listed in the
25 International Classification of Diseases, 9th Re-

1 vision, Clinical Modification, Third Edition or a
2 revised version of such text; or

3 (C) is listed in any authoritative text speci-
4 fying diagnostic criteria for mental disorders or
5 substance abuse disorders that is identified by
6 the National Health Board.

7 (16) DISABLED SSI RECIPIENT.—The term
8 “disabled SSI recipient” means an individual who—

9 (A) is an SSI recipient, and

10 (B) has been determined to be disabled for
11 purposes of the supplemental security income
12 program (under title XVI of the Social Security
13 Act).

14 (17) ESSENTIAL COMMUNITY PROVIDER.—The
15 term “essential community provider” means an en-
16 tity certified as such a provider under subpart B of
17 part 2 of subtitle F.

18 (18) EXPERIENCE-RATED EMPLOYER.—The
19 term “experience-rated employer” means—

20 (A) a large employer that is a large group
21 purchaser, and

22 (B) another employer that participates in a
23 experience-rated plan sponsored by a large
24 group purchaser described in paragraph (6) or
25 (7) of section 1401.

1 (19) EXEMPT INDIVIDUAL.—The term “exempt
2 individual” means an individual that has been grant-
3 ed an exemption from paying Social Security Taxes
4 under section 1402(g) of the Internal Revenue Code
5 of 1986, or an individual who would be eligible for
6 an exemption under such section if the individual
7 were self-employed.

8 (20) EXPERIENCE-RATED INDIVIDUAL.—The
9 term “experience-rated individual” means, with re-
10 spect to a large group purchaser, an eligible individ-
11 ual with respect to whom an experience-rated plan
12 sponsored by the purchaser is the applicable health
13 plan.

14 (21) EXPERIENCE-RATED PLAN.—The term
15 “experience-rated plan” means either—

16 (A) an employer sponsored health plan (as
17 defined in section 1401(e)(5)) offered by a large
18 group purchaser, or

19 (B) an insured health plan offered by a
20 carrier to a large group purchaser.

21 (22) FEE-FOR-SERVICE PLAN.—The term “fee-
22 for-service plan” means a health plan described in
23 section 1211(b)(2)(A).

24 (23) FIRST YEAR.—The term “first year”
25 means, with respect to—

1 (A) a State that is a participating State in
2 a year before 1998, the year in which the State
3 first is a participating State, or

4 (B) any other State, 1998.

5 (24) HEALTH CARE COVERAGE AREA.—The
6 term “health care coverage area” means an area
7 specified by a State under section 1202.

8 (25) HEALTH PLAN SPONSOR.—The term
9 “health plan sponsor” means—

10 (A) with respect to a community-rated
11 plan, the carrier providing the plan,

12 (B) with respect to an insured experience-
13 rated plan, the carrier providing the plan, and

14 (C) with respect to a self-funded experi-
15 ence-rated plan, the large group purchaser pro-
16 viding the plan.

17 (26) HIGHER COST SHARING PLAN.—The term
18 “higher cost sharing plan” means a health plan that
19 provides a higher cost sharing schedule (consistent
20 with section 1133).

21 (27) HOSPITAL.—The term “hospital” has the
22 meaning given such term in section 1861(e) of the
23 Social Security Act, except that such term shall in-
24 clude—

1 (A) in the case of an item or service pro-
2 vided to an individual whose applicable health
3 plan is specified pursuant to section 1005(b)(1),
4 a facility of the uniformed services under title
5 10, United States Code, that is primarily en-
6 gaged in providing services to inpatients that
7 are equivalent to the services provided by a hos-
8 pital defined in such section 1861(e);

9 (B) in the case of an item or service pro-
10 vided to an individual whose applicable health
11 plan is specified pursuant to section 1005(b)(2),
12 a facility operated by the Department of Veter-
13 ans Affairs that is primarily engaged in provid-
14 ing services to inpatients that are equivalent to
15 the services provided by a hospital defined in
16 such section 1861(e); and

17 (C) in the case of an item or service pro-
18 vided to an individual whose applicable health
19 plan is specified pursuant to section 1005(b)(3),
20 a facility operated by the Indian Health Service
21 that is primarily engaged in providing services
22 to inpatients that are equivalent to the services
23 provided by a hospital defined in such section
24 1861(e).

1 (28) INPATIENT HOSPITAL SERVICES.—The
2 term “inpatient hospital services” means items and
3 services described in paragraphs (1) through (3) of
4 section 1861(b) of the Social Security Act when pro-
5 vided to an inpatient of a hospital. The National
6 Health Board shall specify those health professional
7 services described in section 1103 that shall be
8 treated as inpatient hospital services when provided
9 to an inpatient of a hospital.

10 (29) LONG-TERM NONIMMIGRANT.—The term
11 “long-term nonimmigrant” means a nonimmigrant
12 described in subparagraph (E), (H), (I), (J), (K),
13 (L), (M), (N), (O), (Q), or (R) of section 101(a)(15)
14 of the Immigration and Nationality Act or an alien
15 within such other classification of nonimmigrant as
16 the National Health Board may establish by regula-
17 tion.

18 (30) LOWER COST SHARING PLAN.—The term
19 “lower cost sharing plan” means a health plan that
20 provides a lower cost sharing schedule (consistent
21 with section 1132).

22 (31) MEDICARE PROGRAM.—The term “medi-
23 care program” means the health insurance program
24 under title XVIII of the Social Security Act.

1 (32) MEDICARE-ELIGIBLE INDIVIDUAL.—The
2 term “medicare-eligible individual” means, subject to
3 section 1012(a), an individual who is entitled to ben-
4 efits under part A of the medicare program.

5 (33) MEDICATIONS MANAGEMENT.—

6 (A) IN GENERAL.—The term “medications
7 management” refers to the prescription, use,
8 monitoring, and review of medication for treat-
9 ment of a mental disorder or pharmacotherapy
10 for the treatment of a substance abuse disorder,
11 including no more than minimal medical psy-
12 chotherapy or counseling.

13 (B) VISIT.—For purposes of medications
14 management, the term “visit” means one week
15 of treatment.

16 (34) MOVE.—The term “move” means, respect
17 to an individual, a change of residence of the indi-
18 vidual from one health care coverage area to another
19 health care coverage area.

20 (35) NATIONAL HEALTH BOARD; BOARD.—The
21 terms “National Health Board” and “Board” mean
22 the National Health Board created under section
23 1601.

24 (36) NON-QUALIFYING EMPLOYEE.—The term
25 “non-qualifying employee” means, with respect to an

1 employer for a month, an employee (who otherwise
2 would be a qualifying employee) of a nonelecting
3 small employer.

4 (37) PARTICIPATING PROVIDER.—The term
5 “participating provider” means, with respect to a
6 health plan, a provider of health care services who
7 is a member of a provider network of the plan.

8 (38) PLACED FOR ADOPTION.—The term
9 “placed for adoption” in connection with any place-
10 ment for adoption of a child with any person, means
11 the assumption and retention by such person of a
12 legal obligation for total or partial support of such
13 child in anticipation of the adoption of such child.

14 (39) POVERTY LEVEL.—

15 (A) IN GENERAL.—The term “applicable
16 poverty level” means, for a family for a year,
17 the official poverty line (as defined by the Of-
18 fice of Management and Budget, and revised
19 annually in accordance with section 673(2) of
20 the Omnibus Budget Reconciliation Act of
21 1981) applicable to a family of the size involved
22 (as determined under subparagraph (B)) for
23 1994 adjusted by the percentage increase or de-
24 crease described in subparagraph (C) for the
25 year involved.

1 (B) FAMILY SIZE.—In applying the appli-
2 cable poverty level to—

3 (i) an individual enrollment, the fam-
4 ily size is deemed to be one person;

5 (ii) a couple-only enrollment, the fam-
6 ily size is deemed to be two persons;

7 (iii) a single parent enrollment, the
8 family size is deemed to be three persons;

9 or

10 (iv) a dual parent enrollment, the
11 family size is deemed to be four persons.

12 (C) PERCENTAGE ADJUSTMENT.—The per-
13 centage increase or decrease described in this
14 subparagraph for a year is the percentage in-
15 crease or decrease by which the average CPI for
16 the 12-month-period ending with August 31 of
17 the preceding year exceeds such average for the
18 12-month period ending with August 31, 1993.

19 (D) ROUNDING.—Any adjustment made
20 under subparagraph (A) for a year shall be
21 rounded to the nearest multiple of \$100.

22 (40) PRISONER.—The term “prisoner” means,
23 as specified by the Board, an eligible individual dur-
24 ing a period of imprisonment under Federal, State,
25 or local authority after conviction as an adult.

1 (41) PSYCHIATRIC HOSPITAL.—The term “psy-
2 chiatric hospital” has the meaning given such term
3 in section 1861(f) of the Social Security Act, except
4 that such term shall include—

5 (A) in the case of an item or service pro-
6 vided to an individual whose applicable health
7 plan is specified pursuant to section 1005(b)(1),
8 a facility of the uniformed services under title
9 10, United States Code, that is engaged in pro-
10 viding services to inpatients that are equivalent
11 to the services provided by a psychiatric hos-
12 pital;

13 (B) in the case of an item or service pro-
14 vided to an individual whose applicable health
15 plan is specified pursuant to section 1005(b)(2),
16 a facility operated by the Department of Veter-
17 ans Affairs that is engaged in providing services
18 to inpatients that are equivalent to the services
19 provided by a psychiatric hospital; and

20 (C) in the case of an item or service pro-
21 vided to an individual whose applicable health
22 plan is specified pursuant to section 1005(b)(3),
23 a facility operated by the Indian Health Service
24 that is engaged in providing services to inpa-

1 tients that are equivalent to the services pro-
2 vided by a psychiatric hospital.

3 (42) REHABILITATION FACILITY.—The term
4 “rehabilitation facility” means an institution (or a
5 distinct part of an institution) which is established
6 and operated for the purpose of providing diagnostic,
7 therapeutic, and rehabilitation services to individuals
8 for rehabilitation from illness, injury, disorder or
9 other health condition. An entity qualifying as a hos-
10 pital for purposes of section 1102 may also qualify
11 as a rehabilitation facility for purposes of section
12 1110.

13 (43) RESIDE.—

14 (A) An individual is considered to reside in
15 the location in which the individual maintains a
16 primary residence (as established under rules of
17 the National Health Board).

18 (B) Under such rules and subject to sec-
19 tion 1516, in the case of an individual who
20 maintains more than one residence, the primary
21 residence of the individual shall be determined
22 taking into account the proportion of time spent
23 at each residence.

24 (C) In the case of a couple only one spouse
25 of which is a qualifying employee, except as the

1 Board may provide, the residence of the em-
2 ployee shall be the residence of the couple.

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

5 (45) SELF-FUNDED PLAN.—The term “self-
6 funded plan” means (as defined in regulations of the
7 Secretary of Labor) a health plan provided by a
8 large group purchaser and which is not provided by
9 or through a carrier.

10 (46) SEXUAL ORIENTATION.—The term “sexual
11 orientation” means homosexual, bisexual, or hetero-
12 sexual orientation, real or perceived, as manifested
13 by identity, acts, statements, or associations.

14 (47) SKILLED NURSING FACILITY.—The term
15 “skilled nursing facility” means an institution (or a
16 distinct part of an institution) which is primarily en-
17 gaged in providing to residents—

18 (A) skilled nursing care and related serv-
19 ices for residents who require medical or nurs-
20 ing care; or

21 (B) rehabilitation services to residents for
22 rehabilitation from illness, injury, disorder or
23 other health condition.

1 (48) SSI FAMILY.—The term “SSI family”
2 means a family composed entirely of one or more
3 SSI recipients.

4 (49) SSI RECIPIENT.—The term “SSI recipi-
5 ent” means, for a month, an individual—

6 (A) with respect to whom supplemental se-
7 curity income benefits are being paid under title
8 XVI of the Social Security Act for the month,

9 (B) who is receiving a supplementary pay-
10 ment under section 1616 of such Act or under
11 section 212 of Public Law 93–66 for the
12 month, or

13 (C) who is receiving monthly benefits
14 under section 1619(a) of the Social Security
15 Act (whether or not pursuant to section
16 1616(c)(3) of such Act) for the month.

17 (50) STATE.—The term “State” includes the
18 District of Columbia, Puerto Rico, the Virgin Is-
19 lands, Guam, American Samoa, and the Northern
20 Mariana Islands.

21 (51) STATE MEDICAID PLAN.—The term “State
22 medicaid plan” means a plan of medical assistance
23 of a State approved under title XIX of the Social
24 Security Act.

1 (52) SUPPLEMENTAL HEALTH BENEFIT POL-
2 ICY.—

3 (A) IN GENERAL.—The term “supple-
4 mental health benefit policy” means a health in-
5 surance policy or health benefit plan offered to
6 a community rate eligible individual which pro-
7 vides—

8 (i) coverage for services and items not
9 included in the comprehensive benefit
10 package, or

11 (ii) coverage for items and services in-
12 cluded in such package but not covered be-
13 cause of a limitation in amount, duration,
14 or scope provided under this title,

15 or both.

16 (B) EXCLUSIONS.—Such term does not in-
17 clude the following:

18 (i) A cost sharing policy.

19 (ii) A long-term care insurance policy.

20 (iii) Insurance that limits benefits
21 with respect to specific diseases (or condi-
22 tions).

23 (iv) Hospital or nursing home indem-
24 nity insurance.

1 (v) A medicare supplemental policy
2 (as defined in section 1882(g) of the Social
3 Security Act).

4 (vi) Insurance with respect to acci-
5 dents.

6 (53) UNITED STATES.—The term “United
7 States” means the 50 States, the District of Colum-
8 bia, Puerto Rico, the Virgin Islands, Guam, Amer-
9 ican Samoa, and Northern Mariana Islands.

10 **SEC. 1903. REFERENCE TO CERTAIN TERMS.**

11 In any provision in this Act (other than this I, sub-
12 title J of title III, title VI, and subtitle E of title VIII),
13 including any amendment made by such a provision of this
14 Act—

15 (1) any reference to a “corporate alliance em-
16 ployer” is deemed a reference to an “experience-
17 rated employer”;

18 (2) any reference to a “corporate alliance” is
19 deemed a reference either to an “experience-rated
20 employer” or a “large group purchaser”, as specified
21 by the Board;

22 (3) any reference to a “corporate alliance eligi-
23 ble individual” is deemed a reference to an “experi-
24 ence-rated individual”;

1 (4) any reference to a “regional alliance” is
2 deemed a reference either to a contracting entity, a
3 State, or a consumer purchasing cooperative, as
4 specified by the Board;

5 (5) any reference to an “alliance area” is
6 deemed a reference to a “community-rating area”;

7 (6) any reference to a “regional alliance eligible
8 individual” is deemed a reference to a “community-
9 rated individual”;

10 (7) any reference to an “alliance eligible indi-
11 vidual” is deemed a reference to a “community-rated
12 individual” and to an “experience rated individual”;

13 (8) any reference to a “regional alliance health
14 plan” is deemed a reference to a “community-rated
15 plan”;

16 (9) any reference to a “corporate alliance health
17 plan” is deemed a reference to an “experience-rated
18 plan”; and

19 (10) any reference to a “health plan” is deemed
20 a reference either to a health plan or a carrier, as
21 specified by the Board.

22 **PART 2—MISCELLANEOUS PROVISIONS**

23 **SEC. 1911. USE OF INTERIM, FINAL REGULATIONS.**

24 In order to permit the timely implementation of the
25 provisions of this Act, the National Health Board, the Sec-

1 retary of Health and Human Services, the Secretary of
2 Labor are each authorized to issue regulations under this
3 Act on an interim basis that become final on the date of
4 publication, subject to change based on subsequent public
5 comment.

6 **SEC. 1912. NEUTRALITY CONCERNING UNION ORGANIZING.**

7 Amounts appropriated to carry out this Act may not
8 be utilized to assist, promote or deter union organizing.

9 **SEC. 1913. SOCIAL SECURITY ACT REFERENCES.**

10 Except as may otherwise be provided, any reference
11 in this title, or in title V or VI, to a provision of the Social
12 Security Act shall be to that provision of the Social Secu-
13 rity Act as in effect on the date of the enactment of this
14 Act.

15 **SEC. 1914. ANTIDISCRIMINATION.**

16 (a) IN GENERAL.—Neither the National Health
17 Board nor any State, health plan, consumer purchasing
18 cooperative, large group purchaser, employer, or other en-
19 tity subject to this Act shall directly or through contrac-
20 tual arrangements—

21 (1) deny or limit access to or the availability of
22 health care services, or otherwise discriminate in
23 connection with the provision of health care services;
24 or

1 (2) limit, segregate or classify an individual in
2 any way which would deprive or tend to deprive such
3 individual of health care services, or otherwise ad-
4 versely affect his or her access to health care serv-
5 ices;

6 on the basis of race, national origin, sex, religion, lan-
7 guage, income, age, sexual orientation, disability, health
8 status, or anticipated need for health services.

9 (b) DEFINITION.—As used in this section, the term
10 “in connection with the provision of health care services”
11 includes, but is not limited to—

12 (1) establishing the boundaries for health care
13 coverage areas under section 1202 and for premium
14 areas, enrolling persons in a health care plan or
15 marketing a health care plan, and selecting provid-
16 ers or setting the terms or conditions under which
17 providers participate in a health care plan or pro-
18 vider network; and

19 (2) determining the scope of services provided
20 by a health care plan, and providing such services
21 and determining the site or location of health care
22 facilities.

23 (c) REGULATIONS.—Not later than 1 year after the
24 date of enactment of this Act, the Secretary of Health and

1 Human Services shall issue regulations to carry out this
2 section.

3 (d) EFFECT ON OTHER LAWS. Nothing in this Act
4 shall be construed to limit the scope of, or the availability
5 of relief under, any other Federal or State law prohibiting
6 discrimination or providing relief therefore.

7 (e) BENEFITS.—Nothing in this Act shall be con-
8 strued to require or prohibit the provision of benefits to
9 an employee for the benefit of his or her same-sex partner.

10 (f) OUTREACH UNAFFECTED.—Nothing in this sec-
11 tion shall be construed to prevent a person from engaging
12 in activities to encourage the enrollment of community
13 rated individuals residing in underserved areas.

14 **SEC. 1915. COVERAGE OF BENEFITS UNDER HEALTH SECU-**
15 **RITY ACT.**

16 (a) DAVIS-BACON ACT.—Subsection (b)(2) of the
17 first section of the Davis Bacon Act (40 U.S.C.
18 276a(b)(2)) is amended in the matter following subpara-
19 graph (B) by inserting after “local law” the following:
20 “(other than benefits provided pursuant to the Health Se-
21 curity Act)”.

22 (b) SERVICE CONTRACT ACT OF 1965.—The second
23 sentence of section 2(a)(2) of the Service Contract Act of
24 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after

1 “local law” the following: “(other than benefits provided
2 pursuant to the Health Security Act)”.

3 **SEC. 1916. GOVERNMENT REQUIRED DATA.**

4 The set of data referred to in section 5114(a)(5) shall
5 include data on—

6 (1) enrollment and disenrollment in health
7 plans;

8 (2) clinical encounters and other items and
9 services provided by health care providers;

10 (3) administrative, operational and financial as-
11 pects regarding composition, transactions and activi-
12 ties of participating States, health plans, health care
13 providers, employers and individuals that are nec-
14 essary to determine compliance with this Act or an
15 Act amended by this Act;

16 (4) terms of agreement between health plans
17 and the health care providers who are members of
18 provider networks of the plans;

19 (5) payment of benefits in cases in which bene-
20 fits may be payable under a health plan and any
21 other insurance policy or health program;

22 (6) utilization management by health plans and
23 health care providers;

24 (7) the information collected and reported by
25 the Board or disseminated by other individuals or

1 entities as part of the National Quality Management
2 Program under subtitle A;

3 (8) health care and payment grievances and the
4 resolutions of such grievances; and

5 (9) any other fact that may be necessary to de-
6 termine whether a health plan or a health care pro-
7 vider has complied with a Federal statute pertaining
8 to fraud or misrepresentation in the provision or
9 purchasing of health care or in the submission of a
10 claim for benefits or payment under a health plan.

11 **SEC. 1917. SENSE OF THE COMMITTEE CONCERNING FUND-**
12 **ING SOURCES.**

13 (a) FINANCING.—It is the sense of the Committee on
14 Labor and Human Resources of the Senate that when the
15 Health Security Act is enacted it should include the follow-
16 ing sources of financing not within the jurisdiction of the
17 Committee:

18 (1) The net savings and revenues included in
19 S.1757, the Health Security Act which are outside
20 the jurisdiction of the Committee.

21 (2) The extension to all employers that are not
22 community-rated employers the 1 percent payroll as-
23 sessment applied to corporate alliances under
24 S.1757, the Health Security Act.

- Sec. 2102. State plans.
- Sec. 2103. Individuals with disabilities defined.
- Sec. 2104. Home and community-based services covered under State plan.
- Sec. 2105. Cost sharing.
- Sec. 2106. Quality assurance and safeguards.
- Sec. 2107. Advisory groups.
- Sec. 2108. Payments to States.
- Sec. 2109. Total Federal budget; allotments to States.
- Sec. 2110. Federal evaluations.

SUBPART B—STATE PROGRAMS FOR EXTENDED SERVICES FOR CHILDREN
WITH SPECIAL HEALTH CARE NEEDS

- Sec. 2111. State programs for extended services for children with special health care needs.
- Sec. 2112. Extended services covered under the State plan.
- Sec. 2213. Children eligible for services.
- Sec. 2114. Application and administration.
- Sec. 2115. Cost-sharing.
- Sec. 2116. Program evaluation.
- Sec. 2117. Total Federal budget and Federal allotment to States.

PART 2—LONG-TERM CARE INSURANCE IMPROVEMENT AND ACCOUNTABILITY

- Sec. 2201. Short title.
- Sec. 2202. Establishment of Federal standards for long-term care insurance.

PART 3—LIFE CARE

- Sec. 2301. Short title.
- Sec. 2302. Life care: public insurance program for nursing home care.
- Sec. 2303. Sense of the Committee concerning PACE (Program of All-Inclusive Care for the Elderly).

1 PART 1—STATE PROGRAMS FOR HOME AND COM-
2 MUNITY-BASED SERVICES FOR INDIVIDUALS
3 WITH DISABILITIES

4 Subpart A—Home and Community-Based Services

5 SEC. 2101. STATE PROGRAMS FOR HOME AND COMMUNITY-
6 BASED SERVICES FOR INDIVIDUALS WITH
7 DISABILITIES.

8 (a) IN GENERAL.—Each State that has a plan for
9 the home and community-based services to individuals
10 with disabilities submitted to and approved by the Sec-

1 retary under section 2102(b) is entitled to payment in ac-
2 cordance with section 2108.

3 (b) ENTITLEMENT TO SERVICES.—Nothing in this
4 part shall be construed to create a right to services for
5 individuals or a requirement that a State with an approved
6 plan expend the entire amount of funds to which it is enti-
7 tled under this subtitle, except that nothing in this subtitle
8 shall be construed to restrict or modify an individual's
9 right under existing Federal or State law to enforce the
10 obligations of States entered into pursuant to this Act.

11 (c) DESIGNATION OF AGENCY.—Not later than 6
12 months after the date of enactment of this Act, the Sec-
13 retary shall designate an agency responsible for program
14 administration under this subtitle.

15 **SEC. 2102. STATE PLANS.**

16 (a) PLAN REQUIREMENTS.—In order to be approved
17 under subsection (b), a State plan for home and commu-
18 nity-based services for individuals with disabilities must
19 meet the following requirements:

20 (1) ELIGIBILITY.—

21 (A) IN GENERAL.—Within the amounts
22 provided by the State (and under section 2108)
23 for such plan, the plan shall provide that serv-
24 ices under the plan will be available to individ-

1 uals with disabilities (as defined in section
2 2103(a)) in the State.

3 (B) INITIAL SCREENING.—The plan shall
4 provide a process for the initial screening of in-
5 dividuals who appear to have some reasonable
6 likelihood of being an individual with disabil-
7 ities. Any such process shall require the provi-
8 sion of assistance to individuals who wish to
9 apply but whose disability limits their ability to
10 do so. Except as provided in subparagraph (C),
11 the initial screening, as well as the determina-
12 tion of disability (as defined under section
13 2103(b)(1)) and the comprehensive assessment
14 and individualized plan of care (as defined
15 under section 2104(b)(1)(A) and (B)) and
16 2104(b)(2) (A) and (B) shall be provided by
17 public or private nonprofit agencies that—

18 (i) do not provide home and commu-
19 nity-based services covered under the State
20 plan, with the exception of care manage-
21 ment services;

22 (ii) do not provide nursing facility
23 services; and

24 (iii) do not have a direct or indirect
25 ownership or control interest in an entity

1 that provides home and community-based
2 services or nursing facility services.

3 (C) SCREENING AGENCY EXCEPTIONS.—

4 The provisions of subparagraph (B)(i), (ii) and
5 (iii) shall not apply to providers of residential
6 care. The State agency may elect to waive the
7 provisions of subparagraph (B)(i), (ii), and (iii)
8 in areas of the State in which there is an insuf-
9 ficiency of available service providers.

10 (D) RESTRICTIONS.—The plan may not
11 limit the eligibility of individuals with disabil-
12 ities based on—

13 (i) income,

14 (ii) age,

15 (iii) geography,

16 (iv) nature, severity, or category of
17 disability,

18 (v) residential setting (other than an
19 institutional setting), or

20 (vi) other grounds specified by the
21 Secretary;

22 except that during the initial phase-in period
23 the Secretary may permit a State to limit eligi-
24 bility based on level of disability or geography

1 (if the State assures a balance between urban
2 and rural areas).

3 (E) CONTINUATION OF SERVICES.—The
4 plan must provide assurances that, in the case
5 of an individual receiving medical assistance for
6 home and community-based services under the
7 State medicaid plan as of the date of the enact-
8 ment of this Act, the State will continue to
9 make available (either under this plan, under
10 the State medicaid plan, or otherwise) to such
11 individual an appropriate level of assistance for
12 home and community-based services, taking
13 into account the level of assistance provided as
14 of such date and the individual's need for home
15 and community-based services.

16 (2) SERVICES.—

17 (A) NEEDS ASSESSMENT.—Not later than
18 the end of the second year of implementation,
19 the plan or its amendments shall include the re-
20 sults of a statewide assessment of the needs of
21 individuals with disabilities, in a format re-
22 quired by the Secretary. The needs assessment
23 shall include demographic data concerning the
24 number of individuals within each category of

1 disability described in this Act, and the services
2 available to meet the needs of such individuals.

3 (B) SPECIFICATION.—Consistent with sec-
4 tion 2104, the plan shall specify—

5 (i) the services made available under
6 the plan,

7 (ii) the extent and manner in which
8 such services are allocated and made avail-
9 able to individuals with disabilities, and

10 (iii) the manner in which services
11 under the plan are coordinated with each
12 other and with health and long-term care
13 services available outside the plan for indi-
14 viduals with disabilities.

15 (C) TAKING INTO ACCOUNT INFORMAL
16 CARE.—A State plan may take into account, in
17 determining the amount and array of services
18 made available to covered individuals with dis-
19 ability, the availability of informal care. Any in-
20 dividual care plan that includes informal care
21 shall be required to verify the availability of the
22 informal care.

23 (D) ALLOCATION.—The State plan—

24 (i) shall specify how it will allocate
25 services under the plan, during and after

1 the 7-fiscal-year phase-in period beginning
2 with fiscal year 1996, among covered indi-
3 viduals with disabilities,

4 (ii) shall attempt to meet the needs of
5 individuals with a variety of disabilities
6 and, within the limits of available funding,
7 be sufficient in amount, duration, and
8 scope to provide a substantial assistance in
9 living independently,

10 (iii) shall include services that are de-
11 termined to be necessary to help all cat-
12 egories of individuals with disabilities, re-
13 gardless of their age or the nature of their
14 disabling conditions,

15 (iv) shall demonstrate that services
16 are allocated equitably, in accordance with
17 the needs assessment required under sub-
18 paragraph (A), and

19 (v) shall ensure that—

20 (I) the proportion of the popu-
21 lation of low-income individuals with
22 disabilities in the State that rep-
23 resents individuals with disabilities
24 who are provided home and commu-
25 nity-based services either under the

1 plan, under the State medicaid plan,
2 or under both, is not less than,

3 (II) the proportion of the popu-
4 lation of the State that represents in-
5 dividuals who are low-income individ-
6 uals.

7 (E) LIMITATION ON LICENSURE OR CER-
8 TIFICATION.—The State may not subject
9 consumer-directed providers of personal assist-
10 ance services to licensure, certification, or other
11 requirements which the Secretary finds not to
12 be necessary for the health and safety of indi-
13 viduals with disabilities.

14 (F) CONSUMER CHOICE.—To the extent
15 feasible, the State shall follow the choice of an
16 individual with disabilities (or that individual's
17 designated representative who may be a family
18 member) regarding which covered services to re-
19 ceive and the providers who will provide such
20 services.

21 (3) COST SHARING.—The plan shall impose cost
22 sharing with respect to covered services only in ac-
23 cordance with section 2105.

24 (4) TYPES OF PROVIDERS AND REQUIREMENTS
25 FOR PARTICIPATION.—The plan shall specify—

1 (A) the types of service providers eligible
2 to participate in the program under the plan,
3 which shall include consumer-directed providers,
4 except that the plan—

5 (i) may not limit such benefits to
6 services provided by registered nurses or li-
7 censed practical nurses; and

8 (ii) may not limit such benefits to
9 services provided by agencies or providers
10 certified under title XVIII of the Social Se-
11 curity Act; and

12 (B) any requirements for participation ap-
13 plicable to each type of service provider.

14 (5) BUDGET.—The plan shall specify how the
15 State will manage Federal and State funds available
16 under the plan for each fiscal year during the period
17 beginning with fiscal year 1996 and ending with fis-
18 cal year 2003 and for each 5-fiscal-year periods
19 thereafter to serve all categories of individuals with
20 disabilities and meet the requirements of this sub-
21 section. If the Secretary makes an adjustment under
22 section 2109(a)(5)(C) for a year, each State shall
23 update the specifications under this paragraph to re-
24 flect the impact of such an adjustment.

25 (6) PROVIDER REIMBURSEMENT.—

1 (A) PAYMENT METHODS.—The plan shall
2 specify the payment methods to be used to re-
3 imburse providers for services furnished under
4 the plan. Such methods may include retrospec-
5 tive reimbursement on a fee-for-service basis,
6 prepayment on a capitation basis, payment by
7 cash or vouchers to individuals with disabilities,
8 or any combination of these methods. In the
9 case of payment for consumer-directed services,
10 including the use of cash or vouchers, the plan
11 shall specify how the plan will assure compli-
12 ance with applicable employment tax and health
13 care coverage provisions.

14 (B) PAYMENT RATES.—The plan shall
15 specify the methods and criteria to be used to
16 set payment rates for—

17 (i) agency administered services fur-
18 nished under the plan; and

19 (ii) consumer-directed services fur-
20 nished under the plan, including cash pay-
21 ments or vouchers to individuals with dis-
22 abilities, except that such payments shall
23 be adequate to cover amounts required
24 under the applicable employment tax provi-
25 sions of the Internal Revenue Code of

1 1986 (as added or amended by title VII of
2 the Health Security Act) and the health
3 care coverage provisions under this Act.

4 (C) PLAN PAYMENT AS PAYMENT IN
5 FULL.—The plan shall restrict payment under
6 the plan for covered services to those providers
7 that agree to accept the payment under the
8 plan (at the rates established pursuant to sub-
9 paragraph (B)) and any cost sharing permitted
10 or provided for under section 2105 as payment
11 in full for services furnished under the plan.

12 (7) QUALITY ASSURANCE AND SAFEGUARDS.—
13 The State plan shall provide for quality assurance
14 and safeguards for applicants and beneficiaries in
15 accordance with section 2106.

16 (8) ADVISORY GROUP.—The State plan shall—
17 (A) assure the establishment and mainte-
18 nance of an advisory group under section
19 2107(b), and

20 (B) include the documentation prepared by
21 the group under section 2107(b)(4).

22 (9) ADMINISTRATION AND ACCESS.—

23 (A) STATE AGENCY.—The plan shall des-
24 ignate a State agency or agencies to administer
25 (or to supervise the administration of) the plan.

1 (B) INFORMATION AND ASSISTANCE CEN-
2 TER.—The plan shall provide for a single point
3 of access to information about the system for
4 individuals with disabilities. The plan may des-
5 ignate separate entry points for individuals
6 under the age of 22, for individuals age 65
7 years and older, or for other appropriate classi-
8 fication of individuals.

9 (C) COORDINATION.—The plan shall speci-
10 fy how it will—

11 (i) integrate services provided under
12 the plan, including eligibility prescreening,
13 service coordination, and referrals for indi-
14 viduals with disabilities who are ineligible
15 for services under this part, with the State
16 medicaid plan, titles V and XX of the So-
17 cial Security Act, programs under the
18 Older Americans Act of 1965, programs
19 under the Developmental Disabilities As-
20 sistance and Bill of Rights Act, the Indi-
21 viduals with Disabilities Education Act,
22 and any other Federal or State programs
23 that provide services or assistance targeted
24 to individuals with disabilities, and

25 (ii) coordinate with health plans.

1 (D) ADMINISTRATIVE EXPENDITURES.—

2 The plan shall contain assurances that not
3 more than 10 percent of expenditures under the
4 plan for all quarters in any fiscal year shall be
5 for administrative costs, except that, in fiscal
6 years 1996 through 2002, administrative ex-
7 penditures for the design, development, and in-
8 stallation of mechanical claims processing sys-
9 tems, information retrieval, and infrastructure
10 development may exceed the limit described in
11 this subparagraph by not more than an addi-
12 tional 10 percent of total expenditures. Quality
13 assurance activities shall not be included as ad-
14 ministrative costs. The Secretary shall have the
15 authority to waive the administrative limit.

16 (10) REPORTS AND INFORMATION TO SEC-
17 RETARY; AUDITS.—The plan shall provide that the
18 State will furnish to the Secretary—

19 (A) such reports, and will cooperate with
20 such audits, as the Secretary determines are
21 needed concerning the State's administration of
22 its plan under this part, including the process-
23 ing of claims under the plan, and

1 (B) such data and information as the Sec-
2 retary may require in a uniform format as spec-
3 ified by the Secretary.

4 (11) USE OF STATE FUNDS FOR MATCHING.—
5 The plan shall provide assurances that Federal
6 funds will not be used to provide for the State share
7 of expenditures under this part.

8 (12) HEALTH CARE WORKER REDEPLOYMENT
9 REQUIREMENT.—The plan provides for compliance
10 with the requirement of section 3083(a).

11 (13) TERMINOLOGY.—The plan shall adhere to
12 uniform definitions of terms, as specified by the Sec-
13 retary.

14 (b) APPROVAL OF PLANS.—The Secretary shall ap-
15 prove a plan submitted by a State if the Secretary deter-
16 mines that the plan—

17 (1) was developed by the State after a public
18 comment period of not less than 30 days, and

19 (2) meets the requirements of subsection (a).

20 The approval of such a plan shall take effect as of the
21 first day of the first fiscal year beginning after the date
22 of such approval (except that any approval made before
23 January 1, 1996, shall be effective as of January 1, 1996).

24 In order to budget funds allotted under this part, the Sec-
25 retary may establish a deadline for the submission of such

1 a plan before the beginning of a fiscal year as a condition
2 of its approval effective with that fiscal year. Any signifi-
3 cant changes to the State plan shall be submitted to the
4 Secretary in the form of plan amendments and shall be
5 subject to approval by the Secretary.

6 (c) MONITORING.—The Secretary shall annually
7 monitor the compliance of State plans with the require-
8 ments of this subtitle according to specified performance
9 standards. States that fail to comply with such require-
10 ments may be subject to the withholding of Federal funds
11 for services or administration until such time as compli-
12 ance is achieved.

13 (d) TECHNICAL ASSISTANCE.—The Secretary shall
14 ensure the availability of ongoing technical assistance to
15 States under this section. Such assistance shall include
16 serving as a clearinghouse for information regarding suc-
17 cessful practices in providing long-term care services.

18 (e) REGULATIONS.—The Secretary shall issue such
19 regulations as may be appropriate to carry out this part
20 on a timely basis.

21 **SEC. 2103. INDIVIDUALS WITH DISABILITIES DEFINED.**

22 (a) IN GENERAL.—In this part, the term “individual
23 with disabilities” means any individual within one or more
24 of the following 4 categories of individuals:

1 (1) INDIVIDUALS REQUIRING HELP WITH AC-
2 TIVITIES OF DAILY LIVING.—Except as provided in
3 section 2103(a)(4) an individual of any age who—

4 (A) requires hands-on or standby assist-
5 ance, supervision, or cueing (as defined in regu-
6 lations) to perform three or more activities of
7 daily living (as defined in subsection (c)), and

8 (B) is expected to require such assistance,
9 supervision, or cueing over a period of at least
10 90 days.

11 (2) INDIVIDUALS WITH SEVERE COGNITIVE OR
12 MENTAL IMPAIRMENT.—An individual of any age—

13 (A) whose score, on a standard mental sta-
14 tus protocol (or protocols) appropriate for
15 measuring the individual's particular condition
16 specified by the Secretary, indicates either se-
17 vere cognitive impairment or severe mental im-
18 pairment, or both;

19 (B) who—

20 (i) requires hands-on or standby as-
21 sistance, supervision, or cueing with one or
22 more activities of daily living,

23 (ii) requires hands-on or standby as-
24 sistance, supervision, or cueing with at
25 least such instrumental activity (or activi-

1 ties) of daily living related to cognitive or
2 mental impairment as the Secretary speci-
3 fies, or

4 (iii) displays symptoms of one or more
5 serious behavioral problems (that is on a
6 list of such problems specified by the Sec-
7 retary) which create a need for supervision
8 to prevent harm to self or others; and

9 (C) who is expected to meet the require-
10 ments of subparagraphs (A) and (B) over a pe-
11 riod of at least 90 days.

12 Not later than 2 years after the date of enactment
13 of this Act, the Secretary shall make recommenda-
14 tions regarding the most appropriate duration of dis-
15 ability under this paragraph.

16 (3) INDIVIDUALS WITH SEVERE OR PROFOUND
17 MENTAL RETARDATION.—An individual of any age
18 who has severe or profound mental retardation (as
19 determined according to a protocol specified by the
20 Secretary).

21 (4) YOUNG CHILDREN WITH SEVERE DISABIL-
22 ITIES.—An individual under 6 years of age who—

23 (A) has a severe disability or chronic medi-
24 cal condition that limits functioning in a man-
25 ner that is comparable in severity to the stand-

1 ards established under paragraphs (1), (2), or
2 (3), and

3 (B) is expected to have such a disability or
4 condition and require such services over a pe-
5 riod of at least 90 days.

6 (b) DETERMINATION.—

7 (1) IN GENERAL.—In formulating eligibility cri-
8 teria under subsection (a), the Secretary shall estab-
9 lish criteria for assessing the functional level of dis-
10 ability among all categories of individuals with dis-
11 abilities that are comparable in severity, regardless
12 of the age or the nature of the disabling condition
13 of the individual. The determination of whether an
14 individual is an individual with disabilities shall be
15 made, by persons or entities specified under the
16 State plan, using a uniform protocol consisting of an
17 initial screening and preliminary assessment speci-
18 fied by the Secretary. A State may not impose cost
19 sharing with respect to the preliminary assessment.
20 A State may collect additional information, at the
21 time of obtaining information to make such deter-
22 mination, in order to provide for the assessment and
23 plan described in section 2104(b) or for other pur-
24 poses. The State shall establish a fair hearing proc-
25 ess for appeals of such determinations.

1 (2) INDIVIDUALS WITH COMPARABLE DISABIL-
2 ITIES.—Not more than 2 percent of a State’s allot-
3 ment for services under this part may be expended
4 for the provision of services to individuals with se-
5 vere disabilities that are comparable in severity to
6 the criteria described in subsection (a), but who fail
7 to meet the criteria described in any single category.

8 (3) PERIODIC REASSESSMENT.—The determina-
9 tion that an individual is an individual with disabil-
10 ities shall be considered to be effective under the
11 State plan for a period of not more than 6 months
12 (or for such longer period in such cases as a signifi-
13 cant change in an individual’s condition that may af-
14 fect such determination is unlikely). A reassessment
15 shall be made if there is a significant change in an
16 individual’s condition that may affect such deter-
17 mination.

18 (c) REASSESSMENTS.—The Secretary shall reassess
19 the validity of the eligibility criteria described in sub-
20 section (a) as new knowledge regarding the assessments
21 of functional disabilities becomes available. The Secretary
22 shall report to the Committee on Labor and Human Re-
23 sources of the Senate and the Committee on Energy and
24 Commerce of the House of Representatives on its findings

1 not later than 5 years after the date of enactment of this
2 Act.

3 (d) ACTIVITY OF DAILY LIVING DEFINED.—In this
4 part, the term “activity of daily living” means any of the
5 following: eating, toileting, dressing, bathing, and trans-
6 ferring.

7 **SEC. 2104. HOME AND COMMUNITY-BASED SERVICES COV-**
8 **ERED UNDER STATE PLAN.**

9 (a) SPECIFICATION.—

10 (1) IN GENERAL.—Subject to the succeeding
11 provisions of this section, the State plan under this
12 part shall specify—

13 (A) the home and community-based serv-
14 ices available under the plan to individuals with
15 disabilities (or to such categories of such indi-
16 viduals), and

17 (B) any limits with respect to such serv-
18 ices, except that within the limits of available
19 funding, such services shall be sufficient in
20 amount, duration, and scope to provide sub-
21 stantial assistance in living independently.

22 (2) FLEXIBILITY IN MEETING INDIVIDUAL
23 NEEDS.—Subject to subsection (e)(1)(B), such serv-
24 ices may be delivered in an individual’s home, a

1 range of community residential arrangements, or
2 outside the home.

3 (b) REQUIREMENT FOR CARE MANAGEMENT.—

4 (1) IN GENERAL.—The State shall make avail-
5 able to each category of individual with disabilities
6 care management services that at a minimum in-
7 clude—

8 (A) a comprehensive assessment of the in-
9 dividual's need for home and community-based
10 services (regardless of whether all needed serv-
11 ices are available under the plan),

12 (B) an individualized plan of care based on
13 such assessment,

14 (C) services consistent with such plan of
15 care,

16 (D) arrangements for the provision of such
17 services, and

18 (E) monitoring of the delivery of services.

19 (2) HOME AND COMMUNITY-BASED SERV-
20 ICES.—The State shall provide for home and com-
21 munity-based services to an individual with disabil-
22 ities only if—

23 (A) a comprehensive assessment of the in-
24 dividual's need for home and community-based
25 services (regardless of whether all needed serv-

1 ices are available under the plan) has been
2 made,

3 (B) an individualized plan of care based on
4 such assessment is developed, and

5 (C) such services are provided consistent
6 with such plan of care.

7 The Secretary shall develop a uniform comprehen-
8 sive assessment tool that shall be used by the States
9 under subparagraph (A). Alternative comprehensive
10 assessment tools may be used by the States only
11 with the approval of the Secretary. The Secretary
12 shall provide guidance to the States with regard to
13 the appropriate qualifications for individuals who
14 conduct comprehensive assessments.

15 (3) INVOLVEMENT OF INDIVIDUALS.—The indi-
16 vidualized plan of care under paragraphs (1)(B) and
17 (2)(B) for an individual with disabilities shall—

18 (A) be developed by qualified individuals
19 (specified under the State plan),

20 (B) be developed and implemented in close
21 consultation with the individual or the individ-
22 ual's designated representative,

23 (C) be approved by the individual (or the
24 individual's designated representative), and

1 (D) be reviewed and updated not less often
2 than every 6 months.

3 (4) PLAN OF CARE.—The plan of care under
4 paragraphs (1)(B) and (2)(B) shall—

5 (A) specify which services specified under
6 the individual plan will be provided under the
7 State plan under this part,

8 (B) identify (to the extent possible) how
9 the individual will be provided any services
10 specified under the plan of care and not pro-
11 vided under the State plan, and

12 (C) specify how the provision of services to
13 the individual under the plan will be coordi-
14 nated with the provision of other health care
15 services to the individual.

16 The State shall make reasonable efforts to identify
17 and arrange for services described in subparagraph
18 (B). Nothing in this subsection shall be construed as
19 requiring a State (under the State plan or other-
20 wise) to provide all the services specified in such a
21 plan.

22 (c) MANDATORY COVERAGE OF PERSONAL ASSIST-
23 ANCE SERVICES.—The State plan shall include, in the
24 array of services made available to each category of indi-
25 viduals with disabilities, both agency-administered and

1 consumer-directed personal assistance services (as defined
2 in subsection (g)).

3 (d) ADDITIONAL SERVICES.—

4 (1) TYPES OF SERVICES.—Subject to subsection
5 (e), services available under a State plan under this
6 part shall include any (or all) of the following:

7 (A) Homemaker and chore assistance.

8 (B) Home modifications.

9 (C) Respite services.

10 (D) Assistive devices, as defined in the
11 Technology Related Assistance for Individuals
12 with Disabilities Act.

13 (E) Adult day services.

14 (F) Habilitation and rehabilitation.

15 (G) Supported employment.

16 (H) Home health services.

17 (I) Transportation.

18 (J) Any other care or assistive services
19 (approved by the Secretary) that the State de-
20 termines will help individuals with disabilities to
21 remain in their homes and communities.

22 (2) CRITERIA FOR SELECTION OF SERVICES.—

23 The State plan shall specify—

24 (A) the methods and standards used to se-
25 lect the types, and the amount, duration, and

1 scope, of services to be covered under the plan
2 and to be available to each category of individ-
3 uals with disabilities, and

4 (B) how the types, and the amount, dura-
5 tion, and scope, of services specified, within the
6 limits of available funding, provide substantial
7 assistance in living independently to individuals
8 within each of the 4 categories of individuals
9 with disabilities.

10 Not later than the date on which the plan is fully
11 phased-in, the State shall ensure that a full array of
12 services is available to meet the needs of individuals
13 with disabilities.

14 (e) EXCLUSIONS AND LIMITATIONS.—A State plan
15 may not provide for coverage of—

16 (1) room and board,

17 (2) services furnished in a hospital, nursing fa-
18 cility, intermediate care facility for the mentally re-
19 tarder, or other institutional setting specified by the
20 Secretary, or

21 (3) items and services to the extent coverage is
22 provided for the individual under a health plan or
23 the medicare program.

24 (f) PAYMENT FOR SERVICES.—A State plan may pro-
25 vide for the use of—

- 1 (1) vouchers,
- 2 (2) cash payments directly to individuals with
- 3 disabilities,
- 4 (3) capitation payments to health plans, and
- 5 (4) payment to providers,
- 6 to pay for covered services.

7 (g) PERSONAL ASSISTANCE SERVICES.—

8 (1) IN GENERAL.—In this section, the term
9 “personal assistance services” means those services
10 specified under the State plan as personal assistance
11 services and shall include at least hands-on and
12 standby assistance, supervision, and cueing with ac-
13 tivities of daily living and for people with primarily
14 mental, cognitive or sensory impairments such in-
15 strumental activities of daily living as deemed nec-
16 essary or appropriate, whether agency-administered
17 or consumer-directed (as defined in paragraph (2)).
18 Such services shall include services that are deter-
19 mined to be necessary to help all categories of indi-
20 viduals with disabilities, regardless of their age or
21 the nature of their disabling conditions,

22 (2) CONSUMER-DIRECTED.—In this part:

23 (A) IN GENERAL.—The term “consumer-
24 directed” means, with reference to personal as-
25 sistance services or the provider of such serv-

1 ices, services that are provided by an individual
2 who is selected and managed (and, at the op-
3 tion of the service recipient, trained) by the in-
4 dividual receiving the services.

5 (B) STATE RESPONSIBILITIES.—A State
6 plan shall ensure that where services are pro-
7 vided in a consumer-directed manner, the State
8 shall create or contract with an entity, other
9 than the consumer or the individual provider,
10 to—

11 (i) inform both recipients and provid-
12 ers of rights and responsibilities under all
13 applicable Federal labor and tax law; and

14 (ii) assume responsibility for providing
15 effective billing, payments for services, tax
16 withholding, unemployment insurance, and
17 workers' compensation coverage, and act
18 as the employer of the home care provider.

19 (C) RIGHT OF CONSUMERS.—Notwith-
20 standing the State responsibilities described in
21 subparagraph (B), service recipients, and,
22 where appropriate, their designated representa-
23 tive, shall retain the right to independently se-
24 lect, hire, terminate, and direct (including man-

1 age, train, schedule, and verify services pro-
2 vided) the work of a home care provider.

3 (3) AGENCY ADMINISTERED.—The term “agen-
4 cy-administered” means, with respect to such serv-
5 ices, services that are not consumer-directed.

6 **SEC. 2105. COST SHARING.**

7 (a) NO COST SHARING FOR POOREST.—The State
8 plan may not impose any cost sharing for individuals with
9 income (as determined under subsection (c)) less than 150
10 percent of the official poverty level (referred to in section
11 1902(30)) applicable to a family of the size involved (de-
12 termined without regard to section 1902(30)(B)).

13 (b) SLIDING SCALE FOR REMAINDER.—The State
14 plan shall impose cost sharing in the form of coinsurance
15 (based on the amount paid under the State plan for a serv-
16 ice)—

17 (1) at a rate of 10 percent for individuals with
18 disabilities with income not less than 150 percent,
19 and less than 200 percent, of such official poverty
20 line (as so applied);

21 (2) at a rate of 20 percent for such individuals
22 with income not less than 200 percent, and less than
23 250 percent, of such official poverty line (as so ap-
24 plied); and

1 (3) at a rate of 25 percent for such individuals
2 with income equal to at least 250 percent of such of-
3 ficial poverty line (as so applied).

4 (c) RECOMMENDATION OF THE SECRETARY.—The
5 Secretary shall make recommendations to the States as
6 to how to reduce cost-sharing for individuals with extraor-
7 dinary out-of-pocket costs for whom the cost-sharing pro-
8 visions of section 2105 could jeopardize their ability to
9 take advantage of the services offered under this Act. The
10 Secretary shall establish a methodology for reducing the
11 cost-sharing burden for individuals with exceptionally high
12 out-of-pocket costs under this Act.

13 (d) DETERMINATION OF INCOME FOR PURPOSES OF
14 COST SHARING.—The State plan shall specify the process
15 to be used to determine the income of an individual with
16 disabilities for purposes of this section. Such standards
17 shall include a uniform Federal definition of income and
18 any allowable deductions from income.

19 **SEC. 2106. QUALITY ASSURANCE AND SAFEGUARDS.**

20 (a) MINIMUM REQUIREMENTS FOR PROVIDERS.—

21 (1) IN GENERAL.—Providers of home and com-
22 munity-based services under this subtitle must, as a
23 condition of participation under this subtitle, meet
24 such requirements for quality assurance and safe-
25 guards as shall be established by the Secretary

1 under this section. Such requirements will include at
2 a minimum:

3 (A) QUALITY ASSURANCE.—Not later than
4 January 1, 1995, the Secretary shall promul-
5 gate regulations specifying how the States will
6 ensure and monitor the quality of services, in-
7 cluding—

8 (i) safeguarding the health and safety
9 of individuals with disabilities, including
10 the use of periodic surveys of providers;

11 (ii) the minimum standards for agen-
12 cy providers, including certification, and
13 how such standards will be enforced;

14 (iii) the minimum competency require-
15 ments, including education and training re-
16 quirements, for agency provider employees
17 who provide direct services under this part
18 and how the competency of such employees
19 will be enforced;

20 (iv) obtaining meaningful consumer
21 input, including consumer surveys that
22 measure the extent to which participants
23 receive the services described in the plan of
24 care and participant satisfaction with such
25 services;

1 (v) participation in quality assurance
2 activities; and

3 (vi) the role of existing State
4 consumer protection and advocacy re-
5 sources, particularly the long-term care
6 ombudsman (under the Older Americans
7 Act of 1965) and the Protection and Advo-
8 cacy Agency (under the Developmental
9 Disabilities Assistance and Bill of Rights
10 Act) in assuring quality of services and
11 protecting the rights of individuals with
12 disabilities.

13 (B) SAFEGUARDS.—Not later than Janu-
14 ary 1, 1995, the Secretary shall promulgate
15 regulations providing the following:

16 (i) CONFIDENTIALITY.—The regula-
17 tions shall provide safeguards which re-
18 strict the use of disclosure of information
19 concerning applicants and beneficiaries to
20 purposes directly connected with the ad-
21 ministration of the plan (including per-
22 formance reviews under this section).

23 (ii) SAFEGUARDS AGAINST ABUSE.—
24 The regulations shall provide safeguards
25 against physical, emotional, or financial

1 abuse or exploitation (specifically including
2 appropriate safeguards in cases where pay-
3 ment for program benefits is made by cash
4 payment or vouchers given directly to indi-
5 viduals with disabilities.

6 (2) NO DELEGATION TO STATES.—The Sec-
7 retary’s authority under this subsection shall not be
8 delegated to States.

9 (3) NO PREVENTION OF MORE STRINGENT RE-
10 QUIREMENTS BY STATES .—Nothing in this section
11 shall be construed as preventing States from impos-
12 ing requirements that are more stringent than the
13 requirements established by the Secretary under this
14 subsection.

15 (b) FEDERAL STANDARDS.—The State plan shall ad-
16 here to Federal quality standards in the following areas:

17 (1) Case review of a specified sample of client
18 records.

19 (2) Random home visits for a specified percent-
20 age of cases.

21 (3) The mandatory reporting of abuse, neglect,
22 or exploitation.

23 (4) The establishment of a formal client griev-
24 ance mechanism, including a fair hearing process.

1 (5) State licensure or certification for agency
2 providers that offer home health services.

3 (6) Minimum training requirements for agency-
4 directed home care workers.

5 (7) The development of a registry of provider
6 agencies or home care workers against whom any
7 complaints have been sustained, which shall be avail-
8 able to the public.

9 (8) Sanctions to be imposed on States or pro-
10 viders, including disqualification from the program,
11 if minimum standards are not met.

12 (9) Surveys of client satisfaction.

13 (10) State optional training programs for infor-
14 mal caregivers.

15 (c) FUNDING.—A State that is entitled to a payment
16 in accordance with section 2108 shall receive a separate
17 allocation that may be expended only for client advocacy
18 activities. The State may use such funds to augment the
19 budgets of the long-term care ombudsman (under the
20 Older Americans Act of 1965) and the Protection and Ad-
21 vocacy Agency (under the Developmental Disabilities As-
22 sistance and Bill of Rights Act) or may establish a sepa-
23 rate and independent agency to administer a new program
24 designed to advocate for client rights.

25 (d) FUNCTIONS.—

1 (1) IN GENERAL.—A client advocacy office es-
2 tablished under this section shall—

3 (A) identify, investigate, and resolve com-
4 plaints that—

5 (i) are made by, or on behalf of, cli-
6 ents; and

7 (ii) relate to action, inaction, or deci-
8 sions, that may adversely affect the health,
9 safety, welfare, or rights of the clients (in-
10 cluding the welfare and rights of the cli-
11 ents with respect to the appointment and
12 activities of guardians and representative
13 payees), of—

14 (I) providers, or representatives
15 of providers, of long-term care serv-
16 ices;

17 (II) public agencies; or

18 (III) health and social service
19 agencies;

20 (B) provide services to assist the clients in
21 protecting the health, safety, welfare, and rights
22 of the clients;

23 (C) inform the clients about means of ob-
24 taining services provided by providers or agen-

1 cies described in subparagraph (A)(ii) or serv-
2 ices described in subparagraph (B);

3 (D) ensure that the clients have regular
4 and timely access to the services provided
5 through the office and that the clients and com-
6 plainants receive timely responses from rep-
7 resentatives of the office to complaints; and

8 (E) represent the interests of the clients
9 before governmental agencies and seek adminis-
10 trative, legal, and other remedies to protect the
11 health, safety, welfare, and rights of the clients
12 with regard to the provisions of this title and
13 related concerns under this Act.

14 (2) CONTRACTS AND ARRANGEMENTS.—

15 (A) IN GENERAL.—Except as provided in
16 subparagraph (B), the State agency may estab-
17 lish and operate the office, and carry out the
18 program, directly, or by contract or other ar-
19 rangement with any public agency or nonprofit
20 private organization.

21 (B) LICENSING AND CERTIFICATION ORGA-
22 NIZATIONS; ASSOCIATIONS.—The State agency
23 may not enter into the contract or other ar-
24 rangement described in subparagraph (A) with
25 an agency or organization that is responsible

1 for licensing, certifying, or providing long-term
2 care services in the State.

3 (e) SAFEGUARDS.—

4 (1) CONFIDENTIALITY.—The State plan shall
5 provide safeguards which restrict the use or disclo-
6 sure of information concerning applicants and bene-
7 ficiaries to purposes directly connected with the ad-
8 ministration of the plan (including performance re-
9 views under section 2602).

10 (2) SAFEGUARDS AGAINST ABUSE.—The State
11 plans shall provide safeguards against physical, emo-
12 tional, or financial abuse or exploitation (specifically
13 including appropriate safeguards in cases where pay-
14 ment for program benefits is made by cash pay-
15 ments or vouchers given directly to individuals with
16 disabilities). All providers of services shall be re-
17 quired to register with the State agency.

18 (f) ISSUANCE OF REGULATIONS.—Not later than 1
19 year after the date of enactment of this Act, the Secretary
20 shall issue regulations implementing the quality provisions
21 of this section.

22 **SEC. 2107. ADVISORY GROUPS.**

23 (a) FEDERAL ADVISORY GROUP.—

24 (1) ESTABLISHMENT.—The Secretary shall es-
25 tablish an advisory group, to advise the Secretary

1 and States on all aspects of the program under this
2 part.

3 (2) COMPOSITION.—The group shall be com-
4 posed of individuals with disabilities and their rep-
5 resentatives, providers, Federal and State officials,
6 and local community implementing agencies. A ma-
7 jority of its members shall be individuals with dis-
8 abilities and their representatives.

9 (b) STATE ADVISORY GROUPS.—

10 (1) IN GENERAL.—Each State plan shall pro-
11 vide for the establishment and maintenance of an
12 advisory group to advise the State on all aspects of
13 the State plan under this part.

14 (2) COMPOSITION.—Members of each advisory
15 group shall be appointed by the Governor (or other
16 chief executive officer of the State) and shall include
17 individuals with disabilities and their representa-
18 tives, providers, State officials, and local community
19 implementing agencies. A majority of its members
20 shall be individuals with disabilities and their rep-
21 resentatives. The members of the advisory group
22 shall be selected from the those nominated as de-
23 scribed in section 2107(b)(3).

24 (3) SELECTION OF MEMBERS.—Each State
25 shall establish a process whereby all residents of the

1 State, including individuals with disabilities and
2 their representatives, shall be given the opportunity
3 to nominate members to the advisory group.

4 (4) PARTICULAR CONCERNS.—Each advisory
5 group shall—

6 (A) before the State plan is developed, ad-
7 vise the State on guiding principles and values,
8 policy directions, and specific components of the
9 plan,

10 (B) meet regularly with State officials in-
11 volved in developing the plan, during the devel-
12 opment phase, to review and comment on all as-
13 pects of the plan,

14 (C) participate in the public hearings to
15 help assure that public comments are addressed
16 to the extent practicable,

17 (D) report to the Governor and make
18 available to the public any differences between
19 the group's recommendations and the plan,

20 (E) report to the Governor and make avail-
21 able to the public specifically the degree to
22 which the plan is consumer-directed, and

23 (F) meet regularly with officials of the des-
24 ignated State agency (or agencies) to provide

1 advice on all aspects of implementation and
2 evaluation of the plan.

3 **SEC. 2108. PAYMENTS TO STATES.**

4 (a) IN GENERAL.—Subject to section 2102(a)(9)(D)
5 (relating to limitation on payment for administrative
6 costs), the Secretary, in accordance with the Cash Man-
7 agement Improvement Act, shall authorize payment to
8 each State with a plan approved under this part, for each
9 quarter (beginning on or after January 1, 1996), from its
10 allotment under section 2109(b), an amount equal to—

11 (1) the Federal matching percentage (as de-
12 fined in subsection (b)) of amount demonstrated by
13 State claims to have been expended during the quar-
14 ter for home and community-based services under
15 the plan for individuals with disabilities; plus

16 (2) an amount equal to 90 percent of the
17 amount demonstrated by the State to have been ex-
18 pended during the quarter for quality assurance ac-
19 tivities under the plan; plus

20 (3) an amount equal to 90 percent of amount
21 expended during the quarter under the plan for ac-
22 tivities (including preliminary screening) relating to
23 determination of eligibility and performance of needs
24 assessment; plus

1 (4) an amount equal to 90 percent (or, begin-
2 ning with quarters in fiscal year 2003, 75 percent)
3 of the amount expended during the quarter for the
4 design, development, and installation of mechanical
5 claims processing systems and for information re-
6 trieval; plus

7 (5) an amount equal to 90 percent (or, begin-
8 ning with quarters in fiscal year 2003, the Federal
9 matching percentage) of the amount expended dur-
10 ing the quarter for infrastructure development, as
11 defined by the Secretary; plus

12 (6) an amount equal to 50 percent of the re-
13 mainder of the amounts expended during the quar-
14 ter as found necessary by the Secretary for the prop-
15 er and efficient administration of the State plan;
16 plus

17 (7) an amount equal to .5 percent of the State's
18 total allotment for client advocacy activities de-
19 scribed in section 2106(c).

20 (b) FEDERAL MATCHING PERCENTAGE.—

21 (1) IN GENERAL.—In subsection (a), the term
22 “Federal matching percentage” means, with respect
23 to a State, the reference percentage specified in
24 paragraph (2) increased by 17.5 percentage points,
25 except that the Federal matching percentage shall in

1 no case be less than 67.5 percent or more than 95
2 percent.

3 (2) REFERENCE PERCENTAGE.—

4 (A) IN GENERAL.—The reference percent-
5 age specified in this paragraph is 100 percent
6 less the State percentage specified in subpara-
7 graph (B), except that—

8 (i) the percentage under this para-
9 graph shall in no case be less than 50 per-
10 cent or more than 83 percent, and

11 (ii) the percentage for Puerto Rico,
12 the Virgin Islands, Guam, the Northern
13 Mariana Islands, and American Samoa
14 shall be 50 percent.

15 (B) STATE PERCENTAGE.—The State per-
16 centage specified in this subparagraph is that
17 percentage which bears the same ratio to 45
18 percent as the square of the per capita income
19 of such State bears to the square of the per
20 capita income of the continental United States
21 (including Alaska) and Hawaii.

22 (c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE
23 ADJUSTMENTS.—The method of computing and making
24 payments under this section shall be as follows:

1 (1) The Secretary shall, prior to the beginning
2 of each quarter, estimate the amount to be paid to
3 the State under subsection (a) for such quarter,
4 based on a report filed by the State containing its
5 estimate of the total sum to be expended in such
6 quarter, and such other information as the Secretary
7 may find necessary.

8 (2) From the allotment available therefore, the
9 Secretary shall provide for payment of the amount
10 so estimated, reduced or increased, as the case may
11 be, by any sum (not previously adjusted under this
12 section) by which the Secretary finds that the esti-
13 mate of the amount to be paid the State for any
14 prior period under this section was greater or less
15 than the amount which should have been paid.

16 (d) APPLICATION OF RULES REGARDING LIMITA-
17 TIONS ON PROVIDER-RELATED DONATIONS AND HEALTH
18 CARE RELATED TAXES.—The provisions of section
19 1903(w) of the Social Security Act shall apply to pay-
20 ments to States under this section in the same manner
21 as they apply to payments to States under section 1903(a)
22 of such Act .

23 **SEC. 2109. APPROPRIATION; ALLOTMENTS TO STATES.**

24 (a) APPROPRIATION.—

1 (1) FISCAL YEARS 1996 THROUGH 2003.—Sub-
2 ject to paragraph (5)(C), for purposes of this part,
3 the appropriation authorized under this part for
4 each of fiscal years 1996 through 2003 is the follow-
5 ing:

6 (A) For fiscal year 1996, \$3,900,000,000.

7 (B) For fiscal year 1997, \$6,800,000,000.

8 (C) For fiscal year 1998, \$9,600,000,000.

9 (D) For fiscal year 1999,
10 \$12,900,000,000.

11 (E) For fiscal year 2000,
12 \$16,400,000,000.

13 (F) For fiscal year 2001,
14 \$23,400,000,000.

15 (G) For fiscal year 2002,
16 \$31,100,000,000.

17 (H) For fiscal year 2003,
18 \$33,600,000,000.

19 (2) SUBSEQUENT FISCAL YEARS.—For pur-
20 poses of this part, the total Federal budget for State
21 plans under this part for each fiscal year after fiscal
22 year 2003 is the total Federal budget under this
23 subsection for the preceding fiscal year multiplied
24 by—

1 (A) a factor (described in paragraph (3))
2 reflecting the change in the CPI for the fiscal
3 year, and

4 (B) a factor (described in paragraph (4))
5 reflecting the change in the number of individ-
6 uals with disabilities for the fiscal year.

7 (3) CPI INCREASE FACTOR.—For purposes of
8 paragraph (2)(A), the factor described in this para-
9 graph for a fiscal year is the ratio of—

10 (A) the annual average index of the
11 consumer price index for the preceding fiscal
12 year, to—

13 (B) such index, as so measured, for the
14 second preceding fiscal year.

15 (4) DISABLED POPULATION FACTOR.—For pur-
16 poses of paragraph (2)(B), the factor described in
17 this paragraph for a fiscal year is 100 percent plus
18 (or minus) the percentage increase (or decrease)
19 change in the disabled population of the United
20 States (as determined for purposes of the most re-
21 cent update under subsection (b)(3)(D)).

22 (5) ADDITIONAL FUNDS DUE TO MEDICAID
23 OFFSETS.—

24 (A) IN GENERAL.—Each participating
25 State must provide the Secretary with informa-

1 tion concerning offsets and reductions in the
2 medicaid program resulting from home and
3 community-based services provided disabled in-
4 dividuals under this part, that would have been
5 paid for such individuals under the State medic-
6 aid plan but for the provision of similar services
7 under the program under this part. At the time
8 a State first submits its plan under this title
9 and before each subsequent fiscal year (through
10 fiscal year 2003), the State also must provide
11 the Secretary with such budgetary information
12 (for each fiscal year through fiscal year 2003),
13 as the Secretary determines to be necessary to
14 carry out this paragraph.

15 (B) REPORTS.—Each State with a pro-
16 gram under this part shall submit such reports
17 to the Secretary as the Secretary may require
18 in order to monitor compliance with subpara-
19 graph (A). The Secretary shall specify the for-
20 mat of such reports and establish uniform data
21 reporting elements.

22 (C) ADJUSTMENTS TO FEDERAL
23 BUDGET.—

24 (i) IN GENERAL.—For each fiscal year
25 (beginning with fiscal year 1996 and end-

1 ing with fiscal year 2003) and based on a
2 review of information submitted under sub-
3 paragraph (A), the Secretary shall deter-
4 mine the amount by which the total Fed-
5 eral budget under subsection (a) will in-
6 crease. The amount of such increase for a
7 fiscal year shall be limited to the reduction
8 in Federal expenditures of medical assist-
9 ance (as determined by Secretary) that
10 would have been made under title XIX of
11 the Social Security Act for home and com-
12 munity based services for disabled individ-
13 uals but for the provision of similar serv-
14 ices under the program under this part.

15 (ii) ANNUAL PUBLICATION.—The Sec-
16 retary shall publish before the beginning of
17 such fiscal year, the revised total Federal
18 budget under this subsection for such fis-
19 cal year (and succeeding fiscal years before
20 fiscal year 2003).

21 (D) NO DUPLICATE PAYMENT.—No pay-
22 ment may be made to a State under this section
23 for any services to the extent that the State re-
24 ceived payment for such services under section

1 1903(a) of the Social Security Act or title I of
2 this Act.

3 (E) CONSTRUCTION.—Nothing in this sub-
4 section shall be construed as requiring States to
5 determine eligibility for medical assistance
6 under the State medicaid plan on behalf of indi-
7 viduals receiving assistance under this part.

8 (b) ALLOTMENTS TO STATES.—

9 (1) IN GENERAL.—The Secretary shall allot to
10 each State for each fiscal year an amount that bears
11 the same ratio to the total Federal budget for the
12 fiscal year (specified under paragraph (1) or (2) of
13 subsection (a)) as the State allotment factor (under
14 paragraph (2) for the State for the fiscal year) bears
15 to the sum of such factors for all States for that fis-
16 cal year. One-half of one percent of the allotment
17 provided under this paragraph shall be used exclu-
18 sively for client advocacy activities.

19 (2) STATE ALLOTMENT FACTOR.—

20 (A) IN GENERAL.—For each State for each
21 fiscal year, the Secretary shall compute a State
22 allotment factor equal to the sum of—

23 (i) the base allotment factor (specified
24 in subparagraph (B)), and

1 (ii) the low income allotment factor
2 (specified in subparagraph (C)),
3 for the State for the fiscal year.

4 (B) BASE ALLOTMENT FACTOR.—The base
5 allotment factor, specified in this subparagraph,
6 for a State for a fiscal year is equal to the
7 product of the following:

8 (i) NUMBER OF INDIVIDUALS WITH
9 DISABILITIES.—The number of individuals
10 with disabilities in the State (determined
11 under paragraph (3)) for the fiscal year.

12 (ii) 80 PERCENT OF THE NATIONAL
13 PER CAPITA BUDGET.—80 percent of the
14 national average per capita budget amount
15 (determined under paragraph (4)) for the
16 fiscal year.

17 (iii) WAGE ADJUSTMENT FACTOR.—
18 The wage adjustment factor (determined
19 under paragraph (5)) for the State for the
20 fiscal year.

21 (iv) FEDERAL MATCHING RATE.—The
22 Federal matching rate (determined under
23 section 2108(b)) for the fiscal year.

24 (C) LOW INCOME ALLOTMENT FACTOR.—
25 The low income allotment factor, specified in

1 this subparagraph, for a State for a fiscal year
2 is equal to the product of the following:

3 (i) NUMBER OF INDIVIDUALS WITH
4 DISABILITIES.—The number of individuals
5 with disabilities in the State (determined
6 under paragraph (3)) for the fiscal year.

7 (ii) 10 PERCENT OF THE NATIONAL
8 PER CAPITA BUDGET.—10 percent of the
9 national average per capita budget amount
10 (determined under paragraph (4)) for the
11 fiscal year.

12 (iii) WAGE ADJUSTMENT FACTOR.—
13 The wage adjustment factor (determined
14 under paragraph (5)) for the State for the
15 fiscal year.

16 (iv) FEDERAL MATCHING RATE.—The
17 Federal matching rate (determined under
18 section 2108(b)) for the fiscal year.

19 (v) LOW INCOME INDEX.—The low in-
20 come index (determined under paragraph
21 (6)) for the State for the preceding fiscal
22 year.

23 (3) NUMBER OF INDIVIDUALS WITH DISABIL-
24 ITIES.—The number of individuals with disabilities

1 in a State for a fiscal year shall be determined as
2 follows:

3 (A) BASE.—The Secretary shall determine
4 the number of individuals in the State by age,
5 sex, and income category, based on the 1990
6 decennial census, adjusted (as appropriate) by
7 the March 1994 current population survey.

8 (B) DISABILITY PREVALENCE LEVEL BY
9 POPULATION CATEGORY.—The Secretary shall
10 determine, for each such age, sex, and income
11 category, the national average proportion of the
12 population of such category that represents in-
13 dividuals with disabilities. The Secretary may
14 conduct periodic surveys in order to determine
15 such proportions.

16 (C) BASE DISABLED POPULATION IN A
17 STATE.—The number of individuals with dis-
18 abilities in a State in 1994 is equal to the sum
19 of the products, for such each age, sex, and in-
20 come category, of—

21 (i) the population of individuals in the
22 State in the category (determined under
23 subparagraph (A)), and

1 (ii) the national average proportion
2 for such category (determined under sub-
3 paragraph (B)).

4 (D) UPDATE.—The Secretary shall deter-
5 mine the number of individuals with disabilities
6 in a State in a fiscal year equal to the number
7 determined under subparagraph (C) for the
8 State increased (or decreased) by the percent-
9 age increase (or decrease) in the disabled popu-
10 lation of the State as determined under the cur-
11 rent population survey from 1994 to the year
12 before the fiscal year involved.

13 (4) NATIONAL PER CAPITA BUDGET AMOUNT.—
14 The national average per capita budget amount, for
15 a fiscal year, is—

16 (A) the total Federal budget specified
17 under subsection (a) for the fiscal year; divided
18 by

19 (B) the sum, for the fiscal year, of the
20 numbers of individuals with disabilities (deter-
21 mined under paragraph (3)) for all the States
22 for the fiscal year.

23 (5) WAGE ADJUSTMENT FACTOR.—The wage
24 adjustment factor, for a State for a fiscal year, is
25 equal to the ratio of—

1 (A) the average hourly wages for service
2 workers (other than household or protective
3 services) in the State, to

4 (B) the national average hourly wages for
5 service workers (other than household or protec-
6 tive services).

7 The hourly wages shall be determined under this
8 paragraph based on data from the most recent de-
9 cennial census for which such data are available.

10 (6) LOW INCOME INDEX.—The low income
11 index for each State for a fiscal year is the ratio, de-
12 termined for the preceding fiscal year, of—

13 (A) the percentage of the State's popu-
14 lation that has income below 150 percent of the
15 poverty level, to

16 (B) the percentage of the population of the
17 United States that has income below 150 per-
18 cent of the poverty level.

19 Such percentages shall be based on data from the
20 most recent decennial census for which such data
21 are available, adjusted by data from the most recent
22 current population survey as determined appropriate
23 by the Secretary.

24 (c) CARRY-OVER.—With respect to fiscal years 1996
25 through 2003, a State shall be permitted to carry-over not

1 more than 25 percent of the allotment of such State for
2 expenditures in the subsequent year.

3 (d) STATE ENTITLEMENT.—This part constitutes
4 budget authority in advance of appropriations Acts, and
5 represents the obligation of the Federal Government to
6 provide for the payment to States of amounts described
7 in subsection (a).

8 **SEC. 2110. FEDERAL EVALUATIONS.**

9 Not later than December 31, 2000, December 31,
10 2003, and each December 31 thereafter, the Secretary
11 shall provide to Congress analytical reports that evalu-
12 ate—

13 (1) the extent to which individuals with low in-
14 comes and disabilities are equitably served;

15 (2) the adequacy and equity of service plans to
16 individuals with similar levels of disability across
17 States;

18 (3) the comparability of program participation
19 across States, described by level and type of disabil-
20 ity; and

21 (4) the ability of service providers to sufficiently
22 meet the demand for services.

23 Not later than 18 months after the date of enactment
24 of this Act, the Secretary shall report to Congress concern-
25 ing the feasibility of providing reimbursement under

1 health plans and other payers of health services for full
2 geriatric assessment, when recommended by a physician.

3 **Subpart B—State Programs for Extended Services**
4 **for Children With Special Health Care Needs**

5 **SEC. 2111. STATE PROGRAMS FOR EXTENDED SERVICES**
6 **FOR CHILDREN WITH SPECIAL HEALTH CARE**
7 **NEEDS.**

8 (a) PURPOSE.—The purpose of this subpart is to pro-
9 vide financial assistance to the States to assist each State
10 in developing and implementing, or expanding and en-
11 hancing, a family-centered, culturally competent, commu-
12 nity-centered, comprehensive statewide system of extended
13 services and benefits for children with special health care
14 needs.

15 (b) PAYMENT.—Each State that has a plan for the
16 provision of extended services for children with special
17 health care needs submitted to and approved by the Sec-
18 retary under section 2114 is entitled to payment subject
19 to section 2117. Approval of a plan shall be contingent
20 upon adequacy of funding and fulfillment of criteria estab-
21 lished and published by the Secretary.

22 **SEC. 2112. EXTENDED SERVICES COVERED UNDER THE**
23 **STATE PLAN.**

24 (a) SPECIFICATION.—

1 (1) IN GENERAL.—Subject to the succeeding
2 provisions of this section, the State plan under this
3 subpart shall specify—

4 (A) the extended services available under
5 the plan to eligible children, and

6 (B) any limits with respect to such serv-
7 ices.

8 (2) FLEXIBILITY IN MEETING INDIVIDUAL
9 NEEDS.—Subject to subsection (e)(1)(B), such serv-
10 ices may be delivered in an individual’s home, a
11 range of community residential arrangements, or
12 outside the home.

13 (b) REQUIREMENT FOR NEEDS ASSESSMENT AND
14 PLAN OF CARE.—

15 (1) IN GENERAL.—The State plan shall provide
16 for extended services to an eligible child only if—

17 (A) a comprehensive assessment of the
18 child’s need for home and community-based
19 services (regardless of whether all needed serv-
20 ices are available under the plan) has been
21 made,

22 (B) an individualized plan of care based on
23 such assessment is developed, and

24 (C) such services are provided consistent
25 with such plan of care.

1 (2) INVOLVEMENT OF INDIVIDUALS.—The indi-
2 vidualized plan of care under paragraph (1)(B) for
3 an eligible child shall—

4 (A) be developed by qualified individuals
5 (specified under the State plan),

6 (B) be developed and implemented in close
7 consultation with the child’s designated rep-
8 resentative and the child where appropriate,

9 (C) be approved by the child’s designated
10 representative and the child where appropriate,
11 and

12 (D) be reviewed and updated not less often
13 than every 6 months.

14 (3) PLAN OF CARE.—The plan of care under
15 paragraph (1)(B) shall—

16 (A) specify which services specified under
17 the individual plan will be provided under the
18 State plan under this part,

19 (B) identify (to the extent possible) how
20 the child will be provided any services specified
21 under the plan of care and not provided under
22 the State plan, and

23 (C) specify how the provision of services to
24 the child under the plan will be coordinated

1 with the provision of other health care services
2 to the child.

3 The State shall make reasonable efforts to identify
4 and arrange for services described in subparagraph
5 (B). Nothing in this subsection shall be construed as
6 requiring a State (under the State plan or other-
7 wise) to provide all the services specified in such a
8 plan.

9 (c) EXTENDED SERVICES COVERED UNDER THE
10 STATE PLAN.—

11 (1) IN GENERAL.—The State plan shall include
12 the following extended services:

13 (A) Developmentally appropriate personal
14 assistance services that are family centered and
15 provided in a culturally competent manner, and
16 which meet the standards of 2104(g).

17 (B) Care management.

18 (C) Homemaker and chore assistance.

19 (D) Home modifications.

20 (E) Respite services.

21 (F) Assistive technology devices and
22 assistive technology services as defined in the
23 Technology Related Assistance for Individuals
24 with Disabilities Act.

25 (G) Habilitation and rehabilitation.

1 (H) Home health services.

2 (I) Transportation.

3 (J) Any other care or assistive services
4 (approved by the Secretary) that the State de-
5 termines will help maximize a child's ability to
6 function independently, appropriately, and ef-
7 fectively in an age-appropriate manner, or will
8 facilitate the caregiver's ability to care for the
9 child outside of an institution.

10 (2) CRITERIA FOR SELECTION OF SERVICES.—

11 The State plan shall specify—

12 (A) the methods and standards used to se-
13 lect the types, and the amount, duration, and
14 scope, of services to be covered under the plan
15 and to be available to eligible children, and

16 (B) how the types, and the amount, dura-
17 tion, and scope, of services specified meet the
18 needs of eligible children.

19 (d) NO INDIVIDUAL ENTITLEMENT.—Nothing in this
20 section shall be construed to create an entitlement for eli-
21 gible children.

22 (e) EXCLUSIONS AND LIMITATIONS.—

23 (1) IN GENERAL.—A State plan may not pro-
24 vide for coverage of—

25 (A) room and board,

1 (B) services furnished in a hospital, nurs-
2 ing facility, intermediate care facility for the
3 mentally retarded, or other institutional setting
4 specified by the Secretary, or

5 (C) items and services for which the child
6 may receive payment under title I or title IV of
7 this Act.

8 (f) PAYMENT FOR SERVICES.—A State plan may pro-
9 vide for the use of—

10 (1) vouchers,

11 (2) cash payments directly to a child's des-
12 ignated representative,

13 (3) capitation payments to health plans, and

14 (4) payment to providers,

15 to pay for covered services.

16 **SEC. 2113. CHILDREN ELIGIBLE FOR SERVICES.**

17 (a) ELIGIBILITY CRITERIA.—

18 (1) IN GENERAL.—Children with special health
19 care needs shall be eligible for extended services and
20 benefits under this subpart.

21 (2) CHILD WITH SPECIAL HEALTH CARE
22 NEEDS.—As used in this subpart, the term “child
23 with special health care needs” means an individual
24 between the ages of birth to 21 years who—

1 (A) is not eligible for medical assistance
2 under title IV of this Act;

3 (B) has a significant functional limitation
4 under paragraph (3); and

5 (C) is in need of extended services under
6 paragraph (4).

7 (3) SIGNIFICANT FUNCTIONAL LIMITATION.—

8 (A) IN GENERAL.—As used in this sub-
9 part, the term “significant functional limita-
10 tion” means—

11 (i) in the case of an individual 6 years
12 of age or older, a significant physical or
13 mental impairment as defined pursuant to
14 State policy to the extent that such policy
15 is established without regard to type of
16 disability; and

17 (ii) in the case of infants and young
18 children, birth to age 5, inclusive, a sub-
19 stantial developmental delay or specific
20 congenital or acquired conditions with a
21 high probability of resulting in a disability
22 if services are not provided.

23 (B) PRESUMPTIVE SIGNIFICANT FUNC-
24 TIONAL LIMITATION.—An individual who has a
25 disability or who is blind pursuant to the eligi-

1 bility requirements of title XVI of the Social
2 Security Act (42 U.S.C. 1381 et seq.) shall be
3 considered to have—

4 (i) in the case of an individual 6 years
5 of age or older, a significant physical or
6 mental impairment as defined pursuant to
7 State policy to the extent that such policy
8 is established without regard to type of
9 disability; and

10 (ii) in the case of infants and young
11 children, birth to age 5, inclusive, a sub-
12 stantial developmental delay or specific
13 congenital or acquired conditions with a
14 high probability of resulting in a disability
15 if services are not provided.

16 (4) CHILD IN NEED OF EXTENDED SERVICES.—

17 As used in this subpart, the term “child in need of
18 extended services” means an individual between the
19 ages of birth to 21 years of age who requires serv-
20 ices identified in section 2112(c) in order to maxi-
21 mize or restore function, or prevent or limit disabil-
22 ity.

23 **SEC. 2114. APPLICATION AND ADMINISTRATION.**

24 (a) APPLICATION FOR STATE PARTICIPATION.—

1 (1) IN GENERAL.—A State desiring a grant
2 under this subpart shall submit an application, as an
3 addendum to the State application under section
4 2102, identifying in the State plan—

5 (A) the population to be served under this
6 subpart;

7 (B) the manner in which funds made avail-
8 able would be utilized, and the services to be
9 provided;

10 (C) how the State will define individuals
11 qualified to develop individualized pediatric
12 plans of care as defined in section 2112(b)(3);
13 and

14 (D) how the State will assure that the
15 range of services available under section 2112
16 will also be available to individuals with disabil-
17 ities under the age of 21 who are eligible for
18 services under subpart A to the maximum ex-
19 tent possible consistent with funds available to
20 carry out subpart A; and

21 (E) any other information the Secretary
22 may require.

23 (2) EVALUATION OF PROGRAM.—An applicant
24 under this section shall agree to provide an evalua-
25 tion of the effectiveness, including cost effectiveness

1 when measurable, of offering the benefits and serv-
2 ices under the State plan to children with special
3 health care needs.

4 (b) NUMBER OF PROGRAMS.—

5 (1) REQUEST FOR APPLICATIONS.—The Sec-
6 retary shall publish a request for applications under
7 this section not later than 1 year after the date of
8 the enactment of this Act.

9 (2) MAXIMUM NUMBER OF GRANTS.—The Sec-
10 retary shall make grants available under this sub-
11 part for the maximum number of State programs, in
12 accordance with the current funding level in section
13 2117, that is compatible with services and benefits
14 to be offered under section 2112 for eligible children
15 with special health care needs residing in such State.

16 (3) FORMULA.—The provisions of subsection
17 (b)(2) shall remain in effect through fiscal year
18 2003, at which time the Secretary shall establish a
19 formula by which to distribute funds under this sub-
20 part, in accordance with section 2117, to all States
21 that have a plan approved in accordance with section
22 2111 to provide the benefits described in section
23 2112.

24 (c) ADMINISTRATION.—

1 (1) STATE AGENCY.—The State shall designate
2 a State agency or designee to administer (or to su-
3 pervise the administration of) the program under
4 this subpart.

5 (2) COORDINATION.—The State agency or des-
6 ignee shall specify how the agency or designee will
7 coordinate its activities with health plans and other
8 service providers, and with the agency administering
9 subpart A.

10 (3) REQUIREMENT FOR COORDINATION OF
11 CARE.—The State program under this subpart shall
12 provide for coordinated services and benefits as de-
13 scribed in section 2112 to a family with children
14 with special health care needs integrating services
15 whenever possible in accordance with section
16 2102(a)(9)(C).

17 **SEC. 2115. COST-SHARING.**

18 (a) NO COST SHARING FOR POOREST.—The State
19 plan may not impose any cost sharing for individuals with
20 income (as determined under subsection (c)) less than 150
21 percent of the official poverty level (referred to in section
22 1902(38)(A)) applicable to a family of the size involved
23 (determined without regard to section 1902(38)(B)).

24 (b) SLIDING SCALE FOR REMAINDER.—The State
25 plan shall impose cost sharing in the form of coinsurance

1 (based on the amount paid under the State plan for a serv-
2 ice)—

3 (1) at a rate of 10 percent for individuals with
4 disabilities with income not less than 150 percent,
5 and less than 200 percent, of such official poverty
6 line (as so applied);

7 (2) at a rate of 20 percent for such individuals
8 with income not less than 200 percent, and less than
9 250 percent, of such official poverty line (as so ap-
10 plied); and

11 (3) at a rate of 25 percent for such individuals
12 with income equal to at least 250 percent of such of-
13 ficial poverty line (as so applied).

14 (c) DETERMINATION OF INCOME FOR PURPOSES OF
15 COST SHARING.—The State plan shall specify the process
16 to be used to determine the income of an individual with
17 disabilities for purposes of this section. In making these
18 income determinations, the State shall at a minimum com-
19 ply with standards established by the Secretary. Such
20 standards shall include a uniform Federal definition of in-
21 come and shall allow deductions from income for disabil-
22 ity-related expenses not covered under other titles of this
23 Act as promulgated by the Secretary.

24 (d) RECOMMENDATION FOR REDUCTIONS.—The Sec-
25 retary shall make recommendations to the States as how

1 to reduce cost-sharing based on income standards estab-
2 lished under subsection (c) for individuals with extraor-
3 dinary out of pocket costs for whom the cost-sharing pro-
4 visions of section 2115 could jeopardize their ability to
5 take advantage of the services offered under this Act.

6 (e) REQUEST FOR PAYMENT PLAN.—If copayments
7 under subsection (b) for services utilized by the child pur-
8 suant to section 2112(b)(1) exceed 10 percent of the
9 child's income or the income of their designated represent-
10 ative—

11 (1) the child or child's designated representative
12 may request that the State provide a payment sched-
13 ule for these amounts that shall not exceed 10 per-
14 cent of monthly income, and

15 (2) States may accept such requests from indi-
16 viduals and provide payment plans without interest
17 or finance charges.

18 **SEC. 2116. PROGRAM EVALUATION.**

19 The Secretary shall evaluate the programs under this
20 subpart, and shall submit to Congress interim reports de-
21 tailing the utilization, cost, and cost efficiency of the pro-
22 grams.

1 **SEC. 2117. TOTAL FEDERAL BUDGET AND FEDERAL ALLOT-**
2 **MENT TO STATES.**

3 (a) TOTAL FEDERAL BUDGET.—The amount avail-
4 able to carry out State plans under this subpart shall be
5 an amount equal to the total of a 2 percent set-aside from
6 the amounts for each fiscal year beginning in fiscal year
7 1996 pursuant to section 2109.

8 (b) FEDERAL MATCHING PERCENTAGE.—States
9 shall contribute to the program an amount consistent with
10 the requirements in section 2108(b)(1).

11 (c) REMAINING FUNDS.—Funds remaining under
12 subsection (a) at the end of each fiscal year shall be made
13 available to States under section 2108 for the following
14 fiscal year.

15 **PART 2—LONG-TERM CARE INSURANCE**
16 **IMPROVEMENT AND ACCOUNTABILITY**

17 **SEC. 2201. SHORT TITLE.**

18 This part may be cited as the “Long-Term Care In-
19 surance Improvement and Accountability Act”.

20 **SEC. 2202. ESTABLISHMENT OF FEDERAL STANDARDS FOR**
21 **LONG-TERM CARE INSURANCE.**

22 The Public Health Service Act is amended by adding
23 at the end thereof the following new title:

1 **“TITLE XXVII—LONG-TERM CARE**

2 **“PART 1—LONG-TERM CARE INSURANCE**

3 **STANDARDS**

4 **“Subpart A—Promulgation of Standards and Model**

5 **Benefits**

6 **“SEC. 2701. STANDARDS.**

7 “(a) APPLICATION OF STANDARDS.—

8 “(1) NAIC.—

9 “(A) IN GENERAL.—The Secretary shall
10 request that the National Association of Insur-
11 ance Commissioners (hereafter in this part re-
12 ferred to as the ‘NAIC’)—

13 “(i) develop specific standards that in-
14 corporate the requirements of this part;
15 and

16 “(ii) report to the Secretary concern-
17 ing such standards.

18 “(B) APPLICATION.—If, within 12 months
19 after the date of the enactment of this part, the
20 NAIC develops the model standards under sub-
21 paragraph (A)(i), the Secretary shall have 60
22 days in which to determine whether such stand-
23 ards implement the requirements of this part. If
24 such standards are approved by the Secretary,

1 they shall be the standards that apply as pro-
2 vided in this part.

3 “(2) DEFAULT.—If the NAIC does not promul-
4 gate the model standards under paragraph (1) by
5 the deadline established in that paragraph, the Sec-
6 retary shall promulgate, within 12 months after such
7 deadline, a regulation that provides standards that
8 incorporate the requirements of this part and such
9 standards shall apply as provided for in this part.

10 “(3) RELATION TO STATE LAW.—Nothing in
11 this part shall be construed as preventing a State
12 from applying standards that provide greater protec-
13 tion to policyholders of long-term care insurance
14 policies than the standards promulgated under this
15 part, except that such State standards may not be
16 inconsistent or in conflict with any of the require-
17 ments of this part.

18 “(b) DEADLINE FOR APPLICATION OF STAND-
19 ARDS.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 the date specified in this subsection for a State is—

22 “(A) the date the State adopts the stand-
23 ards established under subsection (a)(1); or

24 “(B) the date that is 1 year after the first
25 day of the first regular legislative session that

1 begins after the date such standards are first
2 established under subsection (a)(2);
3 whichever is earlier.

4 “(2) STATE REQUIRING LEGISLATION.—In the
5 case of a State which the Secretary identifies, in
6 consultation with the NAIC, as—

7 “(A) requiring State legislation (other than
8 legislation appropriating funds) in order for the
9 standards established under subsection (a) to be
10 applied; but

11 “(B) having a legislature which is not
12 scheduled to meet within 1 year following the
13 beginning of the next regular legislative session
14 in which such legislation may be considered;

15 the date specified in this subsection is the first day
16 of the first calendar quarter beginning after the
17 close of the first legislative session of the State legis-
18 lature that begins on or after January 1, 1995. For
19 purposes of the previous sentence, in the case of a
20 State that has a 2-year legislative session, each year
21 of such session shall be deemed to be a separate reg-
22 ular session of the State legislature.

23 “(c) ITEMS INCLUDED IN STANDARDS.—The stand-
24 ards promulgated under subsection (a) shall include—

1 “(1) minimum Federal standards for long-term
2 care insurance consistent with the provisions of this
3 part;

4 “(2) standards for the enhanced protection of
5 consumers with long-term care insurance; and

6 “(3) procedures for the modification of the
7 standards established under paragraph (1) in a
8 manner consistent with future laws to expand exist-
9 ing Federal or State long-term care benefits or es-
10 tablish a comprehensive Federal or State long-term
11 care benefit program.

12 “(d) CONSULTATION.—In establishing standards and
13 models of benefits under this section, the Secretary shall,
14 after consultation with representatives of carriers,
15 consumer groups, and providers of long-term care serv-
16 ices—

17 “(1) recommend the appropriate inflationary
18 index to be used with respect to the inflation protec-
19 tion benefit portion of the standards;

20 “(2) recommend the uniform needs assessment
21 mechanism to be used in determining the eligibility
22 of individuals for benefits under a policy;

23 “(3) recommend appropriate standards for the
24 regulation of the insurance aspects of supported
25 housing arrangements; and

1 “(4) perform such other activities as deter-
2 mined appropriate by the Secretary.

3 **“Subpart B—Establishment and Implementation of**
4 **Long-Term Care Insurance Policy Standards**

5 **“SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.**

6 “(a) IN GENERAL.—

7 “(1) REGULATORY PROGRAM.—No long-term
8 care policy (as defined in section (2721)) may be is-
9 sued, sold, or offered for sale as a long-term care in-
10 surance policy in a State on or after the date speci-
11 fied in section 2701(b) unless—

12 “(A) the Secretary determines that the
13 State has established a regulatory program
14 that—

15 “(i) provides for the application and
16 enforcement of the standards established
17 under section 2701(a); and

18 “(ii) complies with the requirements
19 of subsection (b);

20 by the date specified in section 2701(b), and
21 the policy has been approved by the State com-
22 missioner or superintendent of insurance under
23 such program; or

24 “(B) if the State has not established such
25 a program, or if the State’s regulatory program

1 has been decertified, the policy has been cer-
2 tified by the Secretary (in accordance with such
3 procedures as the Secretary may establish) as
4 meeting the standards established under section
5 2701(a) by the date specified in section
6 2701(b).

7 For purposes of this subsection, the advertising or
8 soliciting with respect to a policy, directly or indi-
9 rectly, shall be deemed the offering for sale of the
10 policy.

11 “(2) REVIEW OF STATE REGULATORY PRO-
12 GRAMS.—The Secretary shall review regulatory pro-
13 grams described in paragraph (1)(A) at least bian-
14 nually to determine if they continue to provide for
15 the application and enforcement of the standards
16 and procedures established under section 2701(a)
17 and (b). If the Secretary determines that a State
18 regulatory program no longer meets such standards
19 and requirements, before making a final determina-
20 tion, the Secretary shall provide the State an oppor-
21 tunity to adopt such a plan of correction as would
22 permit the program to continue to meet such stand-
23 ards and requirements. If the Secretary makes a
24 final determination that the State regulatory pro-
25 gram, after such an opportunity, fails to meet such

1 standards and requirements, the Secretary shall as-
2 sume responsibility under paragraph (1)(B) with re-
3 spect to certifying policies in the State and shall ex-
4 ercise full authority under section 2701 for carriers,
5 agents, or associations or its subsidiary in the State
6 plans in the State.

7 “(b) ADDITIONAL REQUIREMENTS FOR APPROVAL
8 OF STATE REGULATORY PROGRAMS.—For purposes of
9 subsection (a)(1)(A)(ii), the requirements of this sub-
10 section for a State regulatory program are as follows:

11 “(1) ENFORCEMENT.—The enforcement under
12 the program—

13 “(A) shall be designed in a manner so as
14 to secure compliance with the standards within
15 30 days after the date of a finding of non-
16 compliance with such standards; and

17 “(B) shall provide for notice in the annual
18 report required under paragraph (5) to the Sec-
19 retary of cases where such compliance is not se-
20 cured within such 30-day period.

21 “(2) PROCESS.—The enforcement process
22 under each State regulatory program shall provide
23 for—

1 “(A) procedures for individuals and enti-
2 ties to file written, signed complaints respecting
3 alleged violations of the standards;

4 “(B) responding to such complaints within
5 90 days;

6 “(C) the investigation of—

7 “(i) those complaints which have a
8 reasonable probability of validity, and

9 “(ii) such other alleged violations of
10 the standards as the program finds appro-
11 priate; and

12 “(D) the imposition of appropriate sanc-
13 tions (which include, in appropriate cases, the
14 imposition of a civil money penalty as provided
15 for in section 2718) in the case of a carrier,
16 agent, or association or its subsidiary deter-
17 mined to have violated the standards.

18 “(3) PRIVATE ACTIONS.—An individual may
19 commence a civil action in an appropriate State or
20 United States district court to enforce the provisions
21 of this title and may be awarded appropriate relief
22 and reasonable attorney’s fees.

23 “(4) CONSUMER ACCESS TO COMPLIANCE IN-
24 FORMATION.—

1 “(A) IN GENERAL.—A State regulatory
2 program must provide for consumer access to
3 complaints filed with the State commissioner or
4 superintendent of insurance with respect to
5 long-term care insurance policies.

6 “(B) CONFIDENTIALITY.—The access pro-
7 vided under subparagraph (A) shall be limited
8 to the extent required to protect the confiden-
9 tiality of the identity of individual policyholders.

10 “(5) PROCESS FOR APPROVAL OF PREMIUMS.—

11 “(A) IN GENERAL.—Each State regulatory
12 program shall—

13 “(i) provide for a process for approv-
14 ing or disapproving proposed premium in-
15 creases or decreases with respect to long-
16 term care insurance policies; and

17 “(ii) establish a policy for receipt and
18 consideration of public comments before
19 approving such a premium increase or de-
20 crease.

21 “(B) CONDITIONS FOR APPROVAL.—No
22 premium increase shall be approved (or deemed
23 approved) under subparagraph (A) unless the
24 proposed increase is accompanied by an actuar-
25 ial memorandum which—

1 “(i) includes a description of the as-
2 sumptions that justify the increase, includ-
3 ing a financial report on expenditures;

4 “(ii) contains such information as
5 may be required under the Standards; and

6 “(iii) is made available to the public.

7 “(C) APPLICATION.—Except as provided in
8 subparagraph (D), this paragraph shall not
9 apply to a group long-term care insurance pol-
10 icy issued to a group described in section
11 4(E)(1) of the NAIC Long Term Care Insur-
12 ance Model Act (effective January 1991), ex-
13 cept that such group policy shall, pursuant to
14 guidelines developed by the NAIC, provide no-
15 tice to policyholders and certificate holders of
16 any premium change under such group policy.

17 “(D) EXCEPTION.—Subparagraph (C)
18 shall not apply to—

19 “(i) group conversion policies;

20 “(ii) the group continuation feature of
21 a group policy if the insurer separately
22 rates employee and continuation coverages;
23 and

24 “(iii) group policies where the func-
25 tion of the employer is limited solely to col-

1 lecting premiums (through payroll deduc-
2 tions or dues checkoff) and remitting them
3 to the insurer.

4 “(E) CONSTRUCTION.—Nothing in this
5 paragraph shall be construed as preventing the
6 NAIC from promulgating standards, or a State
7 from enacting and enforcing laws, with respect
8 to premium rates or loss ratios for all, including
9 group, long-term care insurance policies.

10 “(6) ANNUAL REPORTS.—Each State regu-
11 latory program shall provide for annual reports to be
12 submitted to the Secretary on the implementation
13 and enforcement of the standards in the State, in-
14 cluding information concerning violations in excess
15 of 30 days.

16 “(7) ACCESS TO OTHER INFORMATION.—The
17 State regulatory program must provide for consumer
18 access to actuarial memoranda, including financial
19 information, provided under paragraph (4).

20 “(8) DEFAULT.—In the case of a State without
21 a regulatory program approved under subsection (a),
22 the Secretary shall provide for the enforcement ac-
23 tivities described in subsection (c).

24 “(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

1 “(1) IN GENERAL.—The Secretary shall exer-
2 cise authority under this section in the case of a
3 State that does not have a regulatory program ap-
4 proved under this section.

5 “(2) COMPLAINTS AND INVESTIGATIONS.—The
6 Secretary shall establish procedures—

7 “(A) for individuals and entities to file
8 written, signed complaints respecting alleged
9 violations of the requirements of this part;

10 “(B) for responding on a timely basis to
11 such complaints; and

12 “(C) for the investigation of—

13 “(i) those complaints that have a rea-
14 sonable probability of validity; and

15 “(ii) such other alleged violations of
16 the requirements of this part as the Sec-
17 retary determines to be appropriate.

18 In conducting investigations under this subsection,
19 agents of the Secretary shall have reasonable access
20 necessary to enable such agents to examine evidence
21 of any carrier, agent, or association or its subsidiary
22 being investigated.

23 “(3) HEARINGS.—

24 “(A) IN GENERAL.—Prior to imposing an
25 order described in paragraph (4) against a car-

1 rier, agent, or association or its subsidiary
2 under this section for a violation of the require-
3 ments of this part, the Secretary shall provide
4 the carrier, agent, association or subsidiary
5 with notice and, upon request made within a
6 reasonable time (of not less than 30 days, as
7 established by the Secretary by regulation) of
8 the date of the notice, a hearing respecting the
9 violation.

10 “(B) CONDUCT OF HEARING.—Any hear-
11 ing requested under subparagraph (A) shall be
12 conducted before an administrative law judge.
13 If no hearing is so requested, the Secretary’s
14 imposition of the order shall constitute a final
15 and unappealable order.

16 “(C) AUTHORITY IN HEARINGS.—In con-
17 ducting hearings under this paragraph—

18 “(i) agents of the Secretary and ad-
19 ministrative law judges shall have reason-
20 able access necessary to enable such agents
21 and judges to examine evidence of any car-
22 rier, agent, or association or its subsidiary
23 being investigated; and

24 “(ii) administrative law judges, may,
25 if necessary, compel by subpoena the at-

1 tendance of witnesses and the production
2 of evidence at any designated place or
3 hearing.

4 In case of contumacy or refusal to obey a sub-
5 poena lawfully issued under this subparagraph
6 and upon application of the Secretary, an ap-
7 propriate district court of the United States
8 may issue an order requiring compliance with
9 such subpoena and any failure to obey such
10 order may be punished by such court as a con-
11 tempt thereof.

12 “(D) ISSUANCE OF ORDERS.—If an admin-
13 istrative law judge determines in a hearing
14 under this paragraph, upon the preponderance
15 of the evidence received, that a carrier, agent,
16 or association or its subsidiary named in the
17 complaint has violated the requirements of this
18 part, the administrative law judge shall state
19 the findings of fact and issue and cause to be
20 served on such carrier, agent, association, or
21 subsidiary an order described in paragraph (4).

22 “(4) CEASE AND DESIST ORDER WITH CIVIL
23 MONEY PENALTY.—

1 “(A) IN GENERAL.—Subject to the provi-
2 sions of subparagraphs (B) through (F), an
3 order under this paragraph—

4 “(i) shall require the agent, associa-
5 tion or its subsidiary, or a carrier—

6 “(I) to cease and desist from
7 such violations; and

8 “(II) to pay a civil penalty in an
9 amount not to exceed \$15,000 in the
10 case of each agent, and not to exceed
11 \$25,000 for each association or its
12 subsidiary or a carrier for each such
13 violation; and

14 “(ii) may require the agent, associa-
15 tion or its subsidiary, or a carrier to take
16 such other remedial action as is appro-
17 priate.

18 “(B) CORRECTIONS WITHIN 30 DAYS.—No
19 order shall be imposed under this paragraph by
20 reason of any violation if the carrier, agent, or
21 association or its subsidiary establishes to the
22 satisfaction of the Secretary that—

23 “(i) such violation was due to reason-
24 able cause and was not intentional and was
25 not due to willful neglect; and

1 “(ii) such violation is corrected within
2 the 30-day period beginning on the earliest
3 date the carrier, agent, association, or sub-
4 sidiary knew, or exercising reasonable dili-
5 gence could have known, that such a viola-
6 tion was occurring.

7 “(C) WAIVER BY SECRETARY.—In the case
8 of a violation under this part that is due to rea-
9 sonable cause and not to willful neglect, the
10 Secretary may waive part or all of the civil
11 money penalty imposed under subparagraph
12 (A)(i)(II) to the extent that payment of such
13 penalty would be grossly excessive relative to
14 the violation involved and to the need for deter-
15 rence of violations.

16 “(D) ADMINISTRATIVE APPELLATE RE-
17 VIEW.—The decision and order of an adminis-
18 trative law judge under this paragraph shall be-
19 come the final agency decision and order of the
20 Secretary unless, within 30 days, the Secretary
21 modifies or vacates the decision and order, in
22 which case the decision and order of the Sec-
23 retary shall become a final order under this
24 paragraph.

1 “(E) JUDICIAL REVIEW.—A carrier, agent,
2 or association or its subsidiary or any other in-
3 dividual adversely affected by a final order is-
4 sued under this paragraph may, within 45 days
5 after the date the final order is issued, file a pe-
6 tition in the Court of Appeals for the appro-
7 priate circuit for review of the order.

8 “(F) ENFORCEMENT OF ORDERS.—If a
9 carrier, agent, or association or its subsidiary
10 fails to comply with a final order issued under
11 this paragraph against the carrier, agent, asso-
12 ciation or subsidiary after opportunity for judi-
13 cial review under subparagraph (E), the Sec-
14 retary shall file a suit to seek compliance with
15 the order in any appropriate district court of
16 the United States. In any such suit, the validity
17 and appropriateness of the final order shall not
18 be subject to review.

19 **“SEC. 2712. REGULATION OF SALES PRACTICES.**

20 “(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

21 “(1) IN GENERAL.—Each agent (as defined in
22 section 2733) or association that is selling or offer-
23 ing for sale a long-term care insurance policy has
24 the duty of good faith and fair dealing to the pur-
25 chaser or potential purchaser of such a policy.

1 “(2) POLICY REPLACEMENT FORM.—With re-
2 spect to any person who elects to replace or effect
3 a change in a long-term care insurance policy, the
4 individual that is selling such policy shall ensure
5 that such person completes a policy replacement
6 form developed by the NAIC. A copy of such form
7 shall be provided to such person and additional cop-
8 ies shall be delivered by the selling individual to the
9 old policy issuer and the new issuer and kept on file
10 for inspection by the State regulatory agency.

11 “(3) PROHIBITED PRACTICES.—An agent or as-
12 sociation is considered to have violated paragraph
13 (1) if the agent or association engages in any of the
14 following practices:

15 “(A) TWISTING.—Knowingly making any
16 misleading representation (including the inac-
17 curate completion of medical histories) or in-
18 complete or fraudulent comparison of any long-
19 term care insurance policy or insurers for the
20 purpose of inducing, or tending to induce, any
21 person to retain or effect a change with respect
22 to a long-term care insurance policy.

23 “(B) HIGH PRESSURE TACTICS.—Employ-
24 ing any method of marketing having the effect
25 of, or intending to, induce the purchase of long-

1 term care insurance policy through force, fright,
2 threat or undue pressure, whether explicit or
3 implicit.

4 “(C) COLD LEAD ADVERTISING.—Making
5 use directly or indirectly of any method of mar-
6 keting which fails to disclose in a conspicuous
7 manner that a purpose of the method of mar-
8 keting is solicitation of insurance and that con-
9 tact will be made by an insurance agent or in-
10 surance company.

11 “(D) OTHERS.—Engaging in such other
12 practices determined inappropriate under guide-
13 lines issued by the NAIC.

14 “(b) FINANCIAL STANDARDS.—The NAIC shall de-
15 velop recommended financial minimum standards (includ-
16 ing both income and asset criteria) for the purpose of ad-
17 vising individuals as to the costs and amounts of insurance
18 needed when considering the purchase of a long-term care
19 insurance policy.

20 “(c) PROHIBITION OF SALE OR ISSUANCE TO MEDIC-
21 AID BENEFICIARIES.—An agent, an association, or a car-
22 rier may not knowingly sell or issue a long-term care in-
23 surance policy to an individual who is eligible for medical
24 assistance under title XIX of the Social Security Act.

1 “(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLI-
2 CATE SERVICE BENEFIT POLICIES.—An agent, associa-
3 tion or its subsidiary, or a carrier may not sell or issue
4 a service-benefit long-term care insurance policy to an in-
5 dividual—

6 “(1) knowing that the policy provides for cov-
7 erage that duplicates coverage already provided in
8 another service-benefit long-term care insurance pol-
9 icy held by such individual (unless the policy is in-
10 tended to replace such other policy); or

11 “(2) for the benefit of an individual unless the
12 individual (or a representative of the individual) pro-
13 vides a written statement to the effect that the cov-
14 erage—

15 “(A) does not duplicate other coverage in
16 effect under a service-benefit long-term care in-
17 surance policy; or

18 “(B) will replace another service-benefit
19 long-term care insurance policy.

20 In this subsection, the term ‘service-benefit long-term care
21 insurance policy’ means a long-term care insurance policy
22 which provides for benefits based on the type and amount
23 of services furnished.

24 “(e) PROHIBITION BASED ON ELIGIBILITY FOR
25 OTHER BENEFITS.—A carrier may not sell or issue a

1 long-term care insurance policy that reduces, limits or co-
2 ordinates the benefits provided under the policy on the
3 basis that the policyholder has or is eligible for other long-
4 term care insurance coverage or benefits.

5 “(f) PROVISION OF OUTLINE OF COVERAGE.—No
6 agent, association or its subsidiary, or carrier may sell or
7 offer for a sale a long-term care insurance policy without
8 providing to every individual purchaser or potential pur-
9 chaser (or representative) an outline of coverage that com-
10 plies with the standards established under section
11 2701(a).

12 “(g) PENALTIES.—Any agent who sells, offers for
13 sale, or issues a long-term care insurance policy in viola-
14 tion of this section may be imprisoned not more than 5
15 years, or fined in accordance with title 18, United States
16 Code, and, in addition, is subject to a civil money penalty
17 of not to exceed \$15,000 for each such violation. Any asso-
18 ciation or its subsidiary or carrier that sells, offers for
19 sale, or issues a long-term care insurance policy in viola-
20 tion of this section may be fined in accordance with title
21 18, United States Code, and in addition, is subject to a
22 civil money penalty of not to exceed \$25,000 for each vio-
23 lation. Nothing in this subsection shall be construed as
24 preempting or otherwise limiting the penalties that may

1 be imposed by a State for conduct that violates this sec-
2 tion.

3 “(h) AGENT TRAINING AND CERTIFICATION RE-
4 QUIREMENTS.—The NAIC, shall establish requirements
5 for long-term care insurance agent training and certifi-
6 cation that—

7 “(1) specify requirements for training insurance
8 agents who desire to sell or offer for sale long-term
9 care insurance policies; and

10 “(2) specify procedures for certifying and
11 recertifying agents who have completed such train-
12 ing and who are as qualified to sell or offer for sale
13 long-term care insurance policies.

14 **“SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CAR-**
15 **RIERS.**

16 “(a) REFUND OF PREMIUMS.—If an application for
17 a long-term care insurance policy (or for a certificate
18 under a group long-term care insurance policy) is denied
19 or an applicant returns a policy or certificate within 30
20 days of the date of its issuance pursuant to subsection
21 2717, the carrier shall refund directly to the applicant,
22 or in the case of an employer to whomever remits the pre-
23 mium, and not by delivery by the agent, not later than
24 30 days after the date of the denial or return, any pre-
25 miums paid with respect to such a policy (or certificate).

1 “(b) MAILING OF POLICY.—If an application for a
2 long-term care insurance policy (or for a certificate under
3 a group long-term care insurance policy) is approved, the
4 carrier shall provide every individual applicant the policy
5 (or certificate) of insurance and outline of coverage not
6 later than 30 days after the date of the approval.

7 “(c) INFORMATION ON DENIALS OF CLAIMS.—If a
8 claim under a long-term care insurance policy is denied,
9 the carrier shall, within 15 days of the date of a written
10 request by the policyholder or certificate holder (or rep-
11 resentative)—

12 “(1) provide a written explanation of the rea-
13 sons for the denial;

14 “(2) make available all medical and patient
15 records directly relating to such denial; and

16 “(3) provide a written explanation of the man-
17 ner in which to appeal the denial.

18 Except as provided in subsection (e) of section 2715, no
19 claim under such a policy may be denied on the basis of
20 a failure to disclose a condition at the time of issuance
21 of the policy if the application for the policy failed to re-
22 quest information respecting the condition.

23 “(d) REPORTING OF INFORMATION.—A carrier that
24 issues one or more long-term care insurance policies shall
25 periodically (not less often than annually) report, in a

1 form and in a manner determined by the NAIC, to the
2 Commissioner, superintendent or director of insurance of
3 each State in which the policy is delivered, and shall make
4 available to the Secretary, upon request, information in
5 a form and manner determined by the NAIC concerning—

6 “(1) the long-term care insurance policies of the
7 carrier that are in force;

8 “(2) the most recent premiums for such policies
9 and the premiums imposed for such policies since
10 their initial issuance;

11 “(3) the lapse rate, replacement rate, and re-
12 scission rates by policy;

13 “(4) the names of that 10 percent of its agents
14 that—

15 “(A) have the greatest lapse and replace-
16 ment rate; and

17 “(B) have produced at least \$50,000 of
18 long-term care insurance sales in the previous
19 year; and

20 “(5) the claims denied (expressed as a number
21 and as a percentage of claims submitted) by policy.

22 Information required under this subsection shall be re-
23 ported in a format specified in the standards established
24 under section 2701(a). For purposes of paragraph (3),
25 there shall be included (but reported separately) data con-

1 cerning lapses due to the death of the policyholder. For
2 purposes of paragraph (4), there shall not be included as
3 a claim any claim that is denied solely because of the fail-
4 ure to meet a deductible, waiting period, or exclusionary
5 period.

6 “(e) STANDARDS ON COMPENSATION FOR SALE OF
7 POLICIES.—

8 “(1) IN GENERAL.—A carrier that issues one or
9 more long-term care insurance policies may provide
10 a commission or other compensation to an agent or
11 other representative for the sale of such a policy only
12 if the first year commission or other first year com-
13 pensation to be paid does not exceed 200 percent of
14 the commission or other compensation paid for sell-
15 ing or servicing the policy in the second year, or if
16 the first year commission or other compensation to
17 be paid does not exceed 50 percent of the premium
18 paid on the first year policy, until the NAIC promul-
19 gates mandatory standards concerning compensation
20 for the sale of such policies.

21 “(2) SUBSEQUENT YEARS.—The commission or
22 other compensation provided for the sale of long-
23 term care insurance policies in years subsequent to
24 the first year of the policy shall be the same as that

1 provided in the second subsequent year and shall be
2 provided for no fewer than 5 subsequent years.

3 “(3) LIMITATION.—No carrier shall provide
4 compensation to its agents for the sale of a long-
5 term care insurance policy and no agent shall receive
6 compensation greater than the renewal compensation
7 payable by the replacing carrier on renewal policies
8 if an existing policy is replaced.

9 “(4) COMPENSATION DEFINED.—As used in
10 this subsection, the term ‘compensation’ includes pe-
11 cuniary or nonpecuniary remuneration of any kind
12 relating to the sale or renewal of the policy, includ-
13 ing but not limited to deferred compensation, bo-
14 nuses, gifts, prizes, awards, and finders fees.

15 **“SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE,**
16 **AND BASIC FOR CANCELLATION OF POLI-**
17 **CIES.**

18 “(a) IN GENERAL.—No long-term care insurance pol-
19 icy may be canceled or nonrenewed for any reason other
20 than nonpayment of premium, material misrepresentation
21 or fraud.

22 “(b) CONTINUATION AND CONVERSION RIGHTS FOR
23 GROUP POLICIES.—

24 “(1) IN GENERAL.—Each group long-term care
25 insurance policy shall provide covered individuals

1 with a basis for continuation or conversion in ac-
2 cordance with this subsection.

3 “(2) BASIS FOR CONTINUATION.—For purposes
4 of paragraph (1), a policy provides a basis for con-
5 tinuation of coverage if the policy maintains cov-
6 erage under the existing group policy when such cov-
7 erage would otherwise terminate and which is sub-
8 ject only to the continued timely payment of pre-
9 mium when due. A group policy which restricts pro-
10 vision of benefits and services to or contains incen-
11 tives to use certain providers or facility, may provide
12 continuation benefits which are substantially equiva-
13 lent to the benefits of the existing group policy.

14 “(3) BASIS FOR CONVERSION.—For purposes of
15 paragraph (1), a policy provides a basis for conver-
16 sion of coverage if the policy entitles each individ-
17 ual—

18 “(A) whose coverage under the group pol-
19 icy would otherwise be terminated for any rea-
20 son; and

21 “(B) who has been continuously insured
22 under the policy (or group policy which was re-
23 placed) for at least 6 months before the date of
24 the termination;

1 to issuance of a policy providing benefits identical to,
2 substantially equivalent to, or in excess of, those of
3 the policy being terminated, without evidence of in-
4 surability.

5 “(4) TREATMENT OF SUBSTANTIAL EQUIVA-
6 LENCE.—In determining under this subsection
7 whether benefits are substantially equivalent, consid-
8 eration should be given to the difference between
9 managed care and non-managed care plans.

10 “(5) GROUP REPLACEMENT OF POLICIES.—If a
11 group long-term care insurance policy is replaced by
12 another long-term care insurance policy purchased
13 by the same policyholder, the succeeding issuer shall
14 offer coverage to all persons covered under the old
15 group policy on its date of termination. Coverage
16 under the new group policy shall not result in any
17 exclusion for preexisting conditions that would have
18 been covered under the group policy being replaced.

19 “(c) STANDARDS FOR ISSUANCE.—

20 “(1) IN GENERAL.—

21 “(A) GUARANTEE.—An agent, association
22 or carrier that sells or issues long-term care in-
23 surance policies shall guarantee that such poli-
24 cies shall be sold or issued to an individual, or
25 eligible individual in the case of a group plan,

1 if such individual meets the minimum medical
2 underwriting requirements of such policy.

3 “(B) PREMIUM FOR CONVERTED POL-
4 ICY.—If a group policy from which conversion
5 is made is a replacement for a previous group
6 policy, the premium for the converted policy
7 shall be calculated on the basis of the insured’s
8 age at the inception of coverage under the
9 group policy from which conversion is made.
10 Where the group policy from which conversion
11 is made replaced previous group coverage, the
12 premium for the converted policy shall be cal-
13 culated on the basis of the insured’s age at in-
14 ception of coverage under the group policy re-
15 placed.

16 “(2) UPGRADE FOR CURRENT POLICIES.—The
17 NAIC shall establish standards, including those pro-
18 viding guidance on medical underwriting and age
19 rating, with respect to the access of individuals to
20 policies offering upgraded benefits.

21 “(3) RATE STABILIZATION.—The NAIC shall
22 establish standards for premium rate stabilization.

23 “(d) EFFECT OF INCAPACITATION.—

24 “(1) IN GENERAL.—

1 “(A) PROHIBITION.—Except as provided
2 in paragraph (2), a long-term care insurance
3 policy in effect as of the effective date of the
4 standards established under section 2701(a)
5 may not be canceled for nonpayment if the pol-
6 icy holder is determined by a long-term care
7 provider, physician or other health care pro-
8 vider, independent of the issuer of the policy, to
9 be cognitively or mentally incapacitated so as to
10 not make payments in a timely manner.

11 “(B) REINSTATEMENT.—A long-term care
12 policy shall include a provision that provides for
13 the reinstatement of such coverage, in the event
14 of lapse, if the insurer is provided with proof of
15 cognitive or mental incapacitation. Such rein-
16 statement option shall remain available for a
17 period of not less than 5 months after termi-
18 nation and shall allow for the collection of past
19 due premium.

20 “(2) PERMITTED CANCELLATION.—A long-term
21 care insurance policy may be canceled under para-
22 graph (1) for nonpayment if—

23 “(A) the period of such nonpayment is in
24 excess of 30 days; and

1 “(B) notice of intent to cancel is provided
2 to the policyholder or designated representative
3 of the policy holder not less than 30 days prior
4 to such cancellation, except that notice may not
5 be provided until the expiration of 30 days after
6 a premium is due and unpaid.

7 Notice under this paragraph shall be deemed to have
8 been given as of 5 days after the mailing date.

9 **“SEC. 2715. BENEFIT STANDARDS.**

10 “(a) USE OF STANDARD DEFINITIONS AND TERMI-
11 NOLOGY, UNIFORM FORMAT, AND STANDARD BENE-
12 FITS.—Each long-term care insurance policy shall, with
13 respect to services, providers or facilities, pursuant to
14 standards established under section 2701(a)—

15 “(1) use uniform language and definitions, ex-
16 cept that such language and definitions may take
17 into account the differences between States with re-
18 spect to definitions and terminology used for long-
19 term care services and providers; and

20 “(2) use a uniform format for presenting the
21 outline of coverage under such a policy;
22 as prescribed under guidelines issued by the NAIC and
23 periodically updated.

24 “(b) DISCLOSURE.—

25 “(1) OUTLINE OF COVERAGE.—

1 “(A) REQUIREMENT.—Each carrier that
2 sells or offers for sale a long-term care insur-
3 ance policy shall provide an outline of coverage
4 to each individual policyholder under such pol-
5 icy that meets the applicable standards estab-
6 lished pursuant to section 2701(a), complies
7 with the requirements of subparagraph (B), and
8 is in a uniform format as prescribed in guide-
9 lines issued by the NAIC and periodically up-
10 dated.

11 “(B) CONTENTS.—The outline of coverage
12 for each long-term care insurance policy shall
13 include at least the following:

14 “(i) A description of the benefits and
15 coverage under the policy.

16 “(ii) A statement of the exclusions, re-
17 ductions, and limitations contained in the
18 policy.

19 “(iii) A statement of the terms under
20 which the policy (or certificate) may be
21 continued in force or discontinued, the
22 terms for continuation or conversion, and
23 any reservation in the policy of a right to
24 change premiums.

1 “(iv) Consumer protection informa-
2 tion, including the manner in which to file
3 a claim and to register complaints.

4 “(v) A statement, in bold face type on
5 the face of the document in language that
6 is understandable to an average individual,
7 that the outline of coverage is a summary
8 only, not a contract of insurance, and that
9 the policy (or master policy) contains the
10 contractual provisions that govern, except
11 that such summary shall substantially and
12 accurately reflect the contents of the policy
13 or the master policy.

14 “(vi) A description of the terms, speci-
15 fied in section 2717, under which a policy
16 or certificate may be returned and pre-
17 mium refunded.

18 “(vii) Information on—

19 “(I) national average costs for
20 nursing facility and home health care
21 and information (in graphic form) on
22 the relationship of the value of the
23 benefits provided under the policy to
24 such national average costs and State
25 average costs; and

1 “(II) other public and private
2 long-term care insurance products and
3 long-term care programs where made
4 available by the Federal Government
5 or by a State government.

6 “(viii) A statement of the percentage
7 limit on annual premium increases that is
8 provided under the policy pursuant to this
9 section.

10 “(2) CERTIFICATES.—A certificate issued pur-
11 suant to a group long-term care insurance policy
12 shall include—

13 “(A) a description of the principal benefits
14 and coverage provided in the policy;

15 “(B) a statement of the principal exclu-
16 sions, reductions, and limitations contained in
17 the policy; and

18 “(C) a statement that the group master
19 policy determines governing contractual provi-
20 sions.

21 “(3) LONG-TERM CARE AS PART OF LIFE IN-
22 SURANCE.—In the case of a long-term care insur-
23 ance policy issued as a part of, or a rider on, a life
24 insurance policy, at the time of policy delivery there
25 shall be provided a policy summary that includes—

1 “(A) an explanation of how the long-term
2 care benefits interact with other components of
3 the policy (including deductions from death
4 benefits);

5 “(B) an illustration of the amount of bene-
6 fits, the length of benefit, and the guaranteed
7 lifetime benefits (if any) for each covered per-
8 son; and

9 “(C) any exclusions, reductions, and limi-
10 tations on benefits of long-term care.

11 “(4) ADDITIONAL INFORMATION.—The NAIC
12 shall develop recommendations with respect to in-
13 forming consumers of the long-term economic viabil-
14 ity of carriers issuing long-term care insurance poli-
15 cies.

16 “(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM
17 BENEFITS.—

18 “(1) IN GENERAL.—A long-term care insurance
19 policy may not condition or limit eligibility—

20 “(A) for benefits for a type of services to
21 the need for or receipt of any other services;

22 “(B) for any benefit on the medical neces-
23 sity for such benefit;

24 “(C) for benefits furnished by licensed or
25 certified providers in compliance with conditions

1 which are in addition to those required for li-
2 censure or certification under State law, except
3 that if no State licensure or certification laws
4 exists, in compliance with qualifications devel-
5 oped by the NAIC; or

6 “(D) for residential care (if covered under
7 the policy) only—

8 “(i) to care provided in facilities
9 which provide a higher level of care; or

10 “(ii) to care provided in facilities
11 which provide for 24-hour or other nursing
12 care not required in order to be licensed by
13 the State.

14 “(2) HOME HEALTH CARE OR COMMUNITY-
15 BASED SERVICES.—If a long-term care insurance
16 policy provides benefits for the payment of specified
17 home health care or community-based services, the
18 policy—

19 “(A) may not limit such benefits to serv-
20 ices provided by registered nurses or licensed
21 practical nurses;

22 “(B) may not require benefits for such
23 services to be provided by a nurse or therapist
24 that can be provided by a home health aide or
25 licensed or certified home care worker, except

1 that if no State licensure or certification laws
2 exists, in compliance with qualifications devel-
3 oped by the NAIC;

4 “(C) may not limit such benefits to serv-
5 ices provided by agencies or providers certified
6 under title XVIII of the Social Security Act;
7 and

8 “(D) must provide, at a minimum, benefits
9 for personal care services (including home
10 health aide and home care worker services as
11 defined by the NAIC) home health services,
12 adult day care, and respite care in an individ-
13 ual’s home or in another setting in the commu-
14 nity, or any of these benefits on a respite care
15 basis.

16 “(3) NURSING FACILITY SERVICES.—If a long-
17 term care insurance policy provides benefits for the
18 payment of specified nursing facility services, the
19 policy must provide such benefits with respect to all
20 nursing facilities (as defined in section 1919(a) of
21 the Social Security Act or until such time as subse-
22 quently provided for by the NAIC in establishing
23 uniform language and definitions under section
24 2715(a)(1)) in the State.

25 “(4) PER DIEM POLICIES.—

1 “(A) DEFINITION.—For purposes of this
2 part, the term ‘per diem long-term care insur-
3 ance policy’ means a long-term care insurance
4 policy (or certificate under a group long-term
5 care insurance policy) that provides for benefit
6 payments on a periodic basis due to cognitive
7 impairment or loss of functional capacity with-
8 out regard to the expenses incurred or services
9 rendered during the period to which the pay-
10 ments relate.

11 “(B) LIMITATION.—No per diem long-term
12 care insurance policy (or certificate) may condi-
13 tion, limit or otherwise exclude benefit pay-
14 ments based on the receipt of any type services
15 from any type providers of long-term care serv-
16 ice providers.

17 “(d) PROHIBITION OF DISCRIMINATION.—A long-
18 term care insurance policy may not treat benefits under
19 the policy in the case of an individual with Alzheimer’s
20 disease, with any related progressive degenerative demen-
21 tia of an organic origin, with any organic or inorganic
22 mental illness, or with mental retardation or any other
23 cognitive or mental impairment differently from an indi-
24 vidual having a functional impairment for which benefits
25 may be made available.

1 “(e) LIMITATION ON USE OF PREEXISTING CONDI-
2 TION LIMITS.—

3 “(1) INITIAL ISSUANCE.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), a long-term care insurance policy
6 may not exclude or condition benefits based on
7 a medical condition for which the policyholder
8 received treatment or was otherwise diagnosed
9 before the issuance of the policy.

10 “(B) 6-MONTH LIMIT.—

11 “(i) IN GENERAL.—No long-term care
12 insurance policy or certificate issued under
13 this part shall utilize a definition of ‘pre-
14 existing condition’ that is more restrictive
15 than the following: The term ‘preexisting
16 condition’ means a condition for which
17 medical advice or treatment was rec-
18 ommended by, or received from a provider
19 of health care services, within 6 months
20 preceding the effective date of coverage of
21 an insured individual.

22 “(ii) PROHIBITION ON EXCLUSION OF
23 COVERAGE.—No long-term care insurance
24 policy or certificate may exclude coverage
25 for a loss or confinement that is the result

1 of a preexisting condition unless such loss
2 or confinement begins within 6 months fol-
3 lowing the effective date of the coverage of
4 the insured individual.

5 “(2) REPLACEMENT POLICIES.—If a long-term
6 care insurance policy replaces another long-term
7 care insurance policy, the issuer of the replacing poli-
8 cy shall waive any time periods applicable to pre-
9 existing conditions, waiting period, elimination peri-
10 ods and probationary periods in the new policy for
11 similar benefits to the extent such time was spent
12 under the original policy.

13 “(f) ELIGIBILITY FOR BENEFITS.—

14 “(1) LONG-TERM CARE POLICIES.—Each long-
15 term care insurance policy shall—

16 “(A) describe the level of benefits available
17 under the policy; and

18 “(B) specify in clear, understandable
19 terms, the level (or levels) of physical, cognitive,
20 or mental impairment required in order to re-
21 ceive benefits under the policy.

22 “(2) FUNCTIONAL ASSESSMENT.—In order to
23 submit a claim under any long-term care insurance
24 policy, each claimant shall have a professional func-
25 tional assessment of his or her functional or cog-

1 nitive abilities. Such initial assessment shall be con-
2 ducted by an individual or entity, meeting the quali-
3 fications established by the NAIC to assure the pro-
4 fessional competence and credibility of such individ-
5 ual or entity and that such individual meets any ap-
6 plicable State licensure and certification require-
7 ments. The individual or entity conducting such as-
8 sessment may not control, or be controlled by, the
9 issuer of the policy. For purposes of this paragraph
10 and paragraph (4), the term ‘control’ means the di-
11 rect or indirect possession of the power to direct the
12 management and policies of a person. Control is pre-
13 sumed to exist, if any person directly or indirectly,
14 owns, controls, holds with the power to vote, or
15 holds proxies representing at least 10 percent of the
16 voting securities of another person.

17 “(3) CLAIMS REVIEW.—Except as provided in
18 paragraph (1), each long-term care insurance policy
19 shall be subject to final claims review by the carrier
20 pursuant to the terms of the long-term care insur-
21 ance policy.

22 “(4) APPEALS PROCESS.—

23 “(A) IN GENERAL.—Each long-term care
24 insurance policy shall provide for a timely and
25 independent appeals process, meeting standards

1 established by the NAIC, for individuals who
2 dispute the results of the claims review, con-
3 ducted under paragraph (3), of the policy-
4 holder's functional assessment, conducted under
5 paragraph (2).

6 “(B) INDEPENDENT ASSESSMENT.—An
7 appeals process under this paragraph shall in-
8 clude, at the request of the claimant, an inde-
9 pendent assessment of the claimant's functional
10 or cognitive abilities.

11 “(C) CONDUCT.—An independent assess-
12 ment under subparagraph (B) shall be con-
13 ducted by an individual or entity meeting the
14 qualifications established by the NAIC to as-
15 sure the professional competence and credibility
16 of such individual or entity and any applicable
17 State licensure and certification requirements
18 and may not be conducted—

19 “(i) by an individual who has a direct
20 or indirect significant or controlling inter-
21 est in, or direct affiliation or relationship
22 with, the issuer of the policy;

23 “(ii) by an entity that provides serv-
24 ices to the policyholder or certificate holder

1 for which benefits are available under the
2 long-term care insurance policy; or

3 “(iii) by an individual or entity in con-
4 trol of, or controlled by, the issuer of the
5 policy.

6 “(5) STANDARD ASSESSMENTS.—Not later than
7 2 years after the date of enactment of this part, the
8 advisory committee established under section
9 2701(d) shall recommend uniform needs assessment
10 mechanisms for the determination of eligibility for
11 benefits under such assessments.

12 “(g) INFLATION PROTECTION.—

13 “(1) OPTION TO PURCHASE.—A carrier may
14 not offer a long-term care insurance policy unless
15 the carrier also offers to the proposed policyholder,
16 including each group policyholder, the option to pur-
17 chase a policy that provides for increases in benefit
18 levels, with benefit maximums or reasonable dura-
19 tions that are meaningful, to account for reasonably
20 anticipated increases in the costs of long-term care
21 services covered by the policy. A carrier may not
22 offer to a policyholder an inflation protection feature
23 that is less favorable to the policyholder than one
24 following:

1 “(A) With respect to policies that provide
2 for automatic periodic increases in benefits, the
3 policy provides for an annual increase in bene-
4 fits in a manner so that such increases are
5 computed annually at a rate of not less than 5
6 percent.

7 “(B) With respect to policies that provide
8 for periodic opportunities to elect an increase in
9 benefits, the policy guarantees that the insured
10 individual will have the right to periodically in-
11 crease the benefit levels under the policy with-
12 out providing evidence of insurability or health
13 status so long as the option for the previous pe-
14 riod was not declined. The amount of any such
15 additional benefit may not be less than the dif-
16 ference between—

17 “(i) the existing policy benefit; and

18 “(ii) such existing benefit compounded
19 annually at a rate of at least 5 percent for
20 the period beginning on the date on which
21 the existing benefit is purchased and ex-
22 tending until the year in which the offer of
23 increase is made.

24 “(C) With respect to service benefit poli-
25 cies, the policy covers a specified percentage of

1 the actual or reasonable charges and does not
2 include a maximum specified indemnity amount
3 or limit.

4 “(2) EXCEPTION.—The requirements of para-
5 graph (1) shall not apply to life insurance policies or
6 riders containing accelerated long-term care benefits.

7 “(3) REQUIRED INFORMATION.—Carriers shall
8 include the following information in or together with
9 the outline of coverage provided under this part:

10 “(A) A graphic comparison of the benefit
11 levels of a policy that increases benefits over the
12 policy period with a policy that does not in-
13 crease benefits. Such comparison shall show
14 benefit levels over not less than a 20-year pe-
15 riod.

16 “(B) Any expected premium increases or
17 additional premiums required to pay for any
18 automatic or optional benefit increases, whether
19 the individual who purchases the policy obtains
20 the inflation protection initially or whether such
21 individual delays purchasing such protection
22 until a future time.

23 “(4) CONTINUATION OF PROTECTION.—Infla-
24 tion protection benefit increases under this sub-
25 section under a policy that contains such protection

1 shall continue without regard to an insured's age,
2 claim status or claim history, or the length of time
3 the individual has been insured under the policy.

4 “(5) CONSTANT PREMIUM.—An offer of infla-
5 tion protection under this subsection that provides
6 for automatic benefit increases shall include an offer
7 of a premium that the carrier expects to remain con-
8 stant. Such offer shall disclose in a conspicuous
9 manner that the premium may change in the future
10 unless the premium is guaranteed to remain con-
11 stant.

12 “(6) REJECTION.—Inflation protection under
13 this subsection shall be included in a long-term care
14 insurance policy unless a carrier obtains a written
15 rejection of such protection signed by the policy-
16 holder.

17 **“SEC. 2716. NONFORFEITURE.**

18 “(a) IN GENERAL.—Each long-term care insurance
19 policy (or certificate) shall provide that if the policy lapses
20 after the policy has been in effect for a minimum period
21 (specified under the standards under section 2701(a)), the
22 policy will provide, without payment of any additional pre-
23 miums, nonforfeiture benefits as determined appropriate
24 by the NAIC.

1 “(b) ESTABLISHMENT OF STANDARDS.—The stand-
2 ards under section 2701(a) shall provide that the percent-
3 age or amount of benefits under subsection (a) must in-
4 crease based upon the policyholder’s equity in the policy.

5 **“SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND**
6 **RIGHT TO RETURN.**

7 “(a) CONTESTABILITY.—A carrier may not cancel or
8 renew a long-term care insurance policy or deny a claim
9 under the policy based on fraud or intentional misrepre-
10 sentation relating to the issuance of the policy unless no-
11 tice of such fraud or misrepresentation is provided within
12 a time period to be determined by the NAIC.

13 “(b) RIGHT TO RETURN.—Each applicant for a long-
14 term care insurance policy shall have the right to return
15 the policy (or certificates) within 30 days of the date of
16 its delivery (and to have the premium refunded) if, after
17 examination of the policy or certificate, the applicant is
18 not satisfied for any reason.

19 **“SEC. 2718. CIVIL MONEY PENALTY.**

20 “(a) CARRIER.—Any carrier, association or its sub-
21 sidiary that sells or offers for sale a long-term care insur-
22 ance policy and that—

23 “(1) fails to make a refund in accordance with
24 section 2713(a);

1 “(2) fails to transmit a policy in accordance
2 with section 2713(b);

3 “(3) fails to provide, make available, or report
4 information in accordance with subsections (c) or (d)
5 of section 2713;

6 “(4) provides a commission or compensation in
7 violation of section 2713(e);

8 “(5) fails to provide an outline of coverage in
9 violation of section 2715(b)(1); or

10 “(6) issues a policy without obtaining certain
11 information in violation of section 2715(f);

12 is subject to a civil money penalty of not to exceed \$25,000
13 for each such violation.

14 “(b) AGENTS.—Any agent that sells or offers for sale
15 a long-term care insurance policy and that—

16 “(1) fails to make a refund in accordance with
17 section 2713(a);

18 “(2) fails to transmit a policy in accordance
19 with section 2713(b);

20 “(3) fails to provide, make available, or report
21 information in accordance with subsections (c) or (d)
22 of section 2713;

23 “(4) fails to provide an outline of coverage in
24 violation of section 2715(b)(1); or

1 “(5) issues a policy without obtaining certain
2 information in violation of section 2715(f);
3 is subject to a civil money penalty of not to exceed \$15,000
4 for each such violation.

5 “(c) EFFECT ON STATE LAW.—Nothing in this sec-
6 tion shall be construed as preempting or otherwise limiting
7 the penalties that may be imposed by a State for the types
8 of conduct described in this section.

9 **“Subpart C—Long-Term Care Insurance Policies,**
10 **Definition and Endorsements**

11 **“SEC. 2721. LONG-TERM CARE INSURANCE POLICY DE-**
12 **FINED.**

13 “(a) IN GENERAL.—As used in this section, the term
14 ‘long-term care insurance policy’ means any insurance pol-
15 icy, rider or certificate advertised, marketed, offered or de-
16 signed to provide coverage for not less than 12 consecutive
17 months for each covered person on an expense incurred,
18 indemnity prepaid or other basis, for one or more nec-
19 essary diagnostic, preventive, therapeutic, rehabilitative,
20 maintenance or personal care services, provided in a set-
21 ting other than an acute care unit of a hospital. Such term
22 includes—

23 “(1) group and individual annuities and life in-
24 surance policies, riders or certificates that provide

1 directly, or that supplement long-term care insur-
2 ance; and

3 “(2) a policy, rider or certificates that provides
4 for payment of benefits based on cognitive impair-
5 ment or the loss of functional capacity.

6 “(b) ISSUANCE.—Long-term care insurance policies
7 may be issued by—

8 “(1) carriers;

9 “(2) fraternal benefit societies;

10 “(3) nonprofit health, hospital, and medical
11 service corporations;

12 “(4) prepaid health plans;

13 “(5) health maintenance organizations; or

14 “(6) any similar organization to the extent they
15 are otherwise authorized to issue life or health insur-
16 ance.

17 “(c) POLICIES EXCLUDED.—The term ‘long-term
18 care insurance policy’ shall not include any insurance pol-
19 icy, rider or certificate that is offered primarily to provide
20 basic Medicare supplement coverage, basic hospital ex-
21 pense coverage, basic medical-surgical expense coverage,
22 hospital confinement indemnity coverage, major medical
23 expense coverage, disability income or related asset-protec-
24 tion coverage, accident only coverage, specified disease or
25 specified accident coverage, or limited benefit health cov-

1 erage. With respect to life insurance, such term shall not
2 include life insurance policies, riders or certificates that
3 accelerate the death benefit specifically for one or more
4 of the qualifying events of terminal illness, medical condi-
5 tions requiring extraordinary medical intervention, or per-
6 manent institutional confinement, and that provide the op-
7 tion of a lump-sum payment for those benefits and in
8 which neither the benefits nor the eligibility for the bene-
9 fits is conditioned upon the receipt of long-term care.

10 “(d) APPLICATIONS.—Notwithstanding any other
11 provision of this part, this part shall apply to any product
12 advertised, marketed or offered as a long-term insurance
13 policy, rider or certificate.

14 **“SEC. 2722. CODE OF CONDUCT WITH RESPECT TO EN-**
15 **DORSEMENTS.**

16 “Not later than 1 year after the date of enactment
17 of this part the NAIC shall issue guidelines that shall
18 apply to organizations and associations, other than em-
19 ployers and labor organizations that do not accept com-
20 pensation, and their subsidiaries that provide endorse-
21 ments of long-term care insurance policies, or that permit
22 such policies to be offered for sale through the organiza-
23 tion or association. Such guidelines shall include at mini-
24 mum the following:

1 “(1) In endorsing or selling long-term care in-
2 surance policies, the primary responsibility of an or-
3 ganization or association shall be to educate their
4 members concerning such policies and assist such
5 members in making informed decisions. Such organi-
6 zations and associations may not function primarily
7 as sales agents for insurance companies.

8 “(2) Organizations and associations shall pro-
9 vide objective information regarding long-term care
10 insurance policies sold or endorsed by such organiza-
11 tions and associations to ensure that members of
12 such organizations and associations have a balanced
13 and complete understanding of both the strengths
14 and weaknesses of the policies that are being en-
15 dorsed or sold.

16 “(3) Organizations and associations selling or
17 endorsing long-term care insurance policies shall dis-
18 close in marketing literature provided to their mem-
19 bers concerning such policies the manner in which
20 such policies and the insurance company issuing
21 such policies were selected. If the organization or as-
22 sociation and the insurance company have interlock-
23 ing directorates, the organization or association shall
24 disclose such fact to their members.

1 “(4) Organizations and associations selling or
2 endorsing long-term care insurance policies shall dis-
3 close in marketing literature provided to their mem-
4 bers concerning such policies the nature and amount
5 of the compensation arrangements (including all
6 fees, commissions, administrative fees and other
7 forms of financial support that the organization or
8 association receives) from the endorsement or sale of
9 the policy to its members.

10 “(5) The Boards of Directors of organizations
11 and associations selling or endorsing long-term care
12 insurance policies, if such organizations and associa-
13 tions have a Board of Directors, shall review and ap-
14 prove such insurance policies, the compensation ar-
15 rangements and the marketing materials used to
16 promote sales of such policies.”.

17 **PART 3—LIFE CARE**

18 **SEC. 2301. SHORT TITLE.**

19 This part may be cited as the “Life Care Act”.

20 **SEC. 2302. LIFE CARE: PUBLIC INSURANCE PROGRAM FOR**
21 **NURSING HOME CARE.**

22 Title XXVII of the Public Health Service Act (as
23 added by section 2301) is amended by adding at the end
24 thereof the following new part:

1 **“PART 2—LIFE CARE: PUBLIC INSURANCE**

2 **PROGRAM FOR NURSING HOME CARE**

3 **“SEC. 2741. ESTABLISHMENT OF VOLUNTARY LONG-TERM**

4 **CARE INSURANCE PROGRAM.**

5 “The Secretary shall establish a voluntary insurance
6 program for individuals 35 years of age and over to cover
7 the nursing home stays of such individuals. The Secretary
8 shall establish a process for enrollment in the Life Care
9 program.

10 **“SEC. 2742. BENEFITS.**

11 “(a) IN GENERAL.—

12 “(1) ELIGIBILITY FOR COVERAGE.—Subject to
13 subsection (c), an individual who meets the eligibility
14 criteria prescribed in section 2743 shall be eligible
15 under the program established under this part for
16 coverage for necessary services described in sub-
17 section (b) (in the amounts described in subsection
18 (c)) that are provided to the individual by a nursing
19 facility while the individual is an inpatient of the fa-
20 cility.

21 “(2) NONFORFEITURE.—The Secretary shall
22 establish standards to ensure the nonforfeiture of
23 benefits for which premiums have been paid.

24 “(b) TYPES.—Coverage may be provided under this
25 part for—

1 “(1) nursing care provided by or under the su-
2 pervision of a registered professional nurse;

3 “(2) physical, occupational, or speech therapy
4 furnished by a facility or by others under arrange-
5 ments with a facility;

6 “(3) medical social work services;

7 “(4) drug, biological, supply, appliance, and
8 equipment for use in the facility, that is ordinarily
9 furnished by the facility for the care and treatment
10 of an inpatient;

11 “(5) such other services necessary to the func-
12 tioning of a patient, including personal care and as-
13 sistance with activities of daily living, as are gen-
14 erally provided by a nursing home facility; and

15 “(6) with respect to the initial 6 months of cov-
16 ered residence in a nursing facility, such room and
17 board costs as are not covered by beneficiary
18 copayment.

19 “(c) COVERAGE AMOUNT.—

20 “(1) IN GENERAL.—The amount of coverage
21 provided with respect to an eligible individual for the
22 services described in subsection (b) shall, based on
23 an election made by the individual, not exceed
24 \$30,000, \$60,000, or \$90,000 over the lifetime of
25 the eligible individual. Such amounts shall be ad-

1 justed by the Secretary to reflect increases in the
2 Consumer Price Index.

3 “(2) ASSET PROTECTION.—An eligible individ-
4 ual shall be entitled to the asset protection provided
5 under section 2748.

6 “(d) PAYMENT.—Amounts provided under this part
7 with respect to an eligible individual for the services de-
8 scribed in subsection (b) shall be paid from the general
9 fund of the Treasury of the United States.

10 “(e) RESIDENTIAL CARE FACILITIES.—The Sec-
11 retary shall consider the feasibility of making payments
12 under this part for services delivered in residential care
13 facilities. Not later than 2 years after the date of enact-
14 ment of this Act, the Secretary shall report its findings
15 to the Congress with respect to the feasibility of making
16 such payments.

17 **“SEC. 2743. ELIGIBILITY.**

18 “(a) IN GENERAL.—An individual shall be eligible for
19 benefits under this part if—

20 “(1) the individual—

21 “(A) is a legal resident of the United
22 States and has elected coverage under sub-
23 section (c); and

1 “(B) has been determined by a Screening
2 Agency through a screening process (conducted
3 in accordance with section 2747)—

4 “(i)(I) to require hands-on or standby
5 assistance, supervision, or cueing (as de-
6 fined in regulations) to perform three or
7 more activities of daily living; or

8 “(II) to require hands-on or standby
9 assistance, supervision, or cueing with at
10 least such instrumental activity (or activi-
11 ties) of daily living related to cognitive or
12 mental impairment as the Secretary speci-
13 fies; or

14 “(III) to display symptoms of one or
15 more serious behavioral problems (that is
16 on a list of such problems specified by the
17 Secretary) which create a need for super-
18 vision to prevent harm to self or others; or

19 “(IV) has achieved a score, on a
20 standard mental status protocol (or proto-
21 cols) appropriate for measuring the indi-
22 vidual’s particular condition specified by
23 the Secretary, that indicates either severe
24 cognitive impairment or severe mental im-
25 pairment, or both; and

1 “(ii) to require such assistance, super-
2 vision, or cueing over a period of at least
3 90 days; and

4 “(2)(A) the individual has filed an application
5 for such benefits, and is in need of, benefits covered
6 under this part; or

7 “(B) the legal guardian of the individual has
8 filed an application on behalf of an individual who
9 is in need of benefits covered under this part; or

10 “(C) the representative of an individual who is
11 cognitively impaired and who is in need of benefits
12 covered under this part has filed an application on
13 behalf of the individual.

14 “(b) CURRENT INDIVIDUALS.—An individual who is
15 in a hospital or nursing home on the date of the enroll-
16 ment of the individual in the program established under
17 this part shall be ineligible for coverage under this section
18 until the individual’s first spell of illness beginning after
19 such date.

20 “(c) ELECTION OF COVERAGE.—

21 “(1) IN GENERAL.—Subject to this subsection,
22 an individual shall have the option to purchase cov-
23 erage under this part when the individual is 35
24 years of age, 45 years of age, 55 years of age, or
25 65 years of age.

1 “(2) INITIAL YEAR.—During the 1-year period
2 beginning on the date on which final regulations
3 that implement this part are issued, an individual
4 who is 35 years of age or older shall be eligible to
5 purchase insurance under this part, except that such
6 an individual shall not be eligible to purchase such
7 insurance—

8 “(A) while confined to a hospital or nurs-
9 ing home;

10 “(B) within the 6-month period after the
11 individual’s confinement in a nursing home; or

12 “(C) within the 90-day period after the in-
13 dividual’s confinement in a hospital.

14 Individuals described in the matter preceding sub-
15 paragraph (A) shall become eligible to receive bene-
16 fits under this part on the expiration of the 3-year
17 period beginning on the date such individuals pur-
18 chase insurance under this part.

19 “(3) EXTENSION BEYOND INITIAL YEAR.—If an
20 individual is confined to a nursing home or hospital
21 during a period that extends beyond the first year
22 after the effective date of this part, an individual
23 shall be eligible to enroll in the program established
24 by this part during the 60-day period beginning
25 after the individual’s spell of illness.

1 “(4) SUBSEQUENT YEARS.—During years sub-
2 sequent to the 1-year period referred to in para-
3 graph (2), an individual shall be eligible to purchase
4 insurance under this part within 6 months of the
5 35th, 45th, 55th or 65th birthday of the individual.

6 “(5) ACTIVATION OF BENEFITS.—To receive
7 coverage under the insurance program established by
8 this part, an individual shall have purchased such
9 coverage not later than 1 month prior to admission
10 to a nursing facility, unless the reason for the need
11 of services is a result of an accident or stroke subse-
12 quent to the date that such individual enrolled for
13 coverage under this part.

14 “(d) PUBLIC EDUCATION.—In the 12 months preced-
15 ing the initial enrollment period, the Secretary shall, either
16 directly or through grants and contracts, conduct a public
17 service and education campaign designed to inform poten-
18 tially eligible individuals as to the nature of the benefits
19 and the limited enrollment period. In conducting such
20 campaigns the Secretary shall make information available
21 to individuals through the open enrollment process for ob-
22 taining health care benefits under this Act.

23 **“SEC. 2744. PREMIUM RATES.**

24 “(a) IN GENERAL.—The Secretary shall determine
25 one premium rate for individuals electing to purchase cov-

1 erage under this part at age 35 (or between the ages of
2 35 and 44 during the initial enrollment period), a separate
3 rate for those individuals who elect coverage at age 45
4 (or between the ages of 45 and 54 during the initial enroll-
5 ment period), a separate rate for those individuals who
6 elect such coverage at age 55 (or between that ages of
7 55 and 64 during the initial enrollment period), and a sep-
8 arate rate for those individuals who elect such coverage
9 at age 65 (or at age 65 and over during the initial enroll-
10 ment period). During the initial enrollment period, the
11 Secretary shall establish actuarially fair, age-rated pre-
12 miums for persons age 65 and over.

13 “(b) REVISION.—The Secretary shall revise premium
14 rates annually to increase such rates to reflect the amount
15 of the increase in the cost of living adjustment with re-
16 spect to benefits under title II of the Social Security Act.

17 “(c) RATES.—In developing premium rates under the
18 program established under this part, the Secretary shall
19 establish rates that are expected to cover 100 percent of
20 the reimbursement amount provided under this part for
21 nursing home stays for those individuals enrolled in the
22 program.

23 “(d) WAIVER.—An individual electing to purchase
24 coverage under this part shall not be required to pay pre-

1 miums during any period in which such individual is re-
2 ceiving benefits under this part.

3 “(e) PAYMENT.—Premiums shall be paid under this
4 section into the general fund of the Treasury of the United
5 States.

6 **“SEC. 2745. QUALIFIED SERVICE PROVIDERS.**

7 “(a) IN GENERAL.—To be considered as a covered
8 nursing home service under this part, such service must
9 have been provided by a qualified service provider.

10 “(b) TYPES.—A provider shall be considered a quali-
11 fied service provider under this part if the provider is a
12 nursing facility that is certified by the State and meets
13 the requirements of this part and any other standards es-
14 tablished by the Secretary by regulation for the safe and
15 efficient provision of services covered under this part.

16 **“SEC. 2746. REIMBURSEMENT.**

17 “(a) AMOUNT.—Monthly reimbursement for nursing
18 facility services under this part shall equal 65 percent (or
19 during the initial 6 months of coverage, 80 percent) of
20 the amount the Secretary determines to be reasonable and
21 appropriate to cover the cost of care provided under this
22 part.

23 “(b) PROSPECTIVE PAYMENT.—To the extent fea-
24 sible, the Secretary shall establish a prospective payment
25 mechanism for payment for nursing home services under

1 this part that takes into account the expected resource uti-
2 lization of individual patients based on their degree of dis-
3 ability, the methodology recommended for reimbursement
4 of skilled nursing facilities under title XVIII of the Social
5 Security Act, and other factors determining service re-
6 quirements.

7 “(c) ROOM AND BOARD PAYMENT.—An individual
8 receiving benefits under this program shall be responsible
9 for the payment of an amount for room and board that
10 is equal to—

11 “(1) with respect to the initial 6 months of resi-
12 dence in a nursing facility, 20 percent of the average
13 per diem rate paid by the Secretary to nursing facili-
14 ties receiving reimbursement under this part; and

15 “(2) with respect to subsequent periods of resi-
16 dence, 35 percent of the average per diem rate paid
17 by the Secretary to nursing facilities receiving reim-
18 bursement under this part. Payments under sub-
19 section (a) and (c) shall be considered payment in
20 full for services received under this section.

21 “(d) PRIORITY PAYERS.—Notwithstanding any other
22 provision of this part, reimbursement for nursing facility
23 services provided under this part to an individual shall,
24 to the extent available, be made under the Medicare pro-
25 gram, under Department of Veterans Affairs’ programs,

1 or under private insurance policies prior to reimbursement
2 under this part.

3 **“SEC. 2747. LONG-TERM CARE SCREENING AGENCY.**

4 “(a) ESTABLISHMENT.—The Secretary shall contract
5 with entities to act as Long-Term Care Screening Agen-
6 cies (hereafter referred to in this part as the ‘Screening
7 Agency’) for each designated area of a State. It shall be
8 the responsibility of such agency to assess the eligibility
9 of individuals residing in the geographic jurisdiction of the
10 Agency, for services provided under this part according to
11 the requirements of this part and regulations prescribed
12 by the Secretary. In entering into such contracts, the Sec-
13 retary shall give preference to State governmental entities
14 and private nonprofit agencies.

15 “(b) ELIGIBILITY.—The Screening Agency shall de-
16 termine the eligibility of an individual under this part
17 based on the results of a preliminary telephone interview
18 or written questionnaire (completed by the applicant, by
19 the caregiver of the applicant, or by the legal guardian
20 or representative of the applicant) that shall be validated
21 through the use of a screening tool administered in person
22 to each applicant determined eligible through initial tele-
23 phone or written questionnaire interviews not later than
24 15 days from the date on which such individual initially
25 applied for services under this part.

1 “(c) QUESTIONNAIRES AND SCREENING TOOLS.—

2 “(1) IN GENERAL.—The Secretary shall estab-
3 lish a telephone or written questionnaire and a
4 screening tool to be used by the Screening Agency
5 to determine the eligibility of an individual for serv-
6 ices under this part consistent with requirements of
7 this part and the standards established by the Sec-
8 retary by regulation.

9 “(2) QUESTIONNAIRES.—The questionnaire
10 shall include questions about the functional impair-
11 ment and mental status of an individual and other
12 criteria that the Secretary shall prescribe by regula-
13 tion.

14 “(3) SCREENING TOOLS.—The screening tool
15 should measure functional impairment caused by
16 physical or cognitive conditions as well as informa-
17 tion concerning cognition disability, behavioral prob-
18 lems (such as wandering or abusive and aggressive
19 behavior), and any other criteria that the Secretary
20 shall prescribe by regulation. The screening tool
21 shall be administered in person.

22 “(d) NOTIFICATION.—Not later than 15 days after
23 the date on which an individual initially applied for serv-
24 ices under this part (by telephone or written question-
25 naire), the Screening Agency shall notify such individual

1 that such individual is not eligible for benefits, or that
2 such individuals must schedule an in-person screening to
3 determine final eligibility for benefits under this part. The
4 Screening Agency shall notify such individual of its final
5 decision not later than 2 working days after the in-person
6 screening.

7 “(e) IN-PERSON SCREENING.—An individual (or the
8 legal guardian or representative of such individual) whose
9 application for benefits under this part is denied on the
10 basis of information provided through a telephone or writ-
11 ten questionnaire, shall be notified of such individual’s
12 right to an in-person screening by a nurse or appropriate
13 health care professionals.

14 “(f) APPEALS.—The Secretary shall establish a
15 mechanism for hearings and appeals in cases in which in-
16 dividuals contest the eligibility findings of the Screening
17 Agency.

18 “(g) PAYMENT.—

19 “(1) PAYMENT FOR SCREENING.—The Screen-
20 ing Agency may require payment from individuals
21 only in accordance with standards established by the
22 Secretary.

23 “(2) NO PAYMENT FOR POOREST.—The Screen-
24 ing Agency may not require payment for individuals

1 with incomes of less than 150 percent of the official
2 poverty line.

3 **“SEC. 2748. ASSET PROTECTION.**

4 “Notwithstanding any other provision of law, the as-
5 sets an eligible individual may retain and be determined
6 eligible for nursing facility benefits, including payments of
7 room and board under this part, under State Medicaid
8 programs (in accordance with section 1902(a)(10)) shall
9 be increased by the amount of coverage (\$30,000,
10 \$60,000, or \$90,000) elected under section 2742.

11 **“SEC. 2749. RELATION TO PRIVATE INSURANCE.**

12 “(a) IN GENERAL.—Except as provided in subsection
13 (b), an insurer may not offer a long-term care insurance
14 policy to an individual who has purchased coverage under
15 this part if the coverage under such policy duplicates the
16 coverage provided under this part.

17 “(b) DEVELOPMENT OF STANDARD PACKAGES.—The
18 Secretary shall develop standard long-term care insurance
19 benefits packages that insurers may offer to insured indi-
20 viduals under this part. Such packages shall provide cov-
21 erage for benefits that compliment, but do not duplicate,
22 those covered under this part.

23 **“SEC. 2750. DEFINITIONS.**

24 “As used in this part:

1 “(1) NURSING FACILITY.—The term ‘nursing
2 facility’ means—

3 “(A) a skilled nursing facility (as defined
4 in section 1819(a) of the Social Security Act);
5 or

6 “(B) a facility that is a nursing facility (as
7 defined in section 1919(a) of such Act) which
8 meets the requirements of section
9 1819(b)(4)(C) of such Act (relating to nursing
10 care).

11 “(2) SPELL OF ILLNESS.—The term ‘spell of
12 illness’ means a period of consecutive days beginning
13 with the first day on which an individual is fur-
14 nished services as an inpatient in a hospital or nurs-
15 ing facility and ending with the close of the first 6
16 consecutive months thereafter during which the indi-
17 vidual is no longer an inpatient of a nursing facility,
18 or 90 days after the individual is no longer an inpa-
19 tient in a hospital.

20 **“SEC. 2751. REPORTS.**

21 “(a) IN GENERAL.—Prior to the promulgation of reg-
22 ulations implementing this title, the Secretary shall report
23 to Congress on—

24 “(1) the actuarially-sound premium rates to be
25 used in the implementation of this Act, including

1 whether the premiums will cover 100 percent of the
2 benefits paid out, and whether Federal funds will be
3 required to support the payment of benefits;

4 “(2) an assessment of the impact of such pre-
5 mium rates on the affordability of coverage under
6 this Act;

7 “(3) a projected enrollment of individuals by
8 age category; and

9 “(4) an estimate of current and projected en-
10 rollment of individuals, by age category in coverage
11 under private long-term care insurance.

12 “(b) LIFE CARE REPORT.—Not later than 2 years
13 after the promulgation of regulations implementing this
14 title, the Secretary shall report to Congress on the follow-
15 ing aspects of the Life Care Act:

16 “(1) The current and projected premium rates.

17 “(2) The current and projected enrollment of
18 individuals, by age category and an estimate of cur-
19 rent and projected enrollment of individuals by age
20 category in private long-term care insurance.

21 “(3) The projected use of benefits and the im-
22 pact of use on premium rates.

23 “(4) An assessment of the impact of projected
24 premium rates on the affordability of coverage under
25 this Act.

1 “(c) RECOMMENDATIONS.—The Secretary shall make
2 recommendations to Congress regarding necessary revi-
3 sions to the Life Care Act as a result of the findings pro-
4 vided in the reports submitted under this section.”.

5 **SEC. 2303. SENSE OF THE COMMITTEE CONCERNING PACE**
6 **(PROGRAM OF ALL-INCLUSIVE CARE FOR THE**
7 **ELDERLY).**

8 (a) FINDINGS.—The Committee on Labor and
9 Human Resources of the Senate finds that—

10 (1) a serious shortcoming in the Nation’s cur-
11 rent health care delivery system is its ability to inte-
12 grate acute and long-term care services;

13 (2) the pioneering efforts of the On Lok pro-
14 gram in San Francisco, which has been replicated as
15 PACE (Program of All-inclusive Care for the Elder-
16 ly), provides a comprehensive range of acute and
17 long-term care services to frail, nursing home eligible
18 individuals, allowing them to avoid unwanted institu-
19 tionalization;

20 (3) two of the current PACE sites are located
21 in East Boston, Massachusetts and Columbia, South
22 Carolina;

23 (4) these programs have done a remarkable job
24 in keeping elderly, low-income, severely disabled indi-

- Sec. 3012. Annual authorization of number of specialty positions; requirements regarding primary health care.
- Sec. 3013. Allocations among specialties and programs.

SUBPART C—COSTS OF GRADUATE MEDICAL EDUCATION

CHAPTER 1—OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

- Sec. 3031. Federal formula payments to qualified entities for the costs of the operation of approved physician training programs.
- Sec. 3032. Application for payments.
- Sec. 3033. Availability of funds for payments; annual amount of payments.

CHAPTER 2—MEDICAL SCHOOL FUND ACCOUNT

- Sec. 3041. Federal payments to the medical school fund.
- Sec. 3042. Application for payments.
- Sec. 3043. Availability of funds for payments; annual amount of payments.

CHAPTER 3—ACADEMIC HEALTH CENTERS

- Sec. 3051. Federal formula payments to academic health centers.
- Sec. 3052. Request for payments.
- Sec. 3053. Availability of funds for payments; annual amount of payments.

SUBPART D—GENERAL PROVISIONS

- Sec. 3055. Definitions.

SUBPART E—TRANSITIONAL PROVISIONS

- Sec. 3061. Transitional payments to institutions.

PART 2—INSTITUTIONAL COSTS OF GRADUATE NURSING EDUCATION;
WORKFORCE PRIORITIES

- Sec. 3071. Authorized graduate nurse training positions; institutional costs.
- Sec. 3072. Applicability of part 1 provisions.

PART 3—RELATED PROGRAMS

SUBPART A—WORKFORCE DEVELOPMENT

- Sec. 3081. Programs of the secretary of health and human services.
- Sec. 3082. Programs of the secretary of labor.
- Sec. 3083. Requirement for certain programs regarding redeployment of health care workers.

SUBPART B—TRANSITIONAL PROVISIONS FOR WORKFORCE PROVISIONS

- Sec. 3091. Application.
- Sec. 3092. Definitions.
- Sec. 3093. Obligations of displacing employer and affiliated enterprises in event of displacement.
- Sec. 3094. Employment with successors.
- Sec. 3095. Collective bargaining obligations during transition period.
- Sec. 3096. General provisions.

Subtitle B—Academic Health Centers

- Sec. 3131. Discretionary grants regarding access to centers.

Subtitle C—Health Research Initiatives

PART 1—PROGRAMS FOR CERTAIN AGENCIES

- Sec. 3201. Biomedical and behavioral research.
- Sec. 3202. Health services research.

PART 2—FUNDING FOR PROGRAM

- Sec. 3211. Authorizations of appropriations.

Subtitle D—Core Functions of Public Health Programs; National Initiatives Regarding Preventive Health

PART 1—FUNDING

- Sec. 3301. Authorizations of appropriations.

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

- Sec. 3311. Purposes.
- Sec. 3312. Grants to States for core functions of public health.
- Sec. 3313. Submission of information.
- Sec. 3314. Reports.
- Sec. 3315. Application for grant.
- Sec. 3316. Allocations for certain activities.
- Sec. 3317. Definitions.
- Sec. 3318. Single application and uniform reporting systems for core functions of public health and public health categorical grant programs administered by the Centers for Disease Control and Prevention.

PART 3—NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

SUBPART A—GENERAL GRANTS

- Sec. 3331. Grants for national prevention initiatives.
- Sec. 3332. Priorities.
- Sec. 3333. Submission of information.
- Sec. 3334. Application for grant.

SUBPART B—DEVELOPMENT OF TELEMEDICINE ON RURAL UNDERSERVED AREAS

- Sec. 3341. Grants for development of rural telemedicine.
- Sec. 3342. Report and evaluation of telemedicine.
- Sec. 3343. Recommendation on reimbursement of telemedicine.

Subtitle E—Health Services for Medically Underserved Populations

PART 1—INITIATIVES FOR ACCESS TO HEALTH CARE

SUBPART A—AUTHORIZATION OF APPROPRIATIONS

- Sec. 3411. Authorizations of appropriations.

SUBPART B—DEVELOPMENT OF COMMUNITY HEALTH GROUPS AND HEALTH CARE SITES AND SERVICES

- Sec. 3421. Grants and contracts for development of plans and networks and the expansion and development of health care sites and services.
- Sec. 3422. Certain uses of awards.
- Sec. 3423. Application.
- Sec. 3424. Purposes and conditions.

SUBPART C—CAPITAL COST OF DEVELOPMENT OF COMMUNITY HEALTH GROUPS AND OTHER PURPOSES

- Sec. 3441. Direct loans and grants.
- Sec. 3442. Certain requirements.
- Sec. 3443. Defaults; right of recovery.
- Sec. 3444. Provisions regarding construction or expansion of facilities.
- Sec. 3445. Application for assistance.
- Sec. 3446. Administration of programs.

SUBPART D—ENABLING AND SUPPLEMENTAL SERVICES

- Sec. 3461. Grants and contracts for enabling and supplemental services.
- Sec. 3462. Authorizations of appropriations.

PART 2—NATIONAL HEALTH SERVICE CORPS

- Sec. 3471. Authorizations of appropriations.
- Sec. 3472. Allocation for participation of nurses in scholarship and loan repayment programs.
- Sec. 3473. Allocation for participation of psychiatrists, psychologists, and clinical social workers in scholarship and loan repayment programs.

PART 3—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

- Sec. 3481. Payments to hospitals.
- Sec. 3482. Identification of eligible hospitals.
- Sec. 3483. Amount of payments.
- Sec. 3484. Base year.

PART 4—SENSE OF THE COMMITTEE

- Sec. 3491. Sense of the Committee.

Subtitle F—Mental Health; Substance Abuse

PART 1—AUTHORITIES REGARDING PARTICIPATING STATES

SUBPART A—REPORT

- Sec. 3511. Report on integration of mental health systems.
- Sec. 3512. Reports during transition period.

PART 2—ASSISTANCE FOR STATE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

- Sec. 3531. Availability of assistance.
- Sec. 3532. Plan requirements.
- Sec. 3533. Additional Federal responsibilities.
- Sec. 3534. Authorization of appropriations.

Subtitle G—Comprehensive School Health Education; School-Related Health Services

PART 1—HEALTHY STUDENTS-HEALTHY SCHOOLS GRANTS FOR SCHOOL HEALTH EDUCATION

- Sec. 3601. Purposes.
- Sec. 3602. Healthy students-health schools.
- Sec. 3603. Healthy students-healthy schools interagency task force.
- Sec. 3604. Duties of the secretary.

PART 5—SCHOOL-RELATED HEALTH SERVICES

SUBPART A—DEVELOPMENT AND OPERATION

- Sec. 3681. Authorizations of appropriations.
- Sec. 3682. Eligibility for grants.
- Sec. 3683. Preferences.
- Sec. 3684. Planning and development grants.
- Sec. 3685. Grants for operation of school health services.

SUBPART B—CAPITAL COSTS OF DEVELOPING PROJECTS

- Sec. 3691. Loans and loan guarantees regarding projects.
- Sec. 3692. Funding.

Subtitle H—Public Health Service Initiative

- Sec. 3695. Public health service initiative.

Subtitle I—Additional Provisions Regarding Public Health

- Sec. 3901. Curriculum development and implementation regarding domestic violence and women's health.

Subtitle J—Occupational Safety and Health

- Sec. 3903. Occupational injury and illness prevention.

Subtitle K—Full funding for WIC

- Sec. 3905. Full funding of WIC.

Subtitle L—Border Health Improvement

- Sec. 3908. Border health commission.

1 **Subtitle A—Workforce Priorities**
2 **Under Federal Payments**

3 **PART 1—INSTITUTIONAL COSTS OF GRADUATE**
4 **MEDICAL EDUCATION; WORKFORCE PRIORITIES**

5 **Subpart A—National Council Regarding Workforce**
6 **Priorities**

7 **SEC. 3001. NATIONAL COUNCIL ON GRADUATE MEDICAL**
8 **EDUCATION.**

9 (a) IN GENERAL.—There is established within the
10 Department of Health and Human Services a council to
11 be known as the National Council on Graduate Medical
12 Education.

13 (b) DUTIES.—The Secretary shall carry out subpart
14 B acting through the National Council.

15 (c) COMPOSITION.—

16 (1) IN GENERAL.—The membership of the Na-
17 tional Council shall include between 12 and 18 indi-
18 viduals who are appointed to the Council from
19 among individuals who are not officers or employees
20 of the United States. Such individuals shall be ap-
21 pointed by the Secretary, and shall include individ-
22 uals from each of the following categories:

23 (A) Consumers of health care services, at
24 least one of whom resides in a rural area.

1 (B) Physicians who are faculty members of
2 medical schools.

3 (C) Physicians in private practice who are
4 not physicians described in subparagraph (B).

5 (D) Officers or employees of regional and
6 corporate health alliances.

7 (E) Officers or employees of health care
8 plans that participate in such alliances.

9 (F) Executives of teaching hospitals.

10 (G) Nurses.

11 (H) Primary care physicians, at least one
12 of whom practices in a rural area.

13 (I) Such other individuals as the Secretary
14 determines to be appropriate.

15 (2) EX OFFICIO MEMBERS; OTHER FEDERAL
16 OFFICERS OR EMPLOYEES.—The membership of the
17 National Council shall include individuals designated
18 by the Secretary to serve as members of the Council
19 from among Federal officers or employees who are
20 appointed by the President, or by the Secretary or
21 other Federal officers who are appointed by the
22 President with the advice and consent of the Senate.

23 (d) CHAIR.—The Secretary shall, from among mem-
24 bers of the National Council appointed under subsection

1 (c)(1), designate an individual to serve as the Chair of
2 the Council.

3 (e) DEFINITIONS.—For purposes of this subtitle:

4 (1) The term “academic health center” means
5 an entity defined in section 3051(c)(1).

6 (2) The term “medical school” means a school
7 of medicine (as defined in section 799 of the Public
8 Health Service Act) or a school of osteopathic medi-
9 cine (as defined in such section).

10 (3) The term “National Council” means the
11 council established in subsection (a).

12 **Subpart B—Authorized Positions in Specialty**

13 **Training**

14 **SEC. 3011. COOPERATION REGARDING APPROVED PHYSI-**
15 **CIAN TRAINING PROGRAMS.**

16 (a) IN GENERAL.—With respect to an approved phy-
17 sician training program in a medical specialty, a funding
18 agreement with a qualified applicant for payments under
19 section 3031 for a calendar year is that the qualified appli-
20 cant will ensure that the number of individuals enrolled
21 in the program in the subsequent academic year is in ac-
22 cordance with this subpart.

23 (b) DEFINITIONS.—

24 (1) APPROVED PROGRAM.—For purposes of this
25 subtitle:

1 (A) The term “approved physician training
2 program”, with respect to the medical speciality
3 involved, means a residency or other post-
4 graduate program that trains physicians and
5 meets the following conditions:

6 (i) Participation in the program may
7 be counted toward certification in the med-
8 ical speciality.

9 (ii) The program is accredited by the
10 Accreditation Council on Graduate Medical
11 Education, or approved by the Council on
12 Postgraduate Training of the American
13 Osteopathic Association.

14 (B) The term “approved physician training
15 program” includes any postgraduate program
16 described in subparagraph (A) that provides
17 health services in an ambulatory setting, with-
18 out regard to whether the program provides in-
19 patient hospital services.

20 (C) The term “approved physician training
21 program” includes any postgraduate program
22 described in subparagraph (A), whether oper-
23 ated by academic health centers, teaching hos-
24 pitals, multispecialty group practices, ambula-

1 tory care providers, prepaid health plans, or
2 other entities.

3 (D) The term “approved physician training
4 program” includes any postgraduate program
5 described in subparagraph (A) that provides fel-
6 lowship training in family medicine, general in-
7 ternal medicine or general pediatrics, and pro-
8 vides training for a faculty position in family
9 medicine, general medicine or general pediat-
10 rics.

11 (2) QUALIFIED APPLICANT; SUBPART DEFINI-
12 TION.—For purposes of this subpart, the term
13 “qualified applicant”, with respect to an academic
14 year, means an entity that trains individuals in an
15 approved physician program that receives payments
16 under subpart C for the calendar year in which the
17 academic year begins.

18 (3) OTHER DEFINITIONS.—For purposes of this
19 subtitle:

20 (A)(i) The term “academic year” means
21 the 1-year period beginning on July 1. The aca-
22 demic year beginning July 1, 1993, is academic
23 year 1993–94.

24 (ii) With respect to the funding agreement
25 described in subsection (a), the term “subse-

1 training participants entering eligible programs for
2 academic year 2000–2001 or any subsequent aca-
3 demic year, the percentage of such class that com-
4 pletes eligible programs in primary health care is not
5 less than 55 percent (without regard to the academic
6 year in which the members of the class complete the
7 programs).

8 (2) RULE OF CONSTRUCTION.—The require-
9 ment of paragraph (1) regarding a percentage ap-
10 plies in the aggregate to training participants enter-
11 ing eligible programs for the academic year involved,
12 and not individually to any eligible program.

13 (c) DESIGNATIONS REGARDING 3-YEAR PERIODS.—

14 (1) DESIGNATION PERIODS.—For each medical
15 specialty, the National Council shall make the an-
16 nual designations under subsection (a) for periods of
17 3 academic years.

18 (2) INITIAL PERIOD.—The first designation pe-
19 riod established by the National Council after the
20 date of the enactment of this Act shall be the aca-
21 demic years 2000–2001 through 2002–03.

22 (d) CERTAIN CONSIDERATIONS IN DESIGNATING AN-
23 NUAL NUMBERS.—

24 (1) IN GENERAL.—Factors considered by the
25 National Council in designating the annual number

1 of specialty positions for an academic year for a
2 medical specialty shall include the extent to which
3 there is a need for additional practitioners in the
4 speciality, as indicated by the following:

5 (A) The characteristics of diseases, dis-
6 orders, or health conditions treated, including—

7 (i) the incidence and prevalence (in
8 the general population and in various other
9 populations) of the diseases, disorders, or
10 other health conditions with which the spe-
11 cialty is concerned;

12 (ii) the intensity of care required for
13 each of these diseases, disorders, or health
14 conditions;

15 (iii) the relevant training received and
16 experience attained by primary care and
17 specialist physicians in caring for each of
18 these diseases, disorders, or health condi-
19 tions; and

20 (iv) when sufficient data becomes
21 available, the extent to which individuals
22 with certain diseases, disorders, or health
23 conditions have better health outcomes
24 when treated by health specialists than by
25 primary care physicians.

1 (B) The number of physicians who will be
2 practicing in the specialty in the academic year.

3 (C) The number of physicians who will be
4 practicing in the specialty at the end of the 5-
5 year period beginning on the first day of the
6 academic year.

7 (2) RECOMMENDATIONS OF PRIVATE ORGANIZA-
8 TIONS.—In designating the annual number of spe-
9 cialty positions for an academic year for a medical
10 specialty, the National Council shall consider the
11 recommendations of organizations representing phy-
12 sicians in the specialty, organizations representing
13 academic medicine, and the recommendations of or-
14 ganizations representing consumers of the services of
15 such physicians.

16 (3) TOTAL OF RESPECTIVE ANNUAL NUM-
17 BERS.—

18 (A) For academic year 2000–2001 and
19 subsequent academic years, the National Coun-
20 cil shall ensure that the total of the respective
21 annual numbers designated under subsection
22 (a) for an academic year is a total that—

23 (i) bears a relationship to the number
24 of individuals who graduated from medical

1 schools in the United States in the preced-
2 ing academic year; and

3 (ii) is consistent with the purposes of
4 this subpart.

5 (B) For each of the academic years 2000-
6 2001 through 2004-05, the total determined
7 under subparagraph (A) shall be reduced by a
8 percentage determined by the National Council.

9 (e) INTERIM VOLUNTARY TARGETS.—

10 (1) ESTABLISHMENT.—Not later than July 1,
11 1996, the National Council shall establish targets
12 with respect to the aggregate number of individuals
13 enrolled in approved physician training programs for
14 each specialty to be achieved by the year 2000.

15 (2) VOLUNTARY COMPLIANCE.—Specialties that
16 meet and continue to be in compliance with the ag-
17 gregate targets established under paragraph (1), as
18 determined by the National Council, shall not be
19 subject to the mandatory allocation system described
20 in section 3013.

21 (3) MEASURE OF COMPLIANCE.—To be consid-
22 ered in compliance with the targets under paragraph
23 (2), a specialty shall demonstrate, not later than
24 July 1, 1998, that the number of individuals en-
25 rolled in approved physician training programs of

1 the specialty is not less than the number of individ-
2 uals enrolled in such programs as of July 1, 1994,
3 increased or decreased, as the case may be, by 45
4 percent of the difference between such enrollment
5 and the target enrollment established under para-
6 graph (1) and, not later than January 1, 2000, have
7 increased or decreased by 90 percent of such dif-
8 ference, and, by January 1, 2001, are deemed by the
9 National Council to be in compliance with the tar-
10 get.

11 (4) LOSS OF COMPLIANCE.—The National
12 Council may, at any time, determine that a specialty
13 is not in compliance with the targets established
14 under paragraph (1) and initiate, with respect to
15 that specialty, the system of mandatory allocations
16 described under section 3013.

17 (f) STUDY.—Not later than January 1, 2005, the
18 Secretary shall arrange for the completion, by the Insti-
19 tute of Medicine or other similar entity, of an independent
20 study concerning the effect of medical workforce regula-
21 tion and planning. The results of such study together with
22 recommendations concerning the appropriateness of modi-
23 fying or eliminating workforce regulations shall be com-
24 piled in a report and transmitted by the Secretary to the
25 President and the Congress.

1 (g) DEFINITIONS.—For purposes of this subtitle:

2 (1) The term “annual number of specialty posi-
3 tions”, with respect to a medical specialty, means
4 the number designated by the National Council
5 under subsection (a) for eligible programs for the
6 academic year involved.

7 (2) The term “designation period” means a 3-
8 year period under subsection (c)(1) for which des-
9 ignations under subsection (a) are made by the Na-
10 tional Council.

11 (3) The term “primary health care” means the
12 following medical specialties: Family medicine, gen-
13 eral internal medicine, general pediatrics, geriatric
14 medicine, obstetrics and gynecology, and medical
15 specialties (including psychiatry), if any, that have
16 been designated to be medical shortage specialties or
17 protected medical specialties by the Council on
18 Graduate Medical Education, or other similar physi-
19 cian advisory body authorized by Congress to pro-
20 vide an ongoing assessment of physician workforce
21 trends, and identify needs and be advisory to the
22 Secretary, the Committee on Labor and Human Re-
23 sources and the Committee on Finance of the Senate
24 and the Committee on Energy and Commerce and
25 the Committee on Ways and Means of the House of

1 Representatives. Only those participants in programs
2 with a significant primary care training emphasis
3 will be considered to have completed an eligible pro-
4 gram in primary care for the purposes of subsection
5 (b)(1). Determination of meeting the definition of a
6 “significant primary care training emphasis” will be
7 made by the National Board.

8 (4) The term “specialty position” means a posi-
9 tion as a training participant.

10 (5) The term “training participant” means an
11 individual who is enrolled in an approved physician
12 training program.

13 **SEC. 3013. ALLOCATIONS AMONG SPECIALITIES AND PRO-**
14 **GRAMS.**

15 (a) IN GENERAL.—For each academic year, the Na-
16 tional Council shall for each medical specialty make alloca-
17 tions among eligible programs of the annual number of
18 specialty positions that the Council has designated for
19 such year. The preceding sentence is subject to subsection
20 (b)(3).

21 (b) ALLOCATIONS REGARDING 3-YEAR PERIOD.—

22 (1) IN GENERAL.—For each medical specialty,
23 the National Council shall make the annual alloca-
24 tions under subsection (a) for periods of 3 academic
25 years.

1 (2) ADVANCE NOTICE TO PROGRAMS.—With re-
2 spect to the first academic year of an allocation pe-
3 riod established by the National Council, the Na-
4 tional Council shall, not later than July 1 of the pre-
5 ceding academic year, notify each eligible program of
6 the allocations made for the program for each of the
7 academic years of the period.

8 (3) INITIAL PERIOD.—The first allocation pe-
9 riod established by the National Council after the
10 date of the enactment of this Act shall be the aca-
11 demic years 2000–2001 through 2002–03.

12 (c) CERTAIN CONSIDERATIONS.—

13 (1) GEOGRAPHIC AREAS; QUALITY OF PRO-
14 GRAMS.—In making allocations under subsection (a)
15 for eligible programs of the various geographic
16 areas, the National Council shall include among the
17 factors considered the historical distribution among
18 the areas of approved physician training programs,
19 and the quality of such programs.

20 (2) UNDERREPRESENTATION OF MINORITY
21 GROUPS AND WOMEN.—In making an allocation
22 under subsection (a) for an eligible program, the
23 National Council shall include among the factors
24 considered the following:

1 (A) The extent to which the population of
2 training participants in the program includes
3 training participants who are members of racial
4 or ethnic minority groups and women.

5 (B) With respect to a racial or ethnic
6 group or women represented among the train-
7 ing participants, the extent to which the group
8 is underrepresented in the field of medicine
9 generally and in the various medical specialties.

10 (3) UNDERSERVED RURAL AND INNER-CITY
11 COMMUNITIES.—In making allocations under sub-
12 section (a) for eligible programs, the National Coun-
13 cil shall consider the extent to which the population
14 of training participants in the program includes
15 training participants who have resided in rural or
16 inner-city communities and the proportion of past
17 participants in the program who are practicing in
18 rural or inner-city communities.

19 (4) RECOMMENDATIONS OF PRIVATE ORGANIZA-
20 TIONS.—In making allocations under subsection (a)
21 for eligible programs, the National Council shall con-
22 sider the recommendations of organizations rep-
23 resenting physicians in the medical specialties, the
24 recommendations of organizations representing aca-
25 demic medicine and the recommendations of organi-

1 zations representing consumers of the services of
2 such physicians.

3 (d) DEFINITIONS.—For purposes of this subtitle, the
4 term “allocation period” means a 3-year period under sub-
5 section (b)(1) for which allocations under subsection (a)
6 are made by the National Council.

7 **CHAPTER 1—OPERATION OF APPROVED**
8 **PHYSICIAN TRAINING PROGRAMS**

9 **SEC. 3031. FEDERAL FORMULA PAYMENTS TO QUALIFIED**
10 **ENTITIES FOR THE COSTS OF THE OPER-**
11 **ATION OF APPROVED PHYSICIAN TRAINING**
12 **PROGRAMS.**

13 (a) IN GENERAL.—In the case of a qualified entity
14 that in accordance with section 3032 submits to the Sec-
15 retary an application for calendar year 1996 or any subse-
16 quent calendar year, the Secretary shall make payments
17 for such year to the qualified entity for the purpose speci-
18 fied in subsection (b). The Secretary shall make the pay-
19 ments in an amount determined in accordance with section
20 3033, and may administer the payments as a contract,
21 grant, or cooperative agreement.

22 (b) PAYMENTS FOR OPERATION OF APPROVED PHY-
23 SICIAN TRAINING PROGRAMS.—The purpose of payments
24 under subsection (a) is to assist a qualified applicant with
25 the costs of operation of an approved physician training

1 program. A funding agreement for such payments is that
2 the qualified applicant involved will expend the payments
3 only for such purpose.

4 (c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

5 (1) IN GENERAL.—For purposes of this sub-
6 part, the term “qualified applicant”, with respect to
7 the calendar year involved, means an entity—

8 (A) that trains individuals in approved
9 physician training programs;

10 (B) that submits to the Secretary an appli-
11 cation for such year in accordance with section
12 3032; and

13 (C) if the entity has an approved physician
14 training program in primary health care, that
15 rotates individuals enrolled in the program to
16 health centers or other community programs in
17 underserved urban or rural areas.

18 (2) ENTITIES INCLUDED.—The term “qualified
19 applicant” may include a teaching hospital, medical
20 school, group practice, an entity representing two or
21 more parties engaged in a formal association, a com-
22 munity health center or another entity operating an
23 approved physician training program.

24 (d) TREATMENT OF PODIATRIC AND DENTAL RESI-
25 DENCY PROGRAMS.—For the purposes of chapters 1 and

1 3 of subpart C, an approved physician training program
2 includes training programs approved by the Commission
3 on Dental Accreditation or the Council of Podiatric Medi-
4 cal Education of the American Podiatric Medical Associa-
5 tion. This subsection shall not apply for purposes of sub-
6 part B.

7 **SEC. 3032. APPLICATION FOR PAYMENTS.**

8 (a) IN GENERAL.—

9 (1) IN GENERAL.—For purposes of section
10 3031(a), an application for payments under such
11 section for a calendar year is in accordance with this
12 section if—

13 (A) the eligible entity involved submits the
14 application not later than the date specified by
15 the Secretary;

16 (B) the application demonstrates that the
17 condition described in subsection (b) is met
18 with respect to the program;

19 (C) the application contains each funding
20 agreement described in this part and the appli-
21 cation provides such assurances of compliance
22 with the agreements as the Secretary may re-
23 quire; and

24 (D) the application is in such form, is
25 made in such manner, and contains such agree-

1 ments, assurances, and information as the Sec-
2 retary determines to be necessary to carry out
3 this part.

4 (2) CERTAIN ENTITIES.—If an applicant under
5 paragraph (1) is an entity representing two or more
6 parties—

7 (A) the application shall contain a written
8 agreement, signed by all participants, in which
9 all of the participants agree as to the manner
10 in which the payments will be allocated; and

11 (B) the applicant shall agree to submit ad-
12 ditional documentation, if requested by the Na-
13 tional Council, that demonstrates that the
14 funds are distributed in the manner agreed
15 upon by all participants.

16 (b) CERTAIN CONDITIONS.—An eligible entity meets
17 the condition described in this subsection for receiving
18 payments under section 3031 for a calendar year if—

19 (1) the entity agrees to use such funds only to
20 support an approved physician training program;

21 (2) with respect to—

22 (A) a specialty for which programs have
23 received allocations under section 3013, the en-
24 tity agrees that funds will only be used to sup-
25 port approved training programs for which the

1 number of specialists in training is consistent
2 with the allotment under section 3013; and

3 (B) a specialty for which a voluntary pro-
4 gram has received allocations under section
5 3012(e), the entity agrees that funds will only
6 be used to support approved training programs
7 for which the number of specialists in training
8 is consistent with the targets under section
9 3012(e); and

10 (3) the application of the entity contains a writ-
11 ten agreement, signed by all participants, in which
12 all participants agree to the manner in which the
13 payments will be allocated; and

14 (4) the entity agrees to submit additional docu-
15 mentation, if requested by the National Council, that
16 demonstrates that the funds will be distributed in a
17 manner agreed upon by all participants.

18 **SEC. 3033. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**

19 **NUAL AMOUNT OF PAYMENTS.**

20 (a) ANNUAL HEALTH PROFESSIONS WORKFORCE
21 ACCOUNT.—Subject to paragraph (2), the amount avail-
22 able for a calendar year for making payments under sec-
23 tions 3031 and 3061 (constituting an account to be known
24 as the annual health professions workforce account) is the
25 following, as applicable to the calendar year:

1 (1) In the case of calendar year 1996,
2 \$3,200,000,000.

3 (2) In the case of calendar year 1997,
4 \$3,550,000,000.

5 (3) In the case of calendar year 1998,
6 \$4,800,000,000.

7 (4) In the case of each of the calendar years
8 1999 and 2000, \$5,800,000,000.

9 (5) In the case of each subsequent calendar
10 year, the amount specified in paragraph (4) in-
11 creased by the product of such amount and the gen-
12 eral health care inflation factor for such year (as de-
13 fined in subsection (d)).

14 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
15 BLE ENTITIES.—

16 (1) IN GENERAL.—Payment amounts with re-
17 spect to any physician training program under this
18 section shall be equal to the product of the number
19 of full time equivalent training participants in the
20 program, and the per resident amount for the train-
21 ing program.

22 (2) PER RESIDENT AMOUNT.—The per resident
23 amount for a training program shall be equal to—

24 (A) with respect to—

1 (i) the first calendar years during
2 which the program is in operation, 90 per-
3 cent;

4 (ii) the second calendar years during
5 which the program is in operation, 80 per-
6 cent;

7 (iii) the third calendar years during
8 which the program is in operation, 70 per-
9 cent;

10 (iv) the fourth calendar years during
11 which the program is in operation, 60 per-
12 cent; and

13 (v) the fifth and subsequent calendar
14 years during which the program is in oper-
15 ation, 50 percent;

16 of the all payer hospital per resident cost; and

17 (B) with respect to—

18 (i) the first calendar years during
19 which the program is in operation, 10 per-
20 cent;

21 (ii) the second calendar years during
22 which the program is in operation, 20 per-
23 cent;

1 (iii) the third calendar years during
2 which the program is in operation, 30 per-
3 cent;

4 (iv) the fourth calendar years during
5 which the program is in operation, 40 per-
6 cent; and

7 (v) the fifth and subsequent calendar
8 years during which the program is in oper-
9 ation, 50 percent;

10 of the geographically adjusted national average
11 per resident amount.

12 (3) ADJUSTMENT FACTOR.—Payments under
13 this section shall be subject to an adjustment factor,
14 as determined by the Secretary, so that total pay-
15 ments in any year will not exceed the amounts speci-
16 fied in section 3033(a) and as provided in section
17 3033(c).

18 (4) ADDITIONAL PROVISIONS REGARDING NA-
19 TIONAL AVERAGE COST.—

20 (A) The Secretary shall in accordance with
21 paragraph (1)(B) determine, for academic year
22 1992–93, an amount equal to the national aver-
23 age described in such paragraph with respect to
24 training a participant in an approved physician
25 training program in the medical specialty in-

1 volved. The national average applicable under
2 such paragraph for a calendar year for such
3 programs is, subject to subparagraph (B), the
4 amount determined under the preceding sen-
5 tence increased by the amount necessary to off-
6 set the effects of inflation occurring since aca-
7 demic year 1992–93, as determined through use
8 of the consumer price index.

9 (B) The national average determined
10 under subparagraph (A) and applicable to a cal-
11 endar year shall, in the case of the eligible en-
12 tity involved, be adjusted by a factor to reflect
13 regional differences in the applicable wage and
14 wage-related costs.

15 (5) FUNDING LEVEL AND ALLOCATION METH-
16 OD.—Not later than January 1, 1998, the Secretary
17 shall complete a study to determine the effect of the
18 funding level and allocation method described in sub-
19 section (a) and paragraphs (1) and (2) of this sub-
20 section on the operation of training programs and
21 shall compile the findings and recommendations de-
22 rived from such study in a report to be submitted
23 to the President and the Congress.

24 (c) LIMITATION.—If, subject to subsection (a)(2), the
25 annual health professions workforce account available for

1 a calendar year is insufficient for providing each eligible
2 entity with the amount of payments determined under
3 subsection (b) for the entity for such year, the Secretary
4 shall make such pro rata reductions in the amounts so
5 determined as may be necessary to ensure that the total
6 of payments made under section 3031 for such year equals
7 the total of such account.

8 (d) DEFINITIONS.—For purposes of this subtitle:

9 (1) The term “annual health professions
10 workforce account” means the account established
11 pursuant to subsection (a)(1).

12 (2) The term “consumer price index” has the
13 meaning given such term in section 1902(11).

14 (3) The term “general health care inflation fac-
15 tor”, with respect to a year, has the meaning given
16 such term in section 6001(a)(3) for such year.

17 **CHAPTER 2—MEDICAL SCHOOL FUND**
18 **ACCOUNT**

19 **SEC. 3041. FEDERAL PAYMENTS TO THE MEDICAL SCHOOL**
20 **FUND.**

21 (a) IN GENERAL.—In the case of an eligible medical
22 school that in accordance with section 3042 submits to
23 the Secretary an application for academic year 1996, or
24 any subsequent academic year, the Secretary shall make
25 payments for such year to the school for the purpose speci-

1 fied in subsection (b). The Secretary shall make the pay-
2 ments in an amount determined in accordance with section
3 3043, and shall administer the payments as a grant.

4 (b) PAYMENTS FOR THE MEDICAL SCHOOL FUND.—
5 The purpose specified in this subsection is to assist an
6 eligible medical school with the direct costs of academic
7 programs, including the education of medical students (es-
8 pecially in ambulatory and preventive medicine), graduate
9 students in biomedical sciences, and otherwise unfunded
10 faculty research. A funding agreement for such payments
11 is that the medical school involved will expend the pay-
12 ments only for direct expenses determined as allowable by
13 the Secretary.

14 (c) ELIGIBLE MEDICAL SCHOOL; SUBPART DEFINI-
15 TION.—For purposes of this subpart, the term “eligible
16 medical school” with respect to the academic year in-
17 volved, means an approved medical school that submits to
18 the Secretary an application for such year in accordance
19 with section 3043.

20 **SEC. 3042. APPLICATION FOR PAYMENTS.**

21 For purposes of section 3041(a), an application for
22 payments under such section for an academic year is in
23 accordance with this section if—

1 (1) the dean (or appropriate presiding official)
2 of the eligible medical school submits the application
3 not later than the date specified by the Secretary;

4 (2) the application contains each funding agree-
5 ment described in this subpart and provides such as-
6 surances of compliance with the agreements as the
7 Secretary may require; and

8 (3) the application is in such form, is made in
9 such manner, and contains such agreements, assur-
10 ances, and information as the Secretary determines
11 to be necessary to carry out this part.

12 **SEC. 3043. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
13 **NUAL AMOUNT OF PAYMENTS.**

14 (a) ANNUAL MEDICAL SCHOOL FUND ACCOUNT.—
15 Subject to section 3043, the amount available for an aca-
16 demic year for making payments under section 3041 (con-
17 stituting an account to be known as the annual medical
18 school fund account) shall be the following, as applicable
19 to the academic year:

20 (1) In the case of academic year 1996,
21 \$200,000,000.

22 (2) In the case of academic year 1997,
23 \$300,000,000.

24 (3) In the case of academic year 1998,
25 \$400,000,000.

1 (4) In the case of academic year 1999,
2 \$500,000,000.

3 (5) In the case of academic year 2000,
4 \$600,000,000.

5 (6) In the case of each subsequent calendar
6 year, the amount specified in paragraph (5) in-
7 creased by the product of such amount and the gen-
8 eral health care inflation factor (as defined in sub-
9 section (d)).

10 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
11 BLE PROGRAMS.—Subject to the annual medical school
12 fund account available for an academic year, the amount
13 of payment required under section 3041 to be made to
14 an eligible medical school for the academic year is an
15 amount equal to the sum of—

16 (1) the product of $\frac{3}{4}$ of the fund account avail-
17 able and the proportion of full-time equivalent stu-
18 dents at the eligible medical school in academic year
19 1993–1994 compared to all full-time equivalent stu-
20 dents enrolled in eligible medical schools nationwide
21 in academic year 1993–1994; and

22 (2) the product of $\frac{1}{4}$ of the fund account avail-
23 able and the proportion of research conducted by the
24 faculty at the eligible medical school compared to all

1 research conducted by the faculty at all eligible med-
2 ical schools nationwide.

3 The Secretary shall establish a method for measuring fac-
4 ulty research contributions.

5 (c) STUDIES.—

6 (1) FUNDING LEVEL AND ALLOCATION METH-
7 OD.—Not later than January 1, 1998, the Secretary
8 shall arrange for an independent study and report to
9 be completed, by the Institute of Medicine or other
10 similar entity, concerning the amount of and alloca-
11 tion method for medical school funding. Such report
12 shall be submitted to the President and the Con-
13 gress and shall include findings and recommendation
14 as to the appropriateness of modifying funding levels
15 or allocation.

16 (2) Not later than January 1, 2000, the Sec-
17 retary shall arrange for an independent study and
18 report to be completed, by the Institute of Medicine
19 or other similar entity, concerning the impact of
20 health reform on undergraduate and graduate medi-
21 cal education. Such report shall be submitted to the
22 President and the Congress and shall include appro-
23 priate findings and recommendations.

24 (d) DEFINITIONS.—As used in this subtitle:

1 (1) The term “annual medical school fund ac-
2 count” means the account established under sub-
3 section (a).

4 (2) The term “general health care inflation fac-
5 tor” with respect to a year, has the meaning given
6 such term in section 6001(a)(3) for such year.

7 **CHAPTER 3—ACADEMIC HEALTH**
8 **CENTERS**

9 **SEC. 3051. FEDERAL FORMULA PAYMENTS TO ACADEMIC**
10 **HEALTH CENTERS.**

11 (a) IN GENERAL.—In the case of a qualified aca-
12 demic health center or qualified teaching hospital that in
13 accordance with section 3052 submits to the Secretary a
14 written request for calendar year 1996 or any subsequent
15 calendar year, the Secretary shall make payments for such
16 year to the center or hospital for the purpose specified
17 in subsection (b). The Secretary shall make the payments
18 in an amount determined in accordance with section 3053,
19 and may administer the payments as a contract, grant,
20 or cooperative agreement.

21 (b) PAYMENTS FOR COSTS ATTRIBUTABLE TO ACA-
22 DEMIC NATURE OF INSTITUTIONS.—The purpose of pay-
23 ments under subsection (a) is to assist eligible institutions
24 with costs that are not routinely incurred by other entities
25 in providing health services, but are incurred by such insti-

1 tutions in providing health services by virtue of the aca-
2 demic nature of such institutions. Such costs include—

3 (1) with respect to productivity in the provision
4 of health services, costs resulting from the reduced
5 rate of productivity of faculty due to teaching re-
6 sponsibilities;

7 (2) the uncompensated costs of clinical re-
8 search; and

9 (3) exceptional costs associated with the treat-
10 ment of health conditions with respect to which an
11 eligible institution has specialized expertise (includ-
12 ing treatment of rare diseases, treatment of unusu-
13 ally severe conditions, and providing other special-
14 ized health care).

15 (c) DEFINITIONS.—

16 (1) ACADEMIC HEALTH CENTER.—For purposes
17 of this subtitle, the term “academic health center”
18 means an entity that operates a teaching hospital
19 that carries out an approved physician training pro-
20 gram.

21 (2) TEACHING HOSPITAL.—For purposes of this
22 subtitle, the term “teaching hospital” means a hos-
23 pital that operates an approved physician training
24 program (as defined in section 3011(b) or section
25 3031(d)).

1 (3) QUALIFIED CENTER OR HOSPITAL.—For
2 purposes of this subtitle:

3 (A) The term “qualified academic health
4 center” means an academic health center that
5 operates a teaching hospital.

6 (B) The term “qualified teaching hospital”
7 means any teaching hospital other than a teach-
8 ing hospital that is operated by an academic
9 health center.

10 (4) ELIGIBLE INSTITUTION.—For purposes of
11 this subtitle, the term “eligible institution”, with re-
12 spect to a calendar year, means a qualified academic
13 health center, or a qualified teaching hospital, that
14 submits to the Secretary a written request in accord-
15 ance with section 3052.

16 **SEC. 3052. REQUEST FOR PAYMENTS.**

17 (a) IN GENERAL.—For purposes of section 3051, a
18 written request for payments under such section is in ac-
19 cordance with this section if the qualified academic health
20 center or qualified teaching hospital involved submits the
21 request not later than the date specified by the Secretary;
22 the request is accompanied by each funding agreement de-
23 scribed in this part; and the request is in such form, is
24 made in such manner, and contains such agreements, as-

1 surances, and information as the Secretary determines to
2 be necessary to carry out this part.

3 (b) CONTINUED STATUS AS ACADEMIC HEALTH
4 CENTER.—A funding agreement for payments under sec-
5 tion 3051 is that the qualified academic health center or
6 qualified teaching hospital involved will maintain status as
7 such a center or hospital, respectively. For purposes of
8 this subtitle, the term “funding agreement”, with respect
9 to payments under section 3051 to such a center or hos-
10 pital, means that the Secretary may make the payments
11 only if the center or hospital makes the agreement in-
12 volved.

13 **SEC. 3053. AVAILABILITY OF FUNDS FOR PAYMENTS; AN-**
14 **NUAL AMOUNT OF PAYMENTS.**

15 (a) ANNUAL ACADEMIC HEALTH CENTER AC-
16 COUNT.—The amount available for a calendar year for
17 making payments under section 3051 (constituting an ac-
18 count to be known as the annual academic health center
19 account) is the following, as applicable to the calendar
20 year:

21 (1) In the case of calendar year 1996,
22 \$6,280,000,000.

23 (2) In the case of calendar year 1997,
24 \$7,250,000,000.

1 (3) In the case of calendar year 1998,
2 \$8,220,000,000.

3 (4) In the case of calendar year 1999,
4 \$9,400,000,000.

5 (5) In the case of calendar year 2000,
6 \$10,640,000,000.

7 (6) In the case of each subsequent calendar
8 year, the amount specified in paragraph (5) in-
9 creased by the product of such amount and the gen-
10 eral health care inflation factor (as defined in sub-
11 section (d)).

12 (b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGI-
13 BLE INSTITUTIONS.—

14 (1) FORMULA.—The amount of payments re-
15 quired in section 3051 to be made to an eligible in-
16 stitution for a calendar year is an amount equal to
17 the product of—

18 (A) the annual academic health center ac-
19 count available for the calendar year; and

20 (B) the percentage constituted by the ratio
21 of—

22 (i) the product of—

23 (I) the sum, for all discharges of
24 individuals, of the amounts otherwise

1 paid on behalf of such individuals;
2 and

3 (II) an adjustment factor equal
4 to 1.200 multiplied by $((1+r)^n - 1)$, where “r” equals the
5 nth power) - 1), where “r” equals the
6 ratio of the hospital’s full-time equiva-
7 lent interns and residents to beds and
8 “n” equals .405; and

9 (ii) the sum of the respective amounts
10 determined under clause (i) for eligible in-
11 stitutions.

12 (2) ADJUSTMENT FACTOR.—Payments under
13 this section shall be subject to an adjustment factor,
14 as determined by the Secretary, so that total pay-
15 ments in any year will not exceed the amounts speci-
16 fied in section 3033(a) and as provided in section
17 3033(c).

18 (c) REPORT REGARDING MODIFICATIONS IN FOR-
19 MULA.—Not later than July 1, 2000, the Secretary shall
20 submit to the Congress a report containing any rec-
21 ommendations of the Secretary for the modification of the
22 program of formula payments described in this chapter.
23 In preparing such report the Secretary shall consider—

24 (1) the costs described in subsection (b) in-
25 curred by academic health centers;

1 (2) the adequacy of the formula payments es-
2 tablished in this chapter to cover such costs, taking
3 into account any additional revenues to cover such
4 costs paid by other payers, including private health
5 plans;

6 (3) the importance to the maintenance of a
7 quality national health care system of academic
8 health centers in providing for the training of health
9 professionals, in conducting clinical research, and in
10 providing innovative, technically advanced care; and

11 (4) the overall impact of the reformed health
12 care system on the ability of academic health centers
13 to perform such functions.

14 (d) DEFINITION.—For purposes of this subtitle:

15 (1) The term “annual academic health center
16 account” means the account established pursuant to
17 subsection (a).

18 (2) The term “general health care inflation fac-
19 tor”, with respect to a year, has the meaning given
20 such term in section 6001(a)(3) for such year.

21 **Subpart D—General Provisions**

22 **SEC. 3055. DEFINITIONS.**

23 For purposes of this subtitle:

24 (1) The term “academic year” has the meaning
25 given such term in section 3011(b).

1 (2) The term “allocation period” has the mean-
2 ing given such term in section 3013(d).

3 (3) The term “annual health professions
4 workforce account” has the meaning given such
5 term in section 3033(d).

6 (4) The term “annual number of specialty posi-
7 tions” has the meaning given such term in section
8 3012(e).

9 (5) The term “approved physician training pro-
10 gram” has the meaning given such term in section
11 3011(b).

12 (6) The term “consumer price index” has the
13 meaning given such term in section 3033(d).

14 (7) The term “designation period” has the
15 meaning given such term in section 3012(e).

16 (8) The term “eligible entity” has the meaning
17 given such term in section 3011(b), in the case of
18 subpart B; and has the meaning given such term in
19 section 3031(c), in the case of subpart C.

20 (9) The term “funding agreement” has the
21 meaning given such term in section 3011(b).

22 (10) The term “general health care inflation
23 factor” has the meaning given such term in section
24 3033(d).

1 (11) The term “medical school” has the mean-
2 ing given such term in section 3001(e).

3 (12) The term “medical specialty” has the
4 meaning given such term in section 3011(b).

5 (13) The term “National Council” has the
6 meaning given such term in section 3001(e).

7 (14) The term “primary health care” has the
8 meaning given such term in section 3012(e).

9 (15) The term “specialty position” has the
10 meaning given such term in section 3012(e).

11 (16) The term “training participant” has the
12 meaning given such term in section 3012(e).

13 **Subpart E—Transitional Provisions**

14 **SEC. 3061. TRANSITIONAL PAYMENTS TO INSTITUTIONS.**

15 (a) PAYMENTS REGARDING EFFECTS OF SUBPART B
16 ALLOCATIONS.—For each of the four calendar years speci-
17 fied in subsection (b)(2), in the case of an eligible entity
18 that submits to the Secretary an application for such year
19 in accordance with subsection (d), the Secretary shall
20 make payments for the year to the entity for the purpose
21 specified in subsection (c). The Secretary shall make the
22 payments in an amount determined in accordance with
23 subsection (e), and may administer the payments as a con-
24 tract, grant, or cooperative agreement.

1 (b) ELIGIBLE ENTITIES LOSING SPECIALTY POSI-
2 TIONS; RELEVANT YEARS REGARDING PAYMENTS.—

3 (1) ELIGIBLE ENTITIES LOSING SPECIALTY PO-
4 SITIONS.—The Secretary may make payments under
5 subsection (a) to an eligible entity only if, with re-
6 spect to the calendar year involved, the entity meets
7 the following conditions:

8 (A) The entity operates or operated in the
9 year preceding the initiation of transitional pay-
10 ments one or more programs that—

11 (i) are or were at the time they termi-
12 nated approved physician training pro-
13 grams; and

14 (ii) are or were at the time they ter-
15 minated receiving payments under section
16 3031 for such year.

17 (B) The aggregate number of speciality po-
18 sitions in such programs (in the medical speci-
19 alities with respect to which such payments are
20 made) is below the aggregate number of such
21 positions at the entity for academic year 1993–
22 94 as a result of allocations under subpart B,
23 or as a result of voluntary changes under sec-
24 tion 3012(e) prior to January 1, 2000.

1 (2) RELEVANT YEARS.—The Secretary may
2 make payments under subsection (a) to an eligible
3 entity only for the first four calendar years after the
4 initial calendar year for which the entity meets the
5 conditions described in paragraph (1).

6 (3) ELIGIBLE ENTITY.—For purposes of this
7 section, the term “eligible entity” means an entity
8 that submits to the Secretary an application in ac-
9 cordance with subsection (d).

10 (c) PURPOSE OF PAYMENTS.—The purpose of pay-
11 ments under subsection (a) is to assist an eligible entity
12 with the costs of operation. A funding agreement for such
13 payments is that the entity involved will expend the pay-
14 ments only for such purpose.

15 (d) APPLICATION FOR PAYMENTS.—For purposes of
16 subsection (a), an application for payments under such
17 subsection is in accordance with this subsection if—

18 (1) the eligible entity involved submits the ap-
19 plication not later than the date specified by the
20 Secretary;

21 (2) the application demonstrates that the entity
22 meets the conditions described in subsection (b)(1)
23 and that the entity has cooperated with the approved
24 physician training programs of the entity in meeting
25 the condition described in section 3032(b);

1 (3) the application contains each funding agree-
2 ment described in this subpart and the application
3 provides such assurances of compliance with the
4 agreements as the Secretary may require; and

5 (4) the application is in such form, is made in
6 such manner, and contains such agreements, assur-
7 ances, and information as the Secretary determines
8 to be necessary to carry out this subpart.

9 (e) AMOUNT OF PAYMENTS.—

10 (1) IN GENERAL.—Subject to the annual health
11 professions workforce account available for the cal-
12 endar year involved, the amount of payments re-
13 quired in subsection (a) to be made to an eligible en-
14 tity for such year is the product of the amount de-
15 termined under paragraph (2) and the applicable
16 percentage specified in paragraph (3).

17 (2) NUMBER OF SPECIALTY POSITIONS LOST.—
18 For purposes of paragraph (1), the amount deter-
19 mined under this paragraph for an eligible entity for
20 the calendar year involved is the product of—

21 (A) an amount equal to the aggregate
22 number of full-time equivalent specialty posi-
23 tions lost; and

1 (B) the amount that would be received
2 under section 3033 for each speciality position
3 lost.

4 (3) APPLICABLE PERCENTAGE.—For purposes
5 of paragraph (1), the applicable percentage for a cal-
6 endar year is the following, as applicable to such
7 year:

8 (A) For the first calendar year after cal-
9 endar year 1995 for which the eligible entity in-
10 volved meets the conditions described in sub-
11 section (b)(1), 100 percent.

12 (B) For the second such year, 75 percent.

13 (C) For the third such year, 50 percent.

14 (D) For the fourth such year, 25 percent.

15 (4) DETERMINATION OF SPECIALTY POSITIONS
16 LOST.—

17 (A) For purposes of this subsection, the
18 aggregate number of specialty positions lost,
19 with respect to a calendar year, is the difference
20 between—

21 (i) the aggregate number of specialty
22 positions described in subparagraph (B)
23 that are estimated for the eligible entity in-
24 volved for the academic year beginning in
25 such calendar year; and

1 (ii) the aggregate number of such spe-
2 cialty positions at the entity for academic
3 year 1993–94.

4 (B) For purposes of subparagraph (A), the
5 specialty positions described in this subpara-
6 graph are specialty positions in the medical spe-
7 cialties with respect to which payments under
8 section 3031 are made to the approved physi-
9 cian training programs of the eligible entities
10 involved.

11 (5) ADDITIONAL PROVISION REGARDING NA-
12 TIONAL AVERAGE SALARY.—

13 (A) The Secretary shall determine, for aca-
14 demic year 1992–93, an amount equal to the
15 national average described in paragraph (2)(B).
16 The national average applicable under such
17 paragraph for a calendar year is, subject to
18 subparagraph (B), the amount determined
19 under the preceding sentence increased by an
20 amount necessary to offset the effects of infla-
21 tion occurring since academic year 1992–93, as
22 determined through use of the consumer price
23 index.

24 (B) The national average determined
25 under subparagraph (A) and applicable to a cal-

1 endar year shall, in the case of the eligible en-
2 tity involved, be adjusted by a factor to reflect
3 regional differences in the applicable wage and
4 wage-related costs.

5 **PART 2—INSTITUTIONAL COSTS OF GRADUATE**
6 **NURSING EDUCATION; WORKFORCE PRIORITIES**
7 **SEC. 3071. AUTHORIZED GRADUATE NURSE TRAINING POSI-**
8 **TIONS; INSTITUTIONAL COSTS.**

9 (a) PROGRAM REGARDING GRADUATE NURSE TRAIN-
10 ING PROGRAMS.—The Secretary shall, in accordance with
11 this part, carry out a program with respect to graduate
12 nurse training programs that is equivalent to the program
13 carried out under part 1 with respect to approved physi-
14 cian training programs.

15 (b) DEFINITIONS.—For purposes of this part:

16 (1) The term “graduate nurse training pro-
17 grams” means programs for advanced nurse edu-
18 cation, programs for education as nurse practition-
19 ers, programs for education as nurse midwives, pro-
20 grams for education as nurse anesthetists, and such
21 other programs for training in clinical nurse special-
22 ties as are determined by the Secretary to require
23 advanced education.

1 (2) The term “graduate nurse training posi-
2 tion” means a position as an individual who is en-
3 rolled in a graduate nurse training program.

4 (3) The term “programs for advanced nurse
5 education” means programs meeting the conditions
6 to be programs for which awards of grants and con-
7 tracts may be made under section 821 of the Public
8 Health Service Act.

9 (4) The term “programs for education as nurse
10 practitioners” means programs meeting the condi-
11 tions to be programs for which awards of grants and
12 contracts may be made under section 822 of the
13 Public Health Service Act for education as a nurse
14 practitioners.

15 (5) The term “programs for education as nurse
16 midwives” means programs meeting the conditions
17 to be programs for which awards of grants and con-
18 tracts may be made under section 822 of the Public
19 Health Service Act for education as nurse midwives.

20 (6) The term “programs for education as nurse
21 anesthetists” means programs meeting the condi-
22 tions to be programs for which awards of grants
23 may be made under section 831 of the Public Health
24 Service Act for education as nurse anesthetists.

1 **SEC. 3072. APPLICABILITY OF PART 1 PROVISIONS.**

2 (a) IN GENERAL.—The provisions of part 1 apply to
3 the program carried out under section 3071 to the same
4 extent and in the same manner as such provisions apply
5 to the program carried out under part 1, subject to the
6 subsequent provisions of this section. Section 3061 does
7 not apply for purposes of the preceding sentence.

8 (b) NATIONAL COUNCIL.—With respect to section
9 3001 as applied to this part, the council shall be known
10 as the National Council on Graduate Nurse Education (in
11 this part referred to as the “National Council”). The pro-
12 visions of section 851 of the Public Health Service Act
13 regarding the composition of the council under such sec-
14 tion apply to the composition of the National Council to
15 the same extent and in the same manner as such provi-
16 sions apply to the council under such section 851.

17 (c) ALLOCATION OF GRADUATE NURSE TRAINING
18 POSITIONS; FORMULA PAYMENTS FOR OPERATING
19 COSTS.—With respect to subparts B and C of part 1 as
20 applied to this part—

21 (1) the funding agreement described in section
22 3011 is to be made by graduate nurse training pro-
23 grams;

24 (2) the applicable accrediting bodies described
25 in section 3011 for graduate nurse training pro-

1 grams are the National League of Nursing and oth-
2 ers determined to be appropriate by the Secretary;

3 (3) designations under section 3012 and alloca-
4 tions under section 3013 apply to graduate nurse
5 training positions; and

6 (4) payments under section 3031 are to be
7 made to graduate nurse training programs, subject
8 to the requirements for such payments.

9 **SEC. 3073. FUNDING.**

10 (a) IN GENERAL.—With respect to section 3033 as
11 applied to this part, the provisions of this section apply.

12 (b) ANNUAL GRADUATE NURSE TRAINING AC-
13 COUNT.—The amount available for each of the calendar
14 years 1996 through 2000 for making payments pursuant
15 to section 3072(c)(4) to graduate nurse training programs
16 (constituting an account to be known as the annual grad-
17 uate nurse training account) is \$200,000,000.

18 **PART 3—RELATED PROGRAMS**

19 **Subpart A—Workforce Development**

20 **SEC. 3081. PROGRAMS OF THE SECRETARY OF HEALTH AND**
21 **HUMAN SERVICES.**

22 (a) IN GENERAL.—

23 (1) FUNDING.—For purposes of carrying out
24 the programs described in this section, there is au-
25 thorized to be appropriated \$100,000,000 for each

1 of the fiscal years 1995 and 1996, and
2 \$150,000,000 for each of the fiscal years 1997
3 through 2000 (in addition to amounts that may oth-
4 erwise be authorized to be appropriated for carrying
5 out the programs).

6 (2) ADMINISTRATION.—The programs described
7 in this section and carried out with amounts made
8 available under subsection (a) shall be carried out by
9 the Secretary of Health and Human Services.

10 (b) PRIMARY CARE PHYSICIAN AND PHYSICIAN AS-
11 SISTANT TRAINING.—For purposes of subsection (a), the
12 programs described in this section include programs to
13 support projects to train additional numbers of primary
14 care physicians and physician assistants, including
15 projects to enhance community-based generalist training
16 for medical students, residents, and practicing physicians;
17 to retrain mid-career physicians previously certified in a
18 nonprimary care medical specialty; to expand the supply
19 of physicians with special training to serve in rural and
20 inner-city medically underserved areas; to support expan-
21 sion of service-linked educational networks that train a
22 range of primary care providers in community settings;
23 to provide for training in managed care, cost-effective
24 practice management, and continuous quality improve-
25 ment; to provide interdisciplinary training for medical stu-

1 dents, residents or practicing physicians, and dental stu-
2 dents, residents, and dental hygienists, to deliver primary
3 care to individuals with mental, physical, and developmen-
4 tal disabilities, including mental retardation, particularly
5 those who are more than 18 years of age; and to develop
6 additional information on primary care workforce issues
7 as required to meet future needs in health care.

8 (c) TRAINING OF UNDERREPRESENTED RACIAL AND
9 ETHNIC MINORITIES AND DISADVANTAGED PERSONS.—

10 For purposes of subsection (a), the programs described
11 in this section include a program to support projects to
12 increase the number of racial and ethnic underrepresented
13 minority and disadvantaged persons in medicine, osteop-
14 athy, dentistry, advanced practice nursing, public health,
15 psychology, and other health professions, including
16 projects to provide continuing financial assistance for such
17 persons entering health professions training programs; for
18 financial assistance for facility renovation or construction;
19 to increase support for recruitment and retention of such
20 persons in the health professions; to maintain efforts to
21 foster interest in health careers among such persons at
22 the preprofessional level; and to increase the number of
23 racial and ethnic minority health professions faculty at
24 programs that have a significant number of
25 underrepresented racial and ethnic minorities.

1 (d) EXPANDING RURAL HEALTH CAREER OPPORTU-
2 NITIES AND RETENTION EFFORTS.—

3 (1) IN GENERAL.—For purposes of subsection
4 (a), the programs described in this section include
5 programs to support projects to increase the number
6 of individuals living in rural, underserved commu-
7 nities who enter the fields of medicine, osteopathy,
8 dentistry, advanced practice nursing, public health,
9 psychology, and other health professions, and to en-
10 courage the retention of such health care profes-
11 sionals in rural, underserved communities.

12 (2) RURAL HEALTH CAREER TRAINING.—
13 Projects to increase the number of individuals re-
14 cruited from rural, underserved areas include
15 projects—

16 (A) to provide continuing financial assist-
17 ance for such persons entering health profes-
18 sions education and training programs;

19 (B) to increase efforts to foster interest in
20 health careers among such persons at the
21 preprofessional level;

22 (C) to foster the development of training
23 curricula appropriate to rural health care set-
24 tings; and

1 (D) to increase support for recruitment of
2 such persons in the health professions.

3 (3) RETENTION OF RURAL HEALTH CARE PRO-
4 VIDERS.—Projects to encourage the retention of in-
5 dividuals providing health care in rural, underserved
6 areas include projects—

7 (A) to establish State and regional locum
8 tenans programs in rural health care settings so
9 that substitute health care providers are avail-
10 able when permanent staff is absent from the
11 health care setting;

12 (B) to implement programs to foster inter-
13 disciplinary team approaches to rural health
14 training and practice; and

15 (C) to develop state-of-the-art network
16 telecommunications and telemedicine systems to
17 link rural health professionals to other health
18 care providers and academic health care cen-
19 ters.

20 (e) NURSE TRAINING.—For purposes of subsection
21 (a), the programs described in this section include a pro-
22 gram to support projects to support midlevel provider
23 training and address priority nursing workforce needs, in-
24 cluding projects to train additional nurse practitioners and
25 nurse midwives; to support baccalaureate-level nurse

1 training programs providing preparation for careers in
2 teaching, community health service, and specialized clinical
3 care; to train additional nurse clinicians and nurse an-
4 esthetists; to support interdisciplinary school-based com-
5 munity nursing programs; and to promote research on
6 nursing workforce issues.

7 (f) INAPPROPRIATE PRACTICE BARRIERS; FULL UTI-
8 LIZATION OF SKILLS.—For purposes of subsection (a), the
9 programs described in this section include a program—

10 (1) to develop and encourage the adoption of
11 model professional practice statutes for advanced
12 practice nurses and physician assistants, and to oth-
13 erwise support efforts to remove inappropriate bar-
14 riers to practice by such nurses and such physician
15 assistants; and

16 (2) to promote the full utilization of the profes-
17 sional education and clinical skills of advanced prac-
18 tice nurses and physician assistants.

19 (g) ADVISORY BOARD ON HEALTH CARE
20 WORKFORCE DEVELOPMENT.—

21 (1) IN GENERAL.—The Secretary shall establish
22 an Advisory Board known as the National Advisory
23 Board on Health Care Workforce Development to
24 advise, consult with, and make recommendations to

1 the Secretary and to the Secretary of Labor on mat-
2 ters relating to—

3 (A) health care worker supply and its ade-
4 quacy to assure proper health care delivery sys-
5 tem staffing in both rural and urban areas; and

6 (B) the impact of this Act, and of related
7 changes in law regarding health care, on health
8 care workers and the needs of such workers, in-
9 cluding needs regarding education, training,
10 and other career development matters.

11 (2) COMPOSITION.—The Board established
12 under paragraph (1) shall be composed of the follow-
13 ing members with expertise in health care workforce
14 issues appointed by the Secretary in consultation
15 with the Secretary of Labor:

16 (A) Five representatives of labor organiza-
17 tions representing health care workers.

18 (B) Five representatives of health institu-
19 tions.

20 (C) Two representatives from health care
21 education organizations.

22 (D) Two representatives from consumer
23 organizations.

24 (3) ASSISTANCE.—The Secretary shall provide
25 the Board with such administrative assistance as

1 care services needs of individuals with mental, phys-
2 ical, and developmental disabilities, including mental
3 retardation, particularly those who are more than 18
4 years of age;

5 “(2) develop, evaluate, and disseminate curric-
6 ula relating to the health care service needs of indi-
7 viduals with mental, physical, and developmental dis-
8 abilities, including mental retardation, particularly
9 those individuals who are more than 18 years of age;

10 “(3) support the training and retraining of fac-
11 ulty to provide such instruction; and

12 “(4) support continuing education of health
13 professionals who provide health care services and
14 support to individuals with mental, physical, and de-
15 velopmental disabilities, including mental retarda-
16 tion, particularly those who are more than 18 years
17 of age.

18 “(b) AUTHORIZATION OF APPROPRIATIONS.—For
19 purposes of carrying out this section, there are authorized
20 to be appropriated, \$10,000,000 for each of the fiscal
21 years 1995 through 2000.”.

22 **SEC. 3082. PROGRAMS OF THE SECRETARY OF LABOR.**

23 (a) IN GENERAL.—

24 (1) FUNDING.—For purposes of carrying out
25 the programs described in this section, and for car-

1 rying out section 3083, there is authorized to be ap-
2 propriated \$200,000,000 for fiscal year 1994 and
3 each subsequent fiscal year (in addition to amounts
4 that may otherwise be authorized to be appropriated
5 for carrying out the programs).

6 (2) ADMINISTRATION.—The programs described
7 in this section and carried out with amounts made
8 available under subsection (a) shall be carried out by
9 the Secretary of Labor (in this section referred to as
10 the “Secretary”).

11 (b) RETRAINING PROGRAMS; ADVANCED CAREER
12 POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

13 (1) IN GENERAL.—For purposes of subsection
14 (a), the programs described in this section are the
15 following:

16 (A) A program for skills upgrading and oc-
17 cupational retraining (including retraining
18 health care workers for more advanced positions
19 as technicians, nurses, and physician assist-
20 ants), and for quality and workforce improve-
21 ment.

22 (B) A demonstration program to assist
23 workers in health care institutions in obtaining
24 advanced career positions.

1 (C) A program to develop and operate
2 health care and health insurance industry work-
3 er job banks in local employment services agen-
4 cies or one-stop career centers, subject to the
5 following:

6 (i) Such job banks shall be available
7 to all health care providers in the commu-
8 nity involved.

9 (ii) Such job banks shall begin oper-
10 ation not later than 90 days after the date
11 of the enactment of this Act.

12 (iii)(I) With respect to each affected
13 community, the local employment service
14 agency or one-stop career center serving
15 such community shall be allocated not less
16 than one counselor whose responsibility it
17 shall be to develop and operate health and
18 insurance industry worker job banks.
19 Where the impact of health care industry
20 restructuring in the affected community is
21 such that the functions required under this
22 clause cannot be adequately provided by
23 one counselor, additional counselors shall
24 be allocated to carry out such functions.

1 (II) Such counselor shall solicit job
2 openings from local health care industry
3 employers, maintain frequent contacts with
4 these and other employers, and monitor
5 and update all job listings appropriate for
6 displaced health care and health insurance
7 industry workers seeking employment.

8 (III) The local employment service
9 agency or one-stop career center shall pro-
10 vide directly, or facilitate the provision of,
11 labor exchange services to displaced health
12 care and insurance industry workers, in-
13 cluding assessment, counseling, testing,
14 job-search assistance, job referral and
15 placement, and referral to training and
16 educational programs, where appropriate.

17 (IV) The Secretary of Labor shall de-
18 velop performance goals for the effective
19 performance of such job banks with respect
20 to the number and quality of jobs listed,
21 the degree of participation by employers in
22 the affected community, and success in
23 placement of job bank users in jobs listed,
24 taking into account specific geographic,

1 economic and labor market characteristics
2 of the community served.

3 (D) A program to provide for joint labor-
4 management decision-making in the health care
5 sector on workplace matters related to the re-
6 structuring of the health care delivery system
7 provided for in this Act.

8 (E) A program to collect data regarding
9 the adequacy of the supply of health care work-
10 ers by occupation and sector of the health in-
11 dustry in light of existing and projected demand
12 for such workers.

13 (F)(i) A program to encourage the adop-
14 tion and utilization of high performance, high
15 quality health care delivery systems, including
16 employee participation committees and em-
17 ployee team systems that will contribute to
18 more effective health care by increasing the role
19 and the area of independent decisionmaking of
20 health care workers.

21 (ii) For purposes of this subparagraph, the
22 term “employee participation committees”
23 means committees of workers independently se-
24 lected by and from a facility’s nonmanagerial
25 workforce, or selected by unions where collective

1 bargaining agreements are in effect, and which
2 operate independently without employer inter-
3 ference and consult with management on issues
4 of efficiency, productivity, and quality of care,
5 except that an employee participation commit-
6 tee established under and operating in conform-
7 ity with this subparagraph shall not be consid-
8 ered a labor organization within the meaning of
9 section 2(5) of the National Labor Relations
10 Act or a representative within the meaning of
11 section 1, sixth, of the Railway Labor Act.

12 (2) USE OF FUNDS.—Amounts made available
13 under subsection (a) for carrying out this section
14 may be expended for program support, faculty devel-
15 opment, trainee support, workforce analysis, and dis-
16 semination of information, as necessary to produce
17 required performance outcomes.

18 (c) CERTAIN REQUIREMENTS FOR PROGRAMS.—In
19 carrying out the programs described in subsection (b), the
20 Secretary shall, with respect to the organizations and em-
21 ployment positions involved, provide for the following:

22 (1) Explicit, clearly defined skill requirements
23 developed for all the positions and projections of the
24 number of openings for each position.

25 (2) Opportunities for internal career movement.

1 (3) Opportunities to work while training or
2 completing an educational program.

3 (4) Evaluation and dissemination.

4 (5) Training opportunities in several forms, as
5 appropriate.

6 (d) ADMINISTRATIVE REQUIREMENTS.—In carrying
7 out the programs described in subsection (b), the Sec-
8 retary shall, with respect to the organizations and employ-
9 ment positions involved, provide for the following:

10 (1) Joint labor-management implementation
11 and administration.

12 (2) Discussion with employees as to training
13 needs for career advancement.

14 (3) Commitment to a policy of internal hirings
15 and promotion.

16 (4) Provision of support services.

17 (5) Consultations with employers and with or-
18 ganized labor.

19 **SEC. 3083. REQUIREMENT FOR CERTAIN PROGRAMS RE-**
20 **GARDING REDEPLOYMENT OF HEALTH CARE**
21 **WORKERS.**

22 (a) STATE PROGRAMS FOR HOME AND COMMUNITY-
23 BASED SERVICES FOR INDIVIDUALS WITH DISABIL-
24 ITIES.—With respect to the plan required in section
25 2102(a) (for State programs for home and community-

1 based services for individuals with disabilities under part
2 1 of subtitle B of title II), the plan shall, in addition to
3 requirements under such part, provide for the following:

4 (1) Before initiating the process of implement-
5 ing the State program under such plan, negotiations
6 will be commenced with labor unions representing
7 the employees of the affected hospitals or other fa-
8 cilities.

9 (2) Negotiations under paragraph (1) will ad-
10 dress the following:

11 (A) The impact of the implementation of
12 the program upon the workforce.

13 (B) Methods to redeploy workers to posi-
14 tions in the proposed system, in the case of
15 workers affected by the program.

16 (3) The plan will provide evidence that there
17 has been compliance with paragraphs (1) and (2),
18 including a description of the results of the negotia-
19 tions.

20 (b) PLAN FOR INTEGRATION OF MENTAL HEALTH
21 SYSTEMS.—With respect to the plan required in section
22 3511(a) (relating to the integration of the mental health
23 and substance abuse services of a State and its political
24 subdivisions with the mental health and substance abuse
25 services included in the comprehensive benefit package

1 under title I), the plan shall, in addition to requirements
2 under such section, provide for the following:

3 (1) Before initiating the process of implement-
4 ing the integration of such services, negotiations will
5 be commenced with labor unions representing the
6 employees of the affected hospitals or other facilities.

7 (2) Negotiations under paragraph (1) will ad-
8 dress the following:

9 (A) The impact of the proposed changes
10 upon the workforce.

11 (B) Methods to redeploy workers to posi-
12 tions in the proposed system, in the case of
13 workers affected by the proposed changes.

14 (3) The plan will provide evidence that there
15 has been compliance with paragraphs (1) and (2),
16 including a description of the results of the negotia-
17 tions.

18 **Subpart B—Transitional Provisions for Workforce**

19 **Stability**

20 **SEC. 3091. APPLICATION.**

21 (a) LIMITATION TO TRANSITION PERIOD.—The pro-
22 visions of this subpart are intended to minimize, to the
23 extent possible, disruptions in established employment re-
24 lationships during the period of transition to a restruc-

1 tured health care delivery system, and shall terminate De-
2 cember 31, 2000.

3 (b) HEALTH CARE ENTITIES COVERED BY SUB-
4 PART.—The provisions of this subpart, including ref-
5 erences to displacing employers, hiring employers, succes-
6 sors and contractors, apply only to health care entities
7 that employ more than 25 individuals.

8 **SEC. 3092. DEFINITIONS.**

9 (a) HEALTH CARE ENTITY.—As used in this sub-
10 part, the term “health care entity” includes individuals,
11 sole proprietorships, partnerships, associations, business
12 trusts, corporations, governmental institutions, and public
13 agencies (including state governments and political sub-
14 divisions thereof) that—

15 (1) provide health care services under title I
16 (including nonmandatory health care services under
17 title I) or under the amendments made or programs
18 referred to in titles IV and VIII; or

19 (2) provide necessary related services, including
20 administrative, food service, janitorial or mainte-
21 nance services, to an entity that provides health care
22 services (as described in subparagraph (1));

23 except that an entity that solely manufactures or provides
24 goods or equipment to a health care entity shall not be
25 considered a health care entity.

1 (b) AFFILIATED ENTERPRISE.—As used in this sub-
2 part, the term “affiliated enterprise” means a health care
3 entity that, together with the displacing employer, is con-
4 sidered a single employer as defined under 414 of the In-
5 ternal Revenue Code of 1986.

6 (c) PREFERENCE ELIGIBLE EMPLOYEE.—As used in
7 this subpart, the term “preference eligible employee”
8 means an employee who—

9 (1) has been employed for in excess of 1 year
10 by a health care entity; and

11 (2) has been displaced by or has received notice
12 of an impending displacement by such entity.

13 (d) DISPLACEMENT.—As used in this subpart, the
14 term “displacement” includes a layoff, termination, sig-
15 nificant cutback in paid work hours, or other loss of em-
16 ployment, except that a discharge for just cause shall not
17 constitute a displacement within the meaning of this para-
18 graph.

19 **SEC. 3093. OBLIGATIONS OF DISPLACING EMPLOYER AND**
20 **AFFILIATED ENTERPRISES IN EVENT OF DIS-**
21 **PLACEMENT.**

22 (a) NOTICE.—A health care entity which displaces a
23 preference eligible employee shall provide such employee
24 with—

1 (1) written notice, no later than the date of dis-
2 placement, of employment rights under this subpart,
3 including employment rights with respect to affili-
4 ated enterprises of the displacing employer; and

5 (2) notice of any existing or subsequent vacan-
6 cies with the displacing employer or an affiliated en-
7 terprise, which notice may be given by posting of
8 such vacancies wherever notices to applicants for
9 employment are customarily posted, by listing such
10 vacancies with the local employment services agency,
11 or in such other manner as the Secretary of Labor,
12 by regulation, may hereafter specify.

13 Any such vacancy shall remain open for applications by
14 preference eligible employees for not less than 14 calendar
15 days from the date on which the initial notice is provided.

16 (b) HIRING PREFERENCE.—

17 (1) IN GENERAL.—A qualified preference eligi-
18 ble employee who applies during the notice period
19 described in subsection (a)(2) for a vacant position
20 with the displacing employer or an affiliated enter-
21 prise, which position is in the employee's occupa-
22 tional specialty and is located in the same State or
23 Standard Metropolitan Statistical Area in which the
24 employee was employed prior to the displacement,
25 shall be given the right to accept or decline the posi-

1 tion before the employer may offer the position to a
2 nonpreference eligible employee.

3 (2) MULTIPLE APPLICATIONS.—When consider-
4 ing applications from more than one qualified pref-
5 erence eligible employee, the hiring health care en-
6 tity shall have discretion as to which of such employ-
7 ees will be offered the position.

8 (3) EMPLOYMENT QUALIFICATIONS.—Nothing
9 in this subsection shall be construed to prohibit the
10 hiring health care entity from establishing reason-
11 able employment qualifications for a vacancy to
12 which this subpart applies, except that employees
13 who performed essentially the same work prior to
14 their displacement shall be deemed presumptively
15 qualified for comparable positions.

16 (c) TERMINATION OF PREFERENCE ELIGIBILITY.—
17 A displaced employee's preference eligibility shall termi-
18 nate—

19 (1) at such time as the displaced employee ob-
20 tains substantially equivalent employment with the
21 displacing employer; or

22 (2) if the employee does not obtain such em-
23 ployment—

1 (A) with respect to health care entities
2 other than the displacing employer, 2 years
3 after the date of the displacement; or

4 (B) with respect to the displacing em-
5 ployer, upon the termination of this subpart
6 pursuant to section 3081(a).

7 **SEC. 3094. EMPLOYMENT WITH SUCCESSORS.**

8 A health care entity that succeeds another health care
9 entity through merger, consolidation, acquisition, contract,
10 or other similar manner shall provide employees of the
11 previous health care entity who would otherwise be dis-
12 placed the right to continued employment in the job posi-
13 tions held by such employees prior thereto, unless the em-
14 ployer can establish that such positions no longer exist.

15 **SEC. 3095. COLLECTIVE BARGAINING OBLIGATIONS DUR-**
16 **ING TRANSITION PERIOD.**

17 (a) CONTINUATION OF PREVIOUSLY RECOGNIZED
18 BARGAINING REPRESENTATIVES AND AGREEMENTS.—If
19 a majority of the employees in an appropriate bargaining
20 unit consists of employees who were previously covered by
21 a bargaining agreement or represented by an exclusive
22 representative with respect to terms and conditions of em-
23 ployment, and there has not been a substantial change in
24 the operations performed by the employees in that unit,
25 the employer shall recognize such representative as the ex-

1 clusive representative for the unit and shall assume the
2 bargaining agreement, except that where application of
3 this subsection would result in the recognition of more
4 than one bargaining representative for a single unit, the
5 question concerning which representative shall be recog-
6 nized as the exclusive representative for the unit shall be
7 resolved in accordance with applicable Federal or State
8 law.

9 (b) JOINT EMPLOYER STATUS.—If employees of a
10 contractor are assigned on a regular basis to perform work
11 on the premises of a contracting entity and the tasks per-
12 formed by these employees are functionally integrated with
13 the operations of the contracting entity on whose premises
14 such employees work, both the contractor and the con-
15 tracting entity shall be considered joint employers of the
16 employees with respect to work performed on those prem-
17 ises for purposes of determining compliance with labor re-
18 lations laws. Employees of such joint employers may not
19 be excluded from a bargaining unit within either entity
20 on the basis of such joint employer status.

21 **SEC. 3096. GENERAL PROVISIONS.**

22 (a) REGULATIONS.—Not later than 120 days after
23 the date of enactment of this Act, the Secretary shall pro-
24 mulgate regulations to implement the requirements of sec-
25 tion 3093.

1 (b) OTHER LAWS.—The standards and requirements
2 of this subpart shall not preempt or excuse noncompliance
3 with any other applicable Federal or State law, regulation
4 or municipal ordinance that establishes additional notice
5 and preference standards or requirements concerning em-
6 ployee dislocation, employee representation, or collective
7 bargaining.

8 (c) RULES OF CONSTRUCTION.—Nothing in this sub-
9 part shall be construed—

10 (1) to excuse or otherwise limit the obligation
11 of an employer to comply with any collective bar-
12 gaining agreement or any employment benefit plan
13 that provides rights to employees in addition to
14 those provided under this subpart; or

15 (2) to require an employer to recognize or bar-
16 gain with a labor organization in violation of State
17 law.

18 (d) ENFORCEMENT.—Unless otherwise specifically
19 provided in this subpart, the enforcement provisions of
20 section 107 of the Family and Medical Leave Act of 1993
21 (29 U.S.C. 2617) shall apply with respect to the enforce-
22 ment of the individual rights, including notice require-
23 ments, provided under section 3093. The collective bar-
24 gaining and contractual rights provided under sections
25 3094 and 3095 shall be enforced through administrative

1 and judicial procedures otherwise provided under Federal
2 or State law with respect to such rights.

3 **Subtitle B—Academic Health**
4 **Centers**

5 **SEC. 3131. DISCRETIONARY GRANTS REGARDING ACCESS**
6 **TO CENTERS.**

7 (a) RURAL INFORMATION AND REFERRAL SYS-
8 TEMS.—The Secretary may make grants to eligible centers
9 for the establishment and operation of information and re-
10 ferral systems to provide the services of such centers to
11 rural health plans.

12 (b) OTHER PURPOSES REGARDING URBAN AND
13 RURAL AREAS.—The Secretary may make grants to
14 community- and provider-based health plans under section
15 1651(d) to carry out activities (other than activities car-
16 ried out under subsection (a)) for the purpose of providing
17 the services of eligible centers to residents of rural or
18 urban communities who otherwise would not have ade-
19 quate access to such services.

20 (c) AUTHORIZATION OF APPROPRIATIONS.—For the
21 purpose of carrying out this section, there are authorized
22 to be appropriate, \$3,000,000 for fiscal year 1995,
23 \$4,000,000 for fiscal year 1996, and \$5,000,000 for each
24 of the fiscal years 1997 through 2000.

1 **Subtitle C—Health Research**
2 **Initiatives**

3 **PART 1—PROGRAMS FOR CERTAIN AGENCIES**

4 **SEC. 3201. BIOMEDICAL AND BEHAVIORAL RESEARCH.**

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

6 (1) Nearly 4 of 5 peer reviewed research
7 projects deemed worthy of funding by the National
8 Institutes of Health are not funded.

9 (2) Less than 2 percent of the nearly one tril-
10 lion dollars our Nation spends on health care is de-
11 voted to health research, while the defense industry
12 spends 15 percent of its budget on research.

13 (3) Public opinion surveys have shown that
14 Americans want more Federal resources put into
15 health research and support by having a portion of
16 their health insurance premiums set aside for this
17 purpose.

18 (4) Ample evidence exists to demonstrate that
19 health research has improved the quality of health
20 care in the United States. Advances such as the de-
21 velopment of vaccines, the cure of many childhood
22 cancers, drugs that effectively treat a host of dis-
23 eases and disorders, a process to protect our Na-
24 tion's blood supply from the HIV virus, progress
25 against cardiovascular disease including heart attack

1 and stroke, and new strategies for the early detec-
2 tion and treatment of diseases such as colon, breast,
3 and prostate cancer clearly demonstrates the bene-
4 fits of health research.

5 (5) Among the most effective methods to con-
6 trol health care costs are the prevention of inten-
7 tional and unintentional injury and the prevention
8 and cure of disease and disability, thus, health re-
9 search which holds the promise of prevention of in-
10 tentional and unintentional injury and cure and pre-
11 vention of disease and disability is a critical compo-
12 nent of any comprehensive health care reform plan.

13 (6) The state of our Nation's research facilities
14 at the National Institutes of Health and at univer-
15 sities is deteriorating significantly. Renovation and
16 repair of these facilities are badly needed to main-
17 tain and improve the quality of research.

18 (7) Because the Omnibus Budget Reconciliation
19 Act of 1993 freezes discretionary spending for the
20 next 5 years, the Nation's investment in health re-
21 search through the National Institutes of Health is
22 likely to decline in real terms unless corrective legis-
23 lative action is taken.

24 (8) A health research fund is needed to main-
25 tain our Nation's commitment to health research

1 and to increase the percentage of approved projects
2 which receive funding at the National Institutes of
3 Health to at least 33 percent.

4 (9) Private sector investment in research and
5 development has been responsible for the vast major-
6 ity of new developments in pharmaceuticals, medical
7 devices, biotechnology and other health care innova-
8 tions. Over 90 percent of the most prescribed drugs
9 in the United States were discovered by the re-
10 search-based pharmaceutical industry.

11 (10) United States industry is the preeminent
12 world leader in the research, development and deliv-
13 ery of innovative therapies that improve the quality
14 of care for people throughout the world.

15 (11) Global health care budgets may constrict
16 private sector investment in research and develop-
17 ment. Further, they may be inconsistent with the
18 goal of developing promising new cost effective treat-
19 ment therapies.

20 (b) AVAILABILITY OF FUNDS.—

21 (1) IN GENERAL.—With respect to each cal-
22 endar year, the Secretary shall pay, from funds in
23 the Treasury not otherwise appropriated, for activi-
24 ties under this section in an amount equal to 0.25
25 percent in 1996, 0.50 percent in 1997, 0.75 percent

1 in 1998, and 1.0 percent in 1999 and subsequent
2 years, of all private premiums required to be paid
3 under this Act.

4 (2) For purposes of this subsection, the term
5 “private health premiums” means all premium relat-
6 ed payments made by employers, individuals, and
7 families for coverage under this Act.

8 (c) PURPOSES FOR EXPENDITURES.—Part A of title
9 IV of the Public Health Service Act (42 U.S.C. 281 et
10 seq.) is amended by adding at the end thereof the follow-
11 ing new section:

12 **“SEC. 404F. EXPENDITURES FOR HEALTH RESEARCH.**

13 “(a) IN GENERAL.—From amounts made available
14 under section 3201 of the Health Security Act, the Sec-
15 retary shall distribute—

16 “(1) 2 percent of such amounts during any fis-
17 cal year to the Office of the Director of the National
18 Institutes of Health to be allocated at the Director’s
19 discretion for the following activities:

20 “(A) for carrying out the responsibilities of
21 the Office of the Director, in including the Of-
22 fice of Research on Women’s Health and the
23 Office of Research on Minority Health, the Of-
24 fice of Alternative Medicine and the Office of
25 Rare Diseases Research; and

1 “(B) for construction and acquisition of
2 equipment for or facilities of or used by the Na-
3 tional Institutes of Health;

4 “(2) 2 percent of such amounts for transfer to
5 the National Center for Research Resources to carry
6 out section 1502 of the National Institutes of
7 Health Revitalization Act of 1993 concerning Bio-
8 medical and Behavioral Research Facilities;

9 “(3) 1 percent of such amounts during any fis-
10 cal year for carrying out section 301 and part D of
11 title IV with respect to health information commu-
12 nications; and

13 “(4) the remainder of such amounts during any
14 fiscal year to member institutes of the National In-
15 stitutes of Health and Centers in the same propor-
16 tion to the total amount received under this section,
17 as the amount of annual appropriations under ap-
18 propriations Acts for each member institute and
19 Centers for the fiscal year bears to the total amount
20 of appropriations under appropriations Acts for all
21 member institutes and Centers of the National Insti-
22 tutes of Health for the fiscal year.

23 “(b) PLANS OF ALLOCATION.—The amounts trans-
24 ferred under subsection (a) shall be allocated by the Direc-
25 tor of NIH or the various directors of the institutes and

1 centers, as the case may be, pursuant to allocation plans
2 developed by the various advisory councils to such direc-
3 tors, after consultation with such directors.”.

4 **SEC. 3202. HEALTH SERVICES RESEARCH.**

5 Section 902 of the Public Health Service Act (42
6 U.S.C. 299a), as amended by section 2(b) of Public Law
7 102–410 (106 Stat. 2094), is amended by adding at the
8 end the following subsection:

9 “(f) RESEARCH ON HEALTH CARE REFORM.—

10 “(1) IN GENERAL.—In carrying out section
11 901(b), the Administrator shall conduct and support
12 research on the reform of the health care system of
13 the United States, as directed by the National
14 Board.

15 “(2) PRIORITIES.—In carrying out paragraph
16 (1), the Administrator shall give priority to the fol-
17 lowing:

18 “(A) Conducting and supporting research
19 on the appropriateness and effectiveness of al-
20 ternative clinical strategies (including commu-
21 nity-based programs and preventive services),
22 the quality and outcomes of care, and adminis-
23 trative simplification.

24 “(B) Conducting and supporting research
25 on the appropriateness and effectiveness of al-

1 ternative community-based and clinical strate-
2 gies including integrating preventive services
3 into primary care, the effectiveness of preven-
4 tive counseling and health education, and the
5 efficacy and cost-effectiveness of clinical preven-
6 tive services.

7 “(C) Conducting and supporting research
8 on consumer choice and information resources;
9 the effects of health care reform on health de-
10 livery systems; workplace injury and illness pre-
11 vention; intentional and unintentional injury
12 prevention; methods for risk adjustment; fac-
13 tors influencing access to health care for vulner-
14 able populations, including children, persons
15 with low-income, persons with disabilities, or in-
16 dividuals with chronic or complex health condi-
17 tions, and primary care.

18 “(D) The development of clinical practice
19 guidelines consistent with section 913, the dis-
20 semination of such guidelines consistent with
21 section 903, and the assessment of the effec-
22 tiveness of such guidelines.”.

1 **PART 2—FUNDING FOR PROGRAM**

2 **SEC. 3211. AUTHORIZATIONS OF APPROPRIATIONS.**

3 (a) HEALTH SERVICES RESEARCH.—For the purpose
4 of carrying out activities pursuant to the amendments
5 made by section 3202, there are authorized to be appro-
6 priated \$150,000,000 for fiscal year 1995, \$400,000,000
7 for fiscal year 1996, \$500,000,000 for fiscal year 1997,
8 and \$600,000,000 for each of the fiscal years 1998
9 through 2000.

10 (b) RELATION TO OTHER FUNDS.—The authoriza-
11 tion of appropriations established in subsection (a) are in
12 addition to any other authorizations of appropriations that
13 are available for the purposes described in such sub-
14 section.

15 (c) TRIGGER AND RELEASE OF MONIES.—No ex-
16 penditure shall be made pursuant to section 3201(c) dur-
17 ing any fiscal year in which the annual amount appro-
18 priated for the National Institutes of Health is less than
19 the amount so appropriated for the prior fiscal year. With
20 respect to amounts available for expenditure pursuant to
21 section 3201(c) which, as a result of the application of
22 this subsection remain unexpended, such amounts shall be
23 obligated by the Secretary of Health and Human Services
24 under the public health initiative under subtitle H.

1 **Subtitle D—Core Functions of Pub-**
2 **lic Health Programs; National**
3 **Initiatives Regarding Preven-**
4 **tive Health**

5 **PART 1—FUNDING**

6 **SEC. 3301. AUTHORIZATIONS OF APPROPRIATIONS.**

7 (a) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
8 GRAMS.—For the purpose of carrying out part 2, there
9 are authorized to be appropriated \$150,000,000 for fiscal
10 year 1995, \$225,000,000 for fiscal year 1996,
11 \$325,000,000 for fiscal year 1997, \$425,000,000 for fis-
12 cal year 1998, \$500,000,000 for fiscal year 1999, and
13 \$625,000,000 for fiscal year 2000.

14 (b) NATIONAL INITIATIVES REGARDING HEALTH
15 PROMOTION AND DISEASE PREVENTION.—For the pur-
16 pose of carrying out part 3, there are authorized to be
17 appropriated \$125,000,000 for each of the fiscal years
18 1996 through 1998, and \$150,000,000 for each of the fis-
19 cal years 1999 and 2000.

20 (c) RELATION TO OTHER FUNDS.—The authoriza-
21 tions of appropriations established in subsections (a) and
22 (b) are in addition to any other authorizations of appro-
23 priations that are available for the purposes described in
24 such subsections.

1 **PART 2—CORE FUNCTIONS OF PUBLIC HEALTH**
2 **PROGRAMS**

3 **SEC. 3311. PURPOSES.**

4 Subject to the subsequent provisions of this subtitle,
5 the purposes of this part are to strengthen the capacity
6 of State and local public health agencies to carry out the
7 following functions:

8 (1) To monitor and protect the health of com-
9 munities against communicable diseases and expo-
10 sure to toxic environmental pollutants, occupational
11 hazards, harmful products, and poor quality health
12 care.

13 (2) To identify and control outbreaks of infec-
14 tious disease and patterns of chronic disease and in-
15 jury.

16 (3) To inform and educate health care consum-
17 ers and providers about their roles in preventing in-
18 jury, preventing and controlling disease and the ap-
19 propriate use of medical services.

20 (4) To develop and test new prevention and
21 public health control interventions.

22 (5) To integrate and coordinate the prevention
23 programs and services of health plans, community-
24 based providers, local health departments, State
25 health departments, health alliances, and other sec-
26 tors of State and local government that affect

1 health, including education, labor, transportation,
2 welfare, criminal justice, environment, agriculture,
3 and housing.

4 (6) To conduct research on the effectiveness
5 and cost-effectiveness of public health programs.

6 **SEC. 3312. GRANTS TO STATES FOR CORE FUNCTIONS OF**
7 **PUBLIC HEALTH.**

8 (a) IN GENERAL.—The Secretary shall make grants
9 to States that submit applications as prescribed in section
10 3313 in an amount which bears the same ratio to the
11 available amounts for that fiscal year as the amounts pro-
12 vided by the Secretary under the provisions of law listed
13 in section 1902(2) of the Public Health Service Act to the
14 State for fiscal year 1981 bear to the total amount appro-
15 priated for such provisions of law for fiscal year 1981.

16 (b) CORE FUNCTIONS OF PUBLIC HEALTH PRO-
17 GRAMS.—For purposes of subsection (a), the functions de-
18 scribed in this subsection are, subject to subsection (c),
19 as follows:

20 (1)(A) Data collection, activities related to pop-
21 ulation health (including the population of individ-
22 uals ineligible for the comprehensive benefit pack-
23 age) measurement and outcomes monitoring, includ-
24 ing the acquisition and installation of hardware and
25 software, personnel training and technical assistance

1 to operate and support automated and integrated in-
2 formation systems, the regular collection and analy-
3 sis of public health data, vital statistics, and per-
4 sonal health services data and analysis for planning
5 and needs assessment purposes of data collected
6 from health plans through the information system
7 under title V of this Act.

8 (B) Data measures under this paragraph must
9 include an ethnic identifier on all forms. To the ex-
10 tent feasible, ethnic identifiers should be classified
11 by ethnic sub-group populations. Access to data
12 must be ensured for research organizations and data
13 clearinghouses. Population health measurement and
14 outcome monitoring should focus on health status
15 differentials between racial, and ethnic groups, by
16 subpopulation, and gender differences.

17 (2) Activities to protect the environment and to
18 assure the safety of housing, workplaces, food and
19 water, including the following activities:

20 (A) Monitoring and improving the overall
21 public health quality and safety of communities.

22 (B) Assessing exposure to high lead levels
23 and water contamination.

24 (C) Providing support for poison control
25 centers.

1 (D) Monitoring sewage and solid waste dis-
2 posal, radiation exposure, radon exposure, and
3 noise levels.

4 (E) Abatement of lead-related hazards.

5 (F) Assuring recreation, home and worker
6 safety.

7 (G) Public information and education pro-
8 grams that help to reduce intentional and unin-
9 tentional injuries, including training parents
10 and children on use of safety devices.

11 (H) Enforcing public health safety and
12 sanitary codes.

13 (I) Other activities relating to promoting
14 the public health of communities.

15 (3) Investigation and control of adverse health
16 conditions, including improvements in emergency
17 treatment preparedness, injury prevention, coopera-
18 tive activities to reduce violence levels in homes and
19 communities, activities to control the outbreak of
20 disease, exposure related conditions and other
21 threats to the health status of individuals.

22 (4) Public information and education programs
23 to reduce risks to health such as use of tobacco, al-
24 cohol and other drugs, sexual activities that increase
25 the risk to HIV transmission and sexually transmit-

1 ted diseases, domestic violence, poor diet, physical
2 inactivity, and low childhood immunization levels.

3 (5) Accountability and quality assurance activi-
4 ties, including monitoring the quality of personal
5 health services furnished by health plans and provid-
6 ers of medical and health services in a manner con-
7 sistent with the overall quality of care monitoring
8 activities undertaken under title V, and monitoring
9 communities' overall access to health services.

10 (6) Provision of public health laboratory serv-
11 ices to complement private clinical laboratory serv-
12 ices and that screen for diseases and conditions such
13 as metabolic diseases in newborns, provide toxicology
14 assessments of blood lead levels and other environ-
15 mental toxins, diagnose sexually transmitted dis-
16 eases, tuberculosis and other diseases requiring part-
17 ner notification, test for infectious and food-borne
18 diseases, and monitor the safety of water and food
19 supplies.

20 (7) Training and education to assure provision
21 of care by all health professionals, with special em-
22 phasis placed on the training of public health profes-
23 sions including epidemiologists, biostatisticians,
24 health educators, public health administrators,
25 sanitarians and laboratory technicians.

1 (8) Leadership, policy development and admin-
2 istration activities, including needs assessment, the
3 setting of public health standards, the development
4 of community public health policies, and the develop-
5 ment of community public health coalitions.

6 (c) RESTRICTIONS ON USE OF GRANT.—

7 (1) IN GENERAL.—A funding agreement for a
8 grant under subsection (a) for a State is that the
9 grant will not be expended—

10 (A) to provide inpatient services;

11 (B) to make cash payments to intended re-
12 cipients of health services;

13 (C) to purchase or improve land, purchase,
14 construct, or permanently improve (other than
15 minor remodeling) any building or other facil-
16 ity, or purchase major medical equipment;

17 (D) to satisfy any requirement for the ex-
18 penditure of non-Federal funds as a condition
19 for the receipt of Federal funds; or

20 (E) to provide financial assistance to any
21 entity other than a public or nonprofit private
22 entity.

23 (2) LIMITATION ON ADMINISTRATIVE EX-
24 PENSES.—A funding agreement for a grant under
25 subsection (a) is that the State involved will not ex-

1 pend more than 10 percent of the grant for adminis-
2 trative expenses with respect to the grant.

3 (d) MAINTENANCE OF EFFORT.—A funding agree-
4 ment for a grant under subsection (a) is that the State
5 involved will maintain expenditures of non-Federal
6 amounts for core health functions at a level that is not
7 less than the level of such expenditures maintained by the
8 State for the fiscal year preceding the first fiscal year for
9 which the State receives such a grant.

10 **SEC. 3313. SUBMISSION OF INFORMATION.**

11 The Secretary may make a grant under section 3312
12 only if the State involved submits to the Secretary the fol-
13 lowing information:

14 (1) A description of existing deficiencies in the
15 State's public health system (at the State level and
16 the local level), using standards of sufficiency devel-
17 oped by the Secretary.

18 (2) A description of health status measures to
19 be improved within the State (at the State level and
20 the local level) through expanded public health func-
21 tions.

22 (3) Measurable outcomes and process objectives
23 for improving health status and core health func-
24 tions for which the grant is to be expended.

1 (4) Information regarding each such function,
2 which—

3 (A) identifies the amount of State and
4 local funding expended on each such function
5 for the fiscal year preceding the fiscal year for
6 which the grant is sought; and

7 (B) provides a detailed description of how
8 additional Federal funding will improve each
9 such function by both the State and local public
10 health agencies.

11 (5) A description of the core health functions to
12 be carried out at the local level, and a specification
13 for each such function of—

14 (A) the communities in which the function
15 will be carried out; and

16 (B) the amount of the grant to be ex-
17 pended for the function in each community so
18 specified.

19 **SEC. 3314. REPORTS.**

20 A funding agreement for a grant under section 3312
21 is that the States involved will, not later than the date
22 specified by the Secretary, submit to the Secretary a re-
23 port describing—

24 (1) the purposes for which the grant was ex-
25 pended; and

1 (2) describing the extent of progress made by
2 the State in achieving measurable outcomes and
3 process objectives described in section 3313(3).

4 **SEC. 3315. APPLICATION FOR GRANT.**

5 The Secretary may make a grant under section 3312
6 only if an application for the grant is submitted to the
7 Secretary, the application contains each agreement de-
8 scribed in this part, the application contains the informa-
9 tion required in section 3314, and the application is in
10 such form, is made in such manner, and contains such
11 agreements, assurances, and information as the Secretary
12 determines to be necessary to carry out this part.

13 **SEC. 3316. ALLOCATIONS FOR CERTAIN ACTIVITIES.**

14 Of the amounts made available under section 3301
15 for a fiscal year for carrying out this part, the Secretary
16 may reserve not more than 5 percent for carrying out the
17 following activities:

18 (1) Technical assistance with respect to plan-
19 ning, development, and operation of core health
20 functions carried out under section 3312, including
21 provision of biostatistical and epidemiological exper-
22 tise and provision of laboratory expertise.

23 (2) Development and operation of a national in-
24 formation network among State and local health
25 agencies.

1 (3) Program monitoring and evaluation of core
2 health functions carried out under section 3312.

3 (4) Development of a unified electronic report-
4 ing mechanism to improve the efficiency of adminis-
5 trative management requirements regarding the pro-
6 vision of Federal grants to State public health agen-
7 cies.

8 **SEC. 3317. DEFINITIONS.**

9 For purposes of this part:

10 (1) The term “funding agreement”, with re-
11 spect to a grant under section 3312 to a State,
12 means that the Secretary may make the grant only
13 if the State makes the agreement involved.

14 (2) The term “core health functions”, with re-
15 spect to a State, means the functions described in
16 section 3312(b).

17 **SEC. 3318. SINGLE APPLICATION AND UNIFORM REPORT-**
18 **ING SYSTEMS FOR CORE FUNCTIONS OF PUB-**
19 **LIC HEALTH AND PUBLIC HEALTH CATEGOR-**
20 **ICAL GRANT PROGRAMS ADMINISTERED BY**
21 **THE CENTERS FOR DISEASE CONTROL AND**
22 **PREVENTION.**

23 (a) SINGLE APPLICATION.—

24 (1) IN GENERAL.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, shall establish a single con-
2 solidated application to enable States to apply for
3 the Core Functions of Public Health Grants Pro-
4 gram and any or all of the Public Health Service
5 Act categorical programs described in subsection (b).

6 (2) REQUIREMENTS.—The application devel-
7 oped under paragraph (1) shall—

8 (A) be designed so that information col-
9 lected will be consistent with the requirements
10 of this part including subsection (b);

11 (B) be designed and implemented not later
12 than 1 year after the date of enactment of this
13 Act; and

14 (C) be developed with resources made
15 available under section 3316 (not resources
16 made available for the programs described in
17 subsection (b)).

18 (3) STATE PUBLIC HEALTH OFFICERS.—In de-
19 veloping the single consolidated application form to
20 be used under this subsection the Secretary shall
21 consult with Federal, State and local public health
22 agencies.’’.

23 (4) ELIGIBILITY.—States and local govern-
24 ments that have grants, contracts or cooperative
25 agreements in effect with the Centers for Disease

1 Control and Prevention on the date of enactment of
2 this Act shall be eligible to use a single application
3 under this section to apply for any or all of the Pub-
4 lic Health Service Act categorical programs de-
5 scribed in subsection (b).

6 (b) ELIGIBLE PUBLIC HEALTH SERVICE ACT PRO-
7 GRAMS.—Eligible Public Health Service Act categorical
8 programs described in this subsection are the following:

9 (1) The Preventive Health and Health Services
10 Block Grant under section 1903 of the Public
11 Health Service Act.

12 (2) The Childhood Lead Poisoning Prevention
13 Program under section 317A of the Public Health
14 Service Act.

15 (3) The Sexually Transmitted Diseases Pro-
16 gram under section 318 of the Public Health Service
17 Act.

18 (4) The Prevention of Sexually Transmitted
19 Diseases-Related Infertility Program under section
20 318A of the Public Health Service Act.

21 (5) The Breast and Cervical Cancer Early De-
22 tection Program under sections 1501 through 1509
23 of the Public Health Service Act.

1 (6) The National Program of Cancer Registries
2 under section 399H of the Public Health Service
3 Act.

4 (7) The Injury Control and Prevention Pro-
5 gram under sections 391 through 394 of the Public
6 Health Service Act.

7 (8) The preventive health for prostate cancer
8 program under section 317D of the Public Health
9 Service Act.

10 (9) The birth defects data program under sec-
11 tion 317C of the Public Health Service Act.

12 (10) Programs under subtitle D of this title.

13 (11) Other relevant programs as determined ap-
14 propriate by the Secretary.

15 (c) ALLOCATION OF FUNDS.—In awarding grants to
16 States and local governments under a single application
17 under this section, the Secretary shall delineate to each
18 grantee the amounts to be dedicated to each of the pro-
19 grams described in subsection (b) and ensure that funding
20 allotments for each of such programs are consistent with
21 the requirements of Federal law.

22 (d) UNIFORM CORE FUNCTIONS OF PUBLIC HEALTH
23 REPORTING SYSTEM.—

24 (1) DEVELOPMENT.—The Secretary, acting
25 through the Director of the Office of Disease Pre-

1 vention and Health Promotion and the Director of
2 the Centers for Disease Control and Prevention, in
3 consultation with other relevant Federal and State
4 health agencies with data collection responsibilities,
5 shall develop and implement a Uniform Core Public
6 Health Functions Reporting System to collect pro-
7 gram and fiscal data concerning the programs de-
8 scribed in subsection (b).

9 (2) REQUIREMENTS.—The system developed
10 under paragraph (1) shall—

11 (A) use outcomes consistent with the goals
12 of Healthy People 2000;

13 (B) be designed so that information col-
14 lected will be consistent with the requirements
15 of this part including subsection (b);

16 (C) be designed and implemented not later
17 than 2 years after the date of enactment of this
18 Act; and

19 (D) be developed with resources made
20 available under section 3316 of this Act (not re-
21 sources made available for the programs de-
22 scribed in subsection (b)).

23 (3) STATE PUBLIC HEALTH OFFICERS.—In de-
24 veloping the data set to be used under Uniform Core
25 Public Health Functions Reporting System the Sec-

1 retary shall consult with Federal, State and local
2 public health agencies.

3 (e) STUDY.—

4 (1) IN GENERAL.—Within a reasonable period
5 of time after the date of enactment of this Act, the
6 Secretary shall request that the Institute of Medi-
7 cine conduct a study concerning—

8 (A) the effects of consolidating any or all
9 of the grant programs administered by the Cen-
10 ters for Disease Control and Prevention and de-
11 scribed in subsection (b) into a Core Functions
12 of Public Health Block Grant Program;

13 (B) the development of alternative methods
14 for implementing a block grant program or cat-
15 egorical grant program; and

16 (C) alternative formulas for allocating
17 State grants that incorporate measures of
18 health status, population and degree of poverty.

19 In particular, the impact of program consolidation
20 on the targeted recipients, including women and vul-
21 nerable populations, shall be addressed in the study.

22 If the Institute of Medicine declines to do the study,
23 the Secretary shall make grants to or enter into con-
24 tracts with a public or nonprofit private entity with
25 relevant expertise for the conduct of such a study.

1 (2) REPORT.—Not later than 1 year after the
2 date of the receipt of the contract under paragraph
3 (1), the contract recipient shall prepare and submit
4 to the Secretary, the Energy and Commerce Com-
5 mittee of the House of Representatives, and the
6 Committee on Labor and Human Resources of the
7 Senate a report that contains the results of the
8 study conducted under paragraph (1).

9 (3) ISSUANCE OF PLAN.—Not later than 1 year
10 after the date on which the report under paragraph
11 (2) is received by the Secretary and the committees
12 referred to in such paragraph, the Secretary shall
13 issue a plan in response to the report. Such a plan
14 shall include the identification of relevant changes in
15 authorizing language.

16 **PART 3—NATIONAL INITIATIVES REGARDING**
17 **HEALTH PROMOTION AND DISEASE PREVENTION**

18 **Subpart A—General Grants**

19 **SEC. 3331. GRANTS FOR NATIONAL PREVENTION INITIA-**
20 **TIVES.**

21 (a) IN GENERAL.—The Secretary may make grants
22 to entities described in subsection (b) for the purpose of
23 carrying out projects to develop and implement innovative
24 community-based strategies to provide for health pro-
25 motion and disease prevention activities for which there

1 is a significant need, as identified under section 1701 of
2 the Public Health Service Act.

3 (b) ELIGIBLE ENTITIES.—The entities referred to in
4 subsection (a) are agencies of State or local government,
5 private nonprofit organizations (including research institu-
6 tions), and coalitions that link two or more of these
7 groups.

8 (c) CERTAIN ACTIVITIES.—The Secretary shall en-
9 sure that projects carried out under subsection (a)—

10 (1) reflect approaches that take into account
11 the special needs and concerns of the affected popu-
12 lations;

13 (2) are targeted to the most needy and vulner-
14 able population groups and geographic areas of the
15 Nation;

16 (3) examine links between various high priority
17 preventable health problems and the potential com-
18 munity-based remedial actions; and

19 (4) establish or strengthen the links between
20 the activities of agencies engaged in public health
21 activities with those of health alliances, health care
22 providers, and other entities involved in the personal
23 health care delivery system described in title I.

24 **SEC. 3332. PRIORITIES.**

25 (a) ESTABLISHMENT.—

1 (1) ANNUAL STATEMENT.—The Secretary shall
2 for each fiscal year develop a statement of proposed
3 priorities for grants under section 3331 for the fiscal
4 year.

5 (2) ALLOCATIONS AMONG PRIORITIES.—With
6 respect to the amounts available under section
7 3301(b) for the fiscal year for carrying out this part,
8 each statement under paragraph (1) for a fiscal year
9 shall include a specification of the percentage of the
10 amount to be devoted to projects addressing each of
11 the proposed priorities established in the statement.

12 (3) PROCESS FOR ESTABLISHING PRIORITIES.—

13 (A) PREFERENCE.—In establishing prior-
14 ities for grants under this part, preference shall
15 be given to projects that—

16 (i) reduce the prevalence of chronic
17 diseases including cardiovascular disease,
18 stroke, diabetes, and cancer;

19 (ii) prevent violence against women by
20 training providers and other health care
21 professionals to identify victims of domes-
22 tic violence, to provide appropriate exam-
23 ination and treatment, and to refer the vic-
24 tims for appropriate social and legal serv-
25 ices; and

1 (iii) establish community health advi-
2 sor programs described in subparagraph
3 (B).

4 (B) COMMUNITY HEALTH ADVISOR PRO-
5 GRAMS.—For purposes of subparagraph
6 (A)(iii), the term “community health advisor
7 program” means a program that performs the
8 following functions:

9 (i) Provides outreach services to in-
10 form the community of the availability of
11 program services.

12 (ii) Collaborate efforts with health
13 care providers and related entities to facili-
14 tate the provision of health services and
15 health related social services.

16 (iii) Provide public education on
17 health promotion and disease prevention
18 and efforts to facilitate the use of available
19 health services and health-related social
20 services.

21 (iv) Provide health-related counseling.

22 (v) Make referrals for available health
23 services and health-related social services.

24 (vi) Improve the ability of individuals
25 to use health services and health-related

1 social services under Federal, State, and
2 local programs, through assisting individ-
3 uals in establishing eligibility under the
4 programs.

5 (vii) Establish a community health ad-
6 visor training program.

7 (viii) Provide services in the language
8 and cultural context most appropriate for
9 the individuals served by the program.

10 (ix) Provide compensation for the
11 services of, and opportunities for training
12 and employment of, community health ad-
13 visors.

14 (x) Such other services as the Sec-
15 retary determines to be appropriate, which
16 may include transportation and translation
17 services.

18 (C) PUBLICATION OF STATEMENT.—Not
19 later than January 1 of each fiscal year, the
20 Secretary shall publish a statement under para-
21 graph (1) in the Federal Register. A period of
22 60 days shall be allowed for the submission of
23 public comments and suggestions concerning
24 the proposed priorities. After analyzing and
25 considering comments on the proposed prior-

1 ities, the Secretary shall publish in the Federal
2 Register final priorities (and associated reserva-
3 tions of funds) for approval of projects for the
4 following fiscal year.

5 (D) DEFINITION OF COMMUNITY HEALTH
6 ADVISOR.—For purposes of subparagraph (B),
7 the term “community health advisor” means an
8 individual—

9 (i) who has demonstrated the capacity
10 to carry out one or more of the authorized
11 program services;

12 (ii) who, for not less than 1 year, has
13 been a resident of the community in which
14 the community health advisor program in-
15 volved is to be operated; and

16 (iii) is a member of a socioeconomic
17 group to be served by the program.

18 (b) APPLICABILITY TO MAKING OF GRANTS.—

19 (1) IN GENERAL.—The Secretary may make
20 grants under section 3331 for projects that the Sec-
21 retary determines—

22 (A) are consistent with the applicable final
23 statement of priorities and otherwise meets the
24 objectives described in subsection (a); and

1 (B) will assist in meeting a health need or
2 concern of a population within a defined health
3 care coverage area or other service area.

4 (2) SPECIAL CONSIDERATION FOR CERTAIN
5 PROJECTS.—In making grants under section 3331,
6 the Secretary shall give special consideration to ap-
7 plicants that will carry out projects that, in addition
8 to being consistent with the applicable published pri-
9 orities under subsection (a) and otherwise meeting
10 the requirements of this part, have the potential for
11 replication in other communities.

12 **SEC. 3333. SUBMISSION OF INFORMATION.**

13 The Secretary may make a grant under section 3331
14 only if the applicant involved submits to the Secretary the
15 following information:

16 (1) A description of the activities to be con-
17 ducted, and the manner in which the activities are
18 expected to contribute to meeting one or more of the
19 priority health needs specified under section 3332
20 for the fiscal year for which the grant is initially
21 sought.

22 (2) A description of the total amount of Federal
23 funding requested, the geographic area and popu-
24 lations to be served, and the evaluation procedures
25 to be followed.

1 (3) Such other information as the Secretary de-
2 termines to be appropriate.

3 **SEC. 3334. APPLICATION FOR GRANT.**

4 The Secretary may make a grant under section 3331
5 only if an application for the grant is submitted to the
6 Secretary, the application contains each agreement de-
7 scribed in this part, the application contains the informa-
8 tion required in section 3333, and the application is in
9 such form, is made in such manner, and contains such
10 agreements, assurances, and information as the Secretary
11 determines to be necessary to carry out this part.

12 **Subpart B—Development of Telemedicine in Rural**
13 **Underserved Areas**

14 **SEC. 3341. GRANTS FOR DEVELOPMENT OF RURAL**
15 **TELEMEDICINE.**

16 (a) IN GENERAL.—

17 (1) GRANTS AWARDED.—The Secretary, acting
18 through the Office of Rural Health Policy, shall
19 award grants to eligible entities that have applica-
20 tions approved under subsection (b) for the purpose
21 of expanding access to health care services for indi-
22 viduals in rural areas through the use of
23 telemedicine. Grants shall be awarded under this
24 section to encourage the initial development of rural
25 telemedicine networks, expand existing networks,

1 link existing networks together, or link such net-
2 works to existing fiber optic telecommunications sys-
3 tems.

4 (2) ELIGIBLE ENTITY DEFINED.—For purposes
5 of this section, the term “eligible entity” means pub-
6 lic or nonprofit entities in nonmetropolitan areas (as
7 defined by the Department of Commerce) in a con-
8 sortium of community-based providers that includes
9 at least three of the following:

10 (A) community or migrant health centers;

11 (B) local health departments;

12 (C) community mental health centers;

13 (D) nonprofit hospitals

14 (E) private practice health professionals,
15 including rural health clinics; or

16 (F) other publicly funded health or social
17 services agencies.

18 (b) APPLICATION.—To be eligible to receive a grant
19 under this section an eligible entity shall prepare and sub-
20 mit to the Secretary for approval an application at such
21 time, in such manner, and containing such information as
22 the Secretary may require, including a description of the
23 use to which the entity will apply any amounts received
24 under the grant.

1 (c) PREFERENCE IN AWARDING GRANTS.—The Sec-
2 retary shall, in awarding grants under this section give
3 preference to applicants that—

4 (1) are health care providers in a rural health
5 care network or that propose to form such a net-
6 work, if a majority of the providers in such network
7 are located in a medically underserved area or health
8 professional shortage area;

9 (2) can demonstrate broad geographic coverage
10 in the rural areas of the State, or States, in which
11 the applicant is located;

12 (3) propose to use the amounts provided under
13 the grant to develop plans for, or to establish,
14 telemedicine systems that will link rural hospitals
15 and other rural health care providers to other hos-
16 pitals and health care providers;

17 (4) will use the amounts provided under the
18 grant for a broad range of health care applications
19 such as teleradiology, telepathology, interactive video
20 consultation and remote educational services, and to
21 promote greater efficiency in the use of health care
22 resources and administrative activities; and

23 (5) propose to use local matching funds to fi-
24 nance projects.

1 (d) USE OF AMOUNTS.—Amounts received under a
2 grant awarded under this section shall be utilized for the
3 development of telemedicine networks involving three or
4 more providers. Such amounts may be used to cover the
5 costs associated with the development of telemedicine net-
6 works and the acquisition or construction of telecommuni-
7 cations facilities and equipment including—

8 (1) the development and acquisition through
9 lease or purchase of computer hardware and soft-
10 ware, audio and visual equipment, computer network
11 equipment, telecommunications transmission facili-
12 ties, telecommunications terminal equipment, inter-
13 active video equipment, data terminal equipment,
14 and other facilities and equipment that would fur-
15 ther the purposes of this section;

16 (2) the provision of technical assistance and in-
17 struction for the development and use of such pro-
18 gramming equipment or facilities;

19 (3) the development and acquisition of instruc-
20 tional programming;

21 (4) demonstration projects for teaching or
22 training medical students, residents, and other
23 health professions students in rural training sites
24 about the applications of telemedicine;

1 (5) transmission costs, maintenance of equip-
2 ment, and compensation of specialists and referring
3 practitioners;

4 (6) demonstration projects to use telemedicine
5 to facilitate collaboration between physicians and
6 nonphysician primary care practitioners such as phy-
7 sician assistants, nurse practitioners, and certified
8 nurse-midwives; or

9 (7) such other uses that are consistent with
10 achieving the purposes of this section as approved by
11 the Secretary.

12 **SEC. 3342. REPORT AND EVALUATION OF TELEMEDICINE.**

13 Three years after the first grant is awarded under
14 section 3341 the Secretary shall submit a report to Con-
15 gress that evaluates all telemedicine projects funded
16 through the Department of Health and Human Services.
17 Such report shall evaluate—

18 (1) whether telemedicine expands access to
19 health care services;

20 (2) the cost effectiveness of telemedicine serv-
21 ices; and

22 (3) the quality of telemedicine services deliv-
23 ered.

1 **SEC. 3343. RECOMMENDATIONS ON REIMBURSEMENT OF**
2 **TELEMEDICINE.**

3 The Secretary, in consultation with the Office of
4 Rural Health and the Health Care Financing Administra-
5 tion, shall issue regulations regarding reimbursement for
6 telemedicine services provided under title XVIII of the So-
7 cial Security Act no later than July 1, 1996.

8 **Subtitle E—Health Services for**
9 **Medically Underserved Popu-**
10 **lations**

11 **PART 1—INITIATIVES FOR ACCESS TO HEALTH**
12 **CARE**

13 **Subpart A—Authorization of Appropriations**

14 **SEC. 3411. AUTHORIZATIONS OF APPROPRIATIONS.**

15 (a) IMPROVING ACCESS TO HEALTH SERVICES.—

16 (1) SUBPART B.—

17 (A) Except as provided in subparagraph
18 (B), for the purpose of carrying out subpart B,
19 there are authorized to be appropriated
20 \$52,500,000 for fiscal year 1995, \$122,500,000
21 for fiscal year 1996, \$192,500,000 for fiscal
22 year 1997, \$157,500,000 for fiscal year 1998,
23 \$122,500,000 for fiscal year 1999, and
24 \$52,500,000 for fiscal year 2000.

25 (B) With respect to awards to federally
26 qualified health centers (as defined in section

1 1861(aa)(4) of the Social Security Act) under
2 subpart B, there are authorized to be appro-
3 priated \$97,500,000 for fiscal year 1995,
4 \$227,500,000 for fiscal year 1996,
5 \$357,500,000 for fiscal year 1997,
6 \$292,500,000 for fiscal year 1998,
7 \$227,500,000 for fiscal year 1999, and
8 \$97,500,000 for fiscal year 2000.

9 (2) SUBPART C.—

10 (A) For the purpose of providing loans
11 under subpart C, there are authorized to be ap-
12 propriated such sums as may be necessary to
13 support a loan level of \$200,000,000 for each
14 of the fiscal years 1995 through 2000.

15 (B) For the purpose of making grants
16 under subpart C, there are authorized to be ap-
17 propriated \$35,000,000 for each of the fiscal
18 year 1995 through 2000.

19 (b) RELATION TO OTHER FUNDS.—The authoriza-
20 tions of appropriations established in subsection (a) are
21 in addition to any other authorizations of appropriations
22 that are available for the purpose described in such sub-
23 section.

24 (c) ELIGIBLE ENTITIES.—For purposes of this part,
25 the term “eligible entities” means—

1 (1) covered entities as defined in section
2 340B(a)(4) of the Public Health Service Act (42
3 U.S.C. 256b(a)(4)), except that subsection
4 (a)(4)(L)(iii) and (a)(7) of such section shall not
5 apply;

6 (2) school health service sites under title III of
7 this Act;

8 (3) nonprofit hospitals meeting the criteria for
9 public hospitals which are eligible entities under sec-
10 tion 340B of the Public Health Service Act, except
11 that subsection (a)(4)(L)(iii) of such section shall
12 not apply, and children's hospitals meeting com-
13 parable criteria as determined appropriate by the
14 Secretary;

15 (4) public and private, nonprofit community
16 mental health centers and substance abuse treat-
17 ment providers receiving funds from the Substance
18 Abuse and Mental Health Services Administration;

19 (5) runaway homeless youth centers or transi-
20 tional living programs for homeless youth for the
21 provision of health services under the Runaway
22 Homeless Youth Act of 1974 (42 U.S.C. 5701 et
23 seq.);

24 (6) rural referral centers under section
25 1886(d)(5)(C) of the Social Security Act, except

1 that such eligibility is restricted to the receipt of
2 grants under section 3441; and

3 (7) public or nonprofit entities in
4 nonmetropolitan areas (as defined by the Depart-
5 ment of Commerce) in a consortium of community-
6 based providers that includes at least three of the
7 following:

8 (A) community or migrant health centers;

9 (B) local health departments;

10 (C) community mental health centers;

11 (D) nonprofit hospitals;

12 (E) private practice health professionals,
13 including rural health clinics; or

14 (F) other publicly funded health or social
15 services agencies;

16 except that such eligibility is restricted to the receipt
17 of grants or contracts under section 3421(a).

18 (d) PRIORITY.—In making awards from amounts ap-
19 propriated under subsection (a)(1)(B) and section 3462,
20 the Secretary shall give the highest priority to providing
21 adequate assistance to federally qualified health centers
22 in order to ensure the provision of comprehensive primary
23 health care services, other covered services and benefits,
24 and enabling services to medically underserved populations
25 that were served by such centers prior to the date of enact-

1 ment of this Act, except that such federally qualified
2 health centers must continue to meet the requirements for
3 designation under section 1861(aa)(4) of the Social Secu-
4 rity Act.

5 (e) **EQUITABLE DISTRIBUTION.**—The Secretary
6 shall, in awarding grants, entering into contracts, and
7 making loans under this part, assure an equitable distribu-
8 tion of funds between rural and urban areas.

9 **Subpart B—Development of Community Health**

10 **Groups and Health Care Sites and Services**

11 **SEC. 3421. GRANTS AND CONTRACTS FOR DEVELOPMENT**
12 **OF PLANS AND NETWORKS AND THE EXPAN-**
13 **SION AND DEVELOPMENT OF HEALTH CARE**
14 **SITES AND SERVICES.**

15 (a) **IN GENERAL.**—The Secretary may make grants
16 to and enter into contracts with eligible entities described
17 in section 3411(c) for—

18 (1) the development of community health
19 groups whose principal purpose is to provide the
20 comprehensive benefit package under title I in one
21 or more health professional shortage areas or to pro-
22 vide such items and services to a significant number
23 of individuals who are members of a medically un-
24 derserved population; and

1 (2) the expansion of existing health delivery
2 sites and services and the development of new health
3 delivery sites and services.

4 (b) SERVICE AREA.—In making an award under sub-
5 section (a), the Secretary shall designate the geographic
6 area with respect to which the community health group
7 involved is to provide health services.

8 (c) PRIORITY.—In making awards under subsection
9 (a)(1), the Secretary shall give priority to proposals in
10 which a greater number of eligible entities and other
11 health care providers, especially providers in community-
12 and provider-based health plans under section 1651(d),
13 are participants in the community health group, except in
14 areas such as rural areas, where providers are severely
15 limited in number.

16 (d) LIMITATION ON AWARDS.—The Secretary may
17 not make awards under subsection (a)(1) for more than
18 5 years to the same community health group.

19 (e) DEFINITIONS.—For purposes of this subpart:

20 (1) The term “community health group”
21 means—

22 (A) a community health network that—

23 (i) is a public or nonprofit private
24 consortium of health care providers that
25 principally provides some of the items and

1 services of the basic benefit package to
2 medically underserved populations, and
3 residents of health professional shortage
4 areas;

5 (ii) has an agreement with one or
6 more health plans; and

7 (iii) has a written agreement govern-
8 ing the participation of health care provid-
9 ers in the consortium to which each par-
10 ticipating provider is a party; or

11 (B) a community health plan that—

12 (i) is a public or nonprofit private en-
13 tity that principally provides all of the
14 items and services of the basic benefit
15 package to medically underserved popu-
16 lations, and residents of health professional
17 shortage areas;

18 (ii) is a participant in one or more
19 health alliances; and

20 (iii) has a written agreement govern-
21 ing the participation of health care provid-
22 ers in the consortium to which each par-
23 ticipating provider is a party.

24 (2) The term “health professional shortage
25 areas” means health professional shortage areas des-

1 ignated under section 332 of the Public Health Serv-
2 ice Act.

3 (3) The term “medically underserved popu-
4 lation” means a medically underserved population
5 designated under section 330(b)(3) of the Public
6 Health Service Act, populations residing in health
7 professional shortage areas under section 332 of the
8 Public Health Service Act, and populations eligible
9 for premium subsidies and cost sharing reductions
10 based on income under title I.

11 **SEC. 3422. CERTAIN USES OF AWARDS.**

12 (a) **IN GENERAL.**—Amounts awarded under section
13 3421 may be expended for—

14 (1) the development of a community health
15 group, including entering into contracts between the
16 recipient of the award and health care providers who
17 are to participate in the group;

18 (2) the expansion, development and on-going
19 operation of health delivery sites and services; and

20 (3) activities under paragraphs (1) and (2)
21 which include—

22 (A) the recruitment, compensation, and
23 training of health professionals and administra-
24 tive staff;

1 (B) the purchase and upgrading of equip-
2 ment, supplies, and information systems includ-
3 ing telemedicine systems; and

4 (C) the establishment of reserves required
5 for furnishing services on a prepaid or capitated
6 basis, except that eligible entities may use non-
7 cash mechanisms (including bonds, letters of
8 credit and federally guaranteed reinsurance
9 pools) for establishing and maintaining finan-
10 cial reserves.

11 (b) LOANS AND GRANTS.—The Secretary may ex-
12 pend, in any fiscal year, not to exceed 10 percent of the
13 amounts appropriated to carry out this subpart to make
14 loans and grants to eligible entities to support the types
15 of activities described in section 3441, subject to the re-
16 quirements of subpart C, except that, with respect to
17 amounts available for non-federally qualified health center
18 activities, such funds may be used to convert facilities
19 from providers of acute care service to providers of pri-
20 mary, emergency or long-term care.

21 **SEC. 3423. APPLICATION.**

22 The Secretary may not make an award to an entity
23 under section 3421 until such entity submits and applica-
24 tion to the Secretary, in such form and containing such

1 assurances and information as the Secretary determines
2 appropriate, including—

3 (1) an assessment of the need that the medi-
4 cally underserved population or populations proposed
5 to be served by the applicant have for health services
6 and for enabling services (as defined in section
7 3461);

8 (2) a description of how the applicant will de-
9 sign the proposed community health plan or practice
10 network (including the service sites involved) for
11 such populations based on the assessment of need;

12 (3) a description of efforts to secure financial
13 and professional assistance and support for the
14 project; and

15 (4) evidence of significant community involve-
16 ment in the initiation, development and ongoing op-
17 eration of the project.

18 **SEC. 3424. PURPOSES AND CONDITIONS.**

19 Grants shall be made under this subpart for the pur-
20 poses and subject to all of the conditions under which eli-
21 gible entities otherwise receive funding to provide health
22 services to medically underserved populations under the
23 Public Health Service Act. The Secretary shall prescribe
24 comparable purposes and conditions for eligible entities
25 not receiving funding under the Public Health Service Act.

1 **Subpart C—Capital Cost of Development of**
2 **Community Health Groups and Other Purposes**

3 **SEC. 3441. DIRECT LOANS AND GRANTS.**

4 (a) IN GENERAL.—The Secretary shall make grants
5 and loans to—

6 (1) eligible entities (as defined in section
7 3412(c));

8 (2) hospitals designated by the Secretary as es-
9 sential access community hospitals under section
10 1820(i)(1) of the Social Security Act; or

11 (3) rural primary care hospitals under section
12 1820(i)(2) of such Act;

13 for the capital costs of developing community health
14 groups (as defined in section 3421(e)) and expanding ex-
15 isting health delivery sites or developing new health deliv-
16 ery sites.

17 (b) USE OF ASSISTANCE.—

18 (1) IN GENERAL.—The capital costs for which
19 grants and loans made pursuant to subsection (a)
20 may be expended are, subject to paragraphs (2) and
21 (3), the following:

22 (A) The acquisition, modernization, expan-
23 sion or construction of facilities, or the conver-
24 sion of unneeded hospital facilities to facilities
25 that will assure or enhance the provision and

1 accessibility of health care and enabling services
2 to medically underserved populations.

3 (B) The purchase of major equipment, in-
4 cluding equipment necessary for the support of
5 external and internal information systems.

6 (C) The establishment of reserves required
7 for furnishing services on a prepaid or capitated
8 basis.

9 (D) Such other capital costs as the Sec-
10 retary may determine are necessary to achieve
11 the objectives of this section.

12 (2) PRIORITIES REGARDING USE OF FUNDS.—
13 In providing grants and loans under subsection (a)
14 for an entity, the Secretary shall give priority to au-
15 thORIZING the use of amounts for projects for the
16 renovation and modernization of medical facilities
17 necessary to prevent or eliminate safety hazards in-
18 cluding asbestos removal, avoid noncompliance with
19 licensure or accreditation standards, or projects to
20 replace obsolete facilities.

21 (3) LIMITATION.—The Secretary may authorize
22 the use of grants and loans under subsection (a) for
23 the construction of new buildings only if the Sec-
24 retary determines that appropriate facilities are not
25 available through acquiring, modernizing, expanding

1 or converting existing buildings, or that construction
2 new buildings will cost less.

3 (c) AMOUNT OF ASSISTANCE.—

4 (1) IN GENERAL.—The principal amount of
5 loans under subsection (a) may cover up to 90 per-
6 cent of the costs involved.

7 (2) GRANTS.—Grants under this subsection
8 may not exceed 75 percent of the costs involved.

9 (d) INTEREST SUBSIDIES.—Amounts provided under
10 this section may be used to provide interest subsidies for
11 loans provided under this section where such subsidies are
12 necessary to make a project financial feasible.

13 **SEC. 3442. CERTAIN REQUIREMENTS.**

14 (a) IN GENERAL.—The Secretary may approve a loan
15 under section 3441 only if—

16 (1) the Secretary is reasonably satisfied that
17 the applicant for the project for which the loan
18 would be made will be able to make payments of
19 principal and interest thereon when due; and

20 (2) the applicant provides the Secretary with
21 reasonable assurances that there will be available to
22 it such additional funds as may be necessary to com-
23 plete the project or undertaking with respect to
24 which such loan is requested.

1 (b) TERMS AND CONDITIONS.—Any loan made under
2 section 3441 shall, subject to the Federal Credit Reform
3 Act of 1990, meet such terms and conditions (including
4 provisions for recovery in case of default) as the Secretary,
5 in consultation with the Secretary of the Treasury, deter-
6 mines to be necessary to carry out the purposes of such
7 section while adequately protecting the financial interests
8 of the United States. Terms and conditions for such loans
9 shall include provisions regarding the following:

10 (1) Security.

11 (2) Maturity date.

12 (3) Amount and frequency of installments.

13 (4) Rate of interest, which shall be at a rate
14 comparable to the rate of interest prevailing on the
15 date the loan is made.

16 **SEC. 3443. DEFAULTS; RIGHT OF RECOVERY.**

17 (a) DEFAULTS.—

18 (1) IN GENERAL.—The Secretary may take
19 such action as may be necessary to prevent a default
20 on loans under section 3441, including the waiver of
21 regulatory conditions, deferral of loan payments, re-
22 negotiation of loans, and the expenditure of funds
23 for technical and consultative assistance, for the
24 temporary payment of the interest and principal on
25 such a loan, and for other purposes.

1 (2) FORECLOSURE.—The Secretary may take
2 such action, consistent with State law respecting
3 foreclosure procedures, as the Secretary deems ap-
4 propriate to protect the interest of the United States
5 in the event of a default on a loan made pursuant
6 to section 3441, including selling real property
7 pledged as security for such a loan and for a reason-
8 able period of time taking possession of, holding,
9 and using real property pledged as security for such
10 a loan.

11 (3) WAIVERS.—The Secretary may, for good
12 cause, but with due regard to the financial interests
13 of the United States, waive any right of recovery
14 which the Secretary has by reasons of the failure of
15 a borrower to make payments of principal of and in-
16 terest on a loan made pursuant to section 3441, ex-
17 cept that if such loan is sold and guaranteed, any
18 such waiver shall have no effect upon the Secretary's
19 guarantee of timely payment of principal and inter-
20 est.

21 (b) TWENTY-YEAR OBLIGATION; RIGHT OF RECOV-
22 ERY; SUBORDINATION; WAIVERS.—

23 (1) IN GENERAL.—With respect to an eligible
24 entity for which a grant or loan was made under
25 section 3441, the Secretary may award the grant or

1 loan only if the applicant involved agrees that the
2 applicant will be liable to the United States for the
3 amount of the grant or loan, together with an
4 amount representing interest, if at any time during
5 the 20-year period beginning on the date of comple-
6 tion of the activities involved, the entity—

7 (A) ceases to be an eligible entity utilized
8 by a community health group, or by another
9 public or nonprofit private entity that provides
10 health services in one or more health profes-
11 sional shortage areas or that provides such
12 services to a significant number of individuals
13 who are members of a medically underserved
14 population; or

15 (B) is sold or transferred to any entity
16 other than an entity that is—

17 (i) a community health group or other
18 entity described in subparagraph (A); and

19 (ii) approved by the Secretary as a
20 purchaser or transferee regarding the facil-
21 ity.

22 (2) SUBORDINATION; WAIVERS.—With respect
23 to essential community providers, the Secretary may
24 subordinate or waive the right of recovery under
25 paragraph (1), and any other Federal interest that

1 (1) Title to such site will be vested in one or
2 more of the entities filing the application (unless the
3 assurance described in subsection (a)(3) has been
4 submitted under such subsection).

5 (2) Adequate financial support will be available
6 for completion of the project and for its maintenance
7 and operation when completed.

8 (3) All laborers and mechanics employed by
9 contractors or subcontractors in the performance of
10 work on a project will be paid wages at rates not
11 less than those prevailing on similar construction in
12 the locality as determined by the Secretary of Labor
13 in accordance with the Act of March 3, 1931 (40
14 U.S.C. 276a et seq; commonly known as the Davis-
15 Bacon Act), and the Secretary of Labor shall have
16 with respect to such labor standards the authority
17 and functions set forth in Reorganization Plan
18 Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Ap-
19 pendix) and section 276c of title 40.

20 (4) The facility will be made available to all
21 persons seeking service regardless of their ability to
22 pay.

23 **SEC. 3445. APPLICATION FOR ASSISTANCE.**

24 The Secretary may provide loans under section 3441
25 only if an application for such assistance is submitted to

1 the Secretary, the application contains each agreement de-
2 scribed in this subpart, the application contains the infor-
3 mation required in section 3444(a), and the application
4 is in such form, is made in such manner, and contains
5 such agreements, assurances, and information as the Sec-
6 retary determines to be necessary to carry out this sub-
7 part.

8 **SEC. 3446. ADMINISTRATION OF PROGRAMS.**

9 This subpart, and any other program of the Secretary
10 that provides loans, shall be carried out by a centralized
11 loan unit established within the Department of Health and
12 Human Services.

13 **Subpart D—Enabling and Supplemental Services**

14 **SEC. 3461. GRANTS AND CONTRACTS FOR ENABLING AND**
15 **SUPPLEMENTAL SERVICES.**

16 (a) IN GENERAL.—The Secretary may make grants
17 to and enter into contracts with eligible entities to assist
18 such entities in providing the services described in sub-
19 sections (b) and (c) for the purpose of increasing the ca-
20 pacity of individuals to utilize the items and services in-
21 cluded in the comprehensive benefits package under title
22 I, and to provide access to essential supplemental services
23 that are not fully reimbursable under title I prior to Janu-
24 ary 2001,.

1 (b) ENABLING SERVICES.—Enabling services shall
2 include transportation, community and patient outreach,
3 patient and family education, translation services, case
4 management, home visiting, and such other services as the
5 Secretary determines to be appropriate in carrying out the
6 purpose described in such subsection.

7 (c) SUPPLEMENTAL SERVICES.—Supplemental serv-
8 ices shall include items or services described in section
9 1106 or section 1118 of this Act that would otherwise be
10 excluded from coverage prior to January 1, 2001.

11 (d) CERTAIN REQUIREMENTS REGARDING PROJECT
12 AREA.—The Secretary may make an award of a grant or
13 contract under subsection (a) only if the applicant in-
14 volved—

15 (1) submits to the Secretary—

16 (A) information demonstrating that the
17 medically underserved populations in the com-
18 munity to be served under the award have a
19 need for enabling services; and

20 (B) a proposed budget for providing such
21 services;

22 (2) the applicant for the award agrees that the
23 medically underserved residents of the community
24 will be consulted with respect to the design and im-

1 plementation of the project carried out with the
2 award;

3 (3) agrees that the services will not be denied
4 because the individual is unable to pay for such serv-
5 ices; and

6 (4) agrees that the applicant will utilize existing
7 resources to the maximum extent practicable.

8 (e) APPLICATION FOR AWARDS OF ASSISTANCE.—
9 The Secretary may make an award of a grant or contract
10 under subsection (a) only if an application for the award
11 is submitted to the Secretary, the application contains
12 each agreement described in this subpart, and the applica-
13 tion is in such form, is made in such manner, and contains
14 such agreements, assurances, and information as the Sec-
15 retary determines to be necessary to carry out this sub-
16 part.

17 **SEC. 3462. AUTHORIZATIONS OF APPROPRIATIONS.**

18 (a) ENABLING SERVICES.—For the purpose of carry-
19 ing out section 3461(b), there are authorized to be appro-
20 priated \$35,000,000 for fiscal year 1996, \$140,000,000
21 for each of the fiscal years 1997 through 1999, and
22 \$175,000,000 for fiscal year 2000.

23 (b) SUPPLEMENTAL SERVICES.—For the purpose of
24 carrying out section 3461(c), there are authorized to be
25 appropriated \$100,000,000 for fiscal year 1995,

1 \$150,000,000 for fiscal year 1996, and \$250,000,000 for
2 each of the fiscal years 1997 through 2000.

3 (c) **FEDERALLY QUALIFIED HEALTH CENTERS.**—
4 With respect to federally qualified health centers (as de-
5 fined in section 1861(aa)(4) of the Social Security Act),
6 for the purpose of carrying out section 3461(b), there are
7 authorized to be appropriated \$65,000,000 for fiscal year
8 1996, \$260,000,000 for each of the fiscal years 1997
9 through 1999, and \$325,000,000 for fiscal year 2000.

10 (d) **RELATION TO OTHER FUNDS.**—The authoriza-
11 tions of appropriations established in subsection (a) are
12 in addition to any other authorizations of appropriations
13 that are available for the purpose described in such sub-
14 section.

15 **PART 2—NATIONAL HEALTH SERVICE CORPS**

16 **SEC. 3471. AUTHORIZATIONS OF APPROPRIATIONS.**

17 (a) **ADDITIONAL FUNDING; GENERAL CORPS PRO-**
18 **GRAM; ALLOCATIONS REGARDING NURSES.**—For the pur-
19 pose of carrying out subpart II of part D of title III of
20 the Public Health Service Act, and for the purpose of car-
21 rying out section 3472, there are authorized to be appro-
22 priated \$150,000,000 for fiscal year 1996, \$150,000,000
23 for fiscal year 1997, and \$250,000,000 for each of the
24 fiscal years 1998 through 2000.

1 (b) RELATION TO OTHER FUNDS.—The authoriza-
2 tions of appropriations established in subsection (a) are
3 in addition to any other authorizations of appropriations
4 that are available for the purpose described in such sub-
5 section.

6 **SEC. 3472. ALLOCATION FOR PARTICIPATION OF NURSES**
7 **IN SCHOLARSHIP AND LOAN REPAYMENT**
8 **PROGRAMS.**

9 Of the amounts appropriated under section 3471, the
10 Secretary shall reserve such amounts as may be necessary
11 to ensure that, of the aggregate number of individuals who
12 are participants in the Scholarship Program under section
13 338A of the Public Health Service Act, or in the Loan
14 Repayment Program under section 338B of such Act, the
15 total number who are being educated as nurse practition-
16 ers, nurse midwives, or nurse anesthetists or are serving
17 as nurse practitioners, nurse midwives, or nurse anes-
18 thetists, respectively, is increased to 20 percent.

19 **SEC. 3473. ALLOCATION FOR PARTICIPATION OF PSYCHIA-**
20 **TRISTS, PSYCHOLOGISTS, AND CLINICAL SO-**
21 **CIAL WORKERS IN SCHOLARSHIP AND LOAN**
22 **REPAYMENT PROGRAMS.**

23 Of the amounts appropriate under section 3471, the
24 Secretary shall reserve such amounts as may be necessary
25 to ensure that of the aggregate number of individuals who

1 are participants in the scholarship program under section
2 338A of the Public Health Service Act, the number who
3 are being educated as psychiatrists, psychologists, and
4 clinical social workers or are serving as psychiatrists, psy-
5 chologists, and clinical social workers, respectively, is in-
6 creased to 15 percent.

7 **PART 3—PAYMENTS TO HOSPITALS SERVING**
8 **VULNERABLE POPULATIONS**

9 **SEC. 3481. PAYMENTS TO HOSPITALS.**

10 (a) ENTITLEMENT STATUS.—The Secretary shall
11 make payments in accordance with this part to eligible
12 hospitals described in section 3482. The preceding sen-
13 tence—

14 (1) is an entitlement in the Secretary on behalf
15 of such eligible hospitals (but is not an entitlement
16 in the State in which any such hospital is located or
17 in any individual receiving services from any such
18 hospital); and

19 (2) constitutes budget authority in advance of
20 appropriations Acts and represents the obligation of
21 the Federal Government to provide funding for such
22 payments in the amounts, and for the fiscal years,
23 specified in subsection (b).

24 (b) APPROPRIATIONS.—

1 (1) IN GENERAL.—For purposes of subsection
2 (a)(2), the amounts and fiscal years specified in this
3 subsection are (in the aggregate for all eligible hos-
4 pitals) \$1,300,000,000 for the fiscal year in which
5 the general effective date occurs and for each subse-
6 quent fiscal year.

7 (2) SPECIAL RULE FOR YEARS BEFORE GEN-
8 ERAL EFFECTIVE DATE.—

9 (A) IN GENERAL.—For each of the fiscal
10 years 1996 and 1997, the amount specified in
11 this subsection for purposes of subsection (a)(2)
12 shall be equal to the aggregate DSH percentage
13 of the amount otherwise determined under
14 paragraph (1).

15 (B) AGGREGATE DSH PERCENTAGE DE-
16 FINED.—In subparagraph (A), the “aggregate
17 DSH percentage” for a year is the amount (ex-
18 pressed as a percentage) equal to—

19 (i) the total amount of payment made
20 by the Secretary under section 1903(a) of
21 the Social Security Act during the base
22 year with respect to payment adjustments
23 made under section 1923(c) of such Act
24 for hospitals in the States in which eligible

1 hospitals for the year are located; divided
2 by

3 (ii) the total amount of payment made
4 by the Secretary under section 1903(a) of
5 such Act during the base year with respect
6 to payment adjustments made under sec-
7 tion 1923(c) of such Act for hospitals in
8 all States.

9 (c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-
10 ments to an eligible hospital under this section for a year
11 shall be made on a quarterly basis during the year.

12 **SEC. 3482. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

13 (a) STATE IDENTIFICATION.—In accordance with the
14 criteria described in subsection (b) and such procedures
15 as the Secretary may require, each State shall identify the
16 hospitals in the State that meet such criteria and provide
17 the Secretary with a list of such hospitals.

18 (b) CRITERIA FOR ELIGIBILITY.—A hospital meets
19 the criteria described in this subsection if the hospital's
20 low-income utilization rate for the base year under section
21 1923(b)(3) of the Social Security Act (as such section is
22 in effect on the day before the date of the enactment of
23 this Act) is not less than 25 percent.

1 **SEC. 3483. AMOUNT OF PAYMENTS.**

2 (a) DISTRIBUTION OF ALLOCATION FOR LOW-IN-
3 COME ASSISTANCE.—

4 (1) ALLOCATION FROM TOTAL AMOUNT.—Of
5 the total amount available for payments under this
6 section in a year, 66.66 percent shall be allocated to
7 hospitals for low-income assistance in accordance
8 with this subsection.

9 (2) DETERMINATION OF HOSPITAL PAYMENT
10 AMOUNT.—The amount of payment to an eligible
11 hospital from the allocation made under paragraph
12 (1) during a year shall be the equal to the hospital's
13 low-income percentage of the allocation for the year.

14 (b) DISTRIBUTION OF ALLOCATION FOR ASSISTANCE
15 FOR UNCOVERED SERVICES.—

16 (1) ALLOCATION FROM TOTAL AMOUNT; DETER-
17 MINATION OF STATE-SPECIFIC PORTION OF ALLOCA-
18 TION.—Of the total amount available for payments
19 under this section in a year, 33.33 percent shall be
20 allocated to hospitals for assistance in furnishing
21 hospital services that are not covered services under
22 title I (in accordance with regulations of the Sec-
23 retary) or in furnishing hospital services to individ-
24 uals, including those residing in Southwestern bor-
25 der States, who are not eligible individuals under
26 title I, in accordance with this subsection. The

1 amount available for payments to eligible hospitals
2 in a State shall be equal to an amount determined
3 in accordance with a methodology specified by the
4 Secretary that shall take into consideration the vol-
5 ume of such services provided by hospital in the
6 State as compared to the volume of such services
7 provided by all eligible hospitals.

8 (2) DETERMINATION OF HOSPITAL PAYMENT
9 AMOUNT.—The amount of payment to an eligible
10 hospital in a State from the amount available for
11 payments to eligible hospitals in the State under
12 paragraph (1) during a year shall be the equal to
13 the hospital’s low-income percentage of such amount
14 for the year.

15 (c) LOW-INCOME PERCENTAGE DEFINED.—

16 (1) IN GENERAL.—In this subsection, an eligi-
17 ble hospital’s “low-income percentage” for a year is
18 equal to the amount (expressed as a percentage) of
19 the total low-income days for all eligible hospitals for
20 the year that are attributable to the hospital.

21 (2) LOW-INCOME DAYS DESCRIBED.—For pur-
22 poses of paragraph (1), an eligible hospital’s low-in-
23 come days for a year shall be equal to the product
24 of—

1 (A) the total number of inpatient days for
2 the hospital for the year (as reported to the
3 Secretary by the State in which the hospital is
4 located, in accordance with a reporting schedule
5 and procedures established by the Secretary);
6 and

7 (B) the hospital's low-income utilization
8 rate for the base year under section 1923(b)(3)
9 of the Social Security Act (as such section is in
10 effect on the day before the date of the enact-
11 ment of this Act).

12 **SEC. 3484. BASE YEAR.**

13 In this part, the "base year" is, with respect to a
14 State and hospitals in a State, the year immediately prior
15 to the year in which the general effective date occurs.

16 **PART 4—SENSE OF THE COMMITTEE**

17 **SEC. 3491. SENSE OF THE COMMITTEE.**

18 It is the sense of the Committee on Labor and
19 Human Resources of the Senate that when the Health Se-
20 curity Act is enacted, it and subsequent appropriations
21 Acts should appropriately recognize the success of commu-
22 nity and migrant health centers as a proven, cost-effective
23 model for the delivery of health care services to those pop-
24 ulations which are medically underserved because of eco-
25 nomic, geographic, and cultural barriers.

1 **Subtitle F—Mental Health;**
2 **Substance Abuse**

3 **PART 1—AUTHORITIES REGARDING**
4 **PARTICIPATING STATES**

5 **SEC. 3510. INTEGRATION OF MENTAL HEALTH AND SUB-**
6 **STANCE ABUSE SYSTEMS.**

7 (a) IN GENERAL.—As a condition of being a partici-
8 pating State under title I, each State shall, not later than
9 January 1, 2001, achieve the integration of the mental
10 illness and substance abuse services of the State and its
11 political subdivisions with the mental illness and substance
12 abuse services offered by health plans pursuant to title I
13 of this Act. A State may petition the Secretary for a waiv-
14 er of the requirement of this subsection under the cir-
15 cumstances described in section 3511(b)(7).

16 (b) CERTIFICATION OF READINESS.—

17 (1) PETITION.—A State may petition the Sec-
18 retary to integrate the mental illness and substance
19 abuse services of the State and its political subdivi-
20 sions with the mental illness and substance abuse
21 services offered by health plans pursuant to title I
22 of this Act prior to January 1, 2001.

23 (2) STATE READINESS TO INTEGRATE.—Upon
24 receiving such a petition, the Secretary shall, based
25 on the reports submitted pursuant to subsections (b)

1 and (c) of section 3511 and the criteria promulgated
2 pursuant to paragraph (3), ascertain the State's
3 readiness to integrate its mental illness and sub-
4 stance abuse services with the mental illness and
5 substance abuse services offered by health plans pur-
6 suant to title I of this Act and certify whether the
7 State is prepared to conduct such an integration.

8 (3) CRITERIA.—The certification by the Sec-
9 retary of a State's readiness to integrate under
10 paragraph (2) shall be based on objective criteria
11 promulgated by the Secretary after consultation with
12 the States.

13 (c) APPLICATION OF PROVISIONS.—Upon the issu-
14 ance of a certification of readiness by the Secretary for
15 a State, the limits set forth in subsections (d)(2)(B) and
16 (e)(2)(A) of section 1106 shall not apply to the provision
17 of mental illness and substance abuse services in the State.

18 **SEC. 3511. REPORT ON INTEGRATION OF MENTAL HEALTH**
19 **SYSTEMS.**

20 (a) IN GENERAL.—As a condition of being a partici-
21 pating State under title I, each State shall, not later than
22 October 1, 1998, submit to the Secretary a report contain-
23 ing the information described in subsection (b) on (includ-
24 ing a plan for) the measures to be implemented by the
25 State to achieve the integration of the mental illness and

1 substance abuse services of the State and its political sub-
2 divisions with the mental illness and substance abuse serv-
3 ices that are included in the comprehensive benefit pack-
4 age under title I. The plan required in the preceding sen-
5 tence shall meet the conditions described in section
6 3083(b). In addition, each State shall submit to the Sec-
7 retary a report containing the information described in
8 subsection (c) for each year in which the State participates
9 under title I up to and including the year 2001 or the
10 date on which an unlimited benefit for mental illness and
11 substance abuse services is provided, whichever occurs
12 later.

13 (b) REQUIRED CONTENTS OF INTEGRATION RE-
14 PORT.—With respect to the provision of items and services
15 relating to mental illness and substance abuse, the report
16 of a State under subsection (a) shall, at a minimum, con-
17 tain the following information:

18 (1) Information on the number of individuals
19 served by or through mental illness and substance
20 abuse programs administered by State and local
21 agencies and the proportion who are eligible persons
22 under title I.

23 (2) Information on the extent to which each
24 health provider furnishing mental illness and sub-
25 stance abuse services under a State program partici-

1 pates or will participate in one or more regional or
2 corporate alliance health plans, and, in the case of
3 providers that do not so participate, the reasons for
4 the lack of participation.

5 (3) With respect to the two years preceding the
6 year in which the State becomes a participating
7 State under title I—

8 (A) the amount of funds expended by the
9 State and its political subdivisions for each of
10 such years for items and services that are in-
11 cluded in the comprehensive benefit package
12 under such title;

13 (B) the amount of funds expended for
14 medically necessary and appropriate items and
15 services not included in such benefit package,
16 including medical care, other health care, and
17 supportive services related to the provision of
18 health care.

19 (4) An estimate of the amount that the State
20 will expend to furnish items and services not in-
21 cluded in such package once the expansion of cov-
22 erage for mental illness and substance abuse services
23 is implemented in the year 2001.

24 (5) A description of how the State will assure
25 that all individuals served by mental illness and sub-

1 stance abuse programs funded by the State will be
2 enrolled in a health plan and how mental illness and
3 substance abuse services not covered under the bene-
4 fit package will continue to be furnished to such en-
5 rollees.

6 (6) A description of the conditions under which
7 the integration of mental illness and substance abuse
8 providers into regional and corporate alliances can
9 be achieved, and an identification of changes in par-
10 ticipation and certification requirements that are
11 needed to achieve the integration of such programs
12 and providers into health plans.

13 (7) If the integration of mental illness and sub-
14 stance abuse programs operated by the State into
15 one or more health plans is not medically appro-
16 priate or feasible for one or more groups of individ-
17 uals treated under State programs, a description of
18 the reasons that integration is not feasible or appro-
19 priate and a plan for assuring the coordination for
20 such individuals of the care and services covered
21 under the comprehensive benefit package with the
22 additional items and services furnished by such pro-
23 grams.

24 (8) A description of the manner in which the
25 resources that the State and its political subdivisions

1 currently spend on mental health and substance
2 abuse services will be used to facilitate integration.

3 (c) REQUIRED CONTENTS OF TRANSITION RE-
4 PORT.—With respect to the a report required under this
5 subsection, the report shall, at a minimum, contain the
6 following information:

7 (1) The amount of funds expended for sub-
8 stance abuse and mental health services by the
9 source of revenue, including, Federal block grant
10 funds, under title XIX of the Public Health Service
11 Act, Federal categorical grant funds, State and local
12 revenues and health plan payments.

13 (2) The amount of funds expended for support-
14 ive services to individuals enrolled in substance
15 abuse and mental health treatment programs, in-
16 cluding transportation, child care, educational and
17 vocational training and coordination with other pub-
18 lic systems such as the social service, child welfare
19 and juvenile and criminal justice systems, by source
20 of revenue.

21 (3) The amount of funds expended on medically
22 necessary and appropriate items and services not
23 covered or reimbursed in the comprehensive benefit
24 package by source of revenue.

1 (4) The amount of funds expended by the State
2 on substance abuse and mental illness services for
3 individuals who are not eligible to receive the com-
4 prehensive benefit package pursuant to this Act, and
5 the source of revenue for such services.

6 (d) GENERAL PROVISIONS.—Reports under sub-
7 sections (b) and (c) shall be provided at the time and in
8 the manner prescribed by the Secretary. The Secretary
9 shall also determine what, if any, reports shall be submit-
10 ted in years following the implementation of an unlimited
11 benefit for mental illness and substance abuse services.

12 (e) REPORTING REQUIREMENT.—Each State shall
13 report annually to the Secretary on the incidence and
14 prevalence of mental illness and substance abuse disorders
15 in the prison population, changes in such incidence and
16 prevalence in the prison population, and potential causa-
17 tive factors with respect to such changes, including an es-
18 timate of the extent to which the denial of treatment, or
19 the provision of inadequate treatment, to individuals with
20 mental illness and substance abuse disorders is contribut-
21 ing to the criminal activity of such individuals.

1 **PART 2—ASSISTANCE FOR STATE MANAGED MEN-**
2 **TAL HEALTH AND SUBSTANCE ABUSE PRO-**
3 **GRAMS**

4 **SEC. 3531. AVAILABILITY OF ASSISTANCE.**

5 (a) IN GENERAL.—The Secretary shall make grants
6 to States for the development and operation of comprehen-
7 sive managed mental health and substance abuse pro-
8 grams that are integrated with the health delivery system
9 established under this Act. Such programs shall—

10 (1) promote the development of integrated de-
11 livery systems for the management of the mental
12 health and substance abuse services provided under
13 the comprehensive benefits package;

14 (2) give priority to providing services to low-in-
15 come adults with serious mental illness or substance
16 abuse disorders and children with serious emotional
17 disturbance or substance abuse disorders and pro-
18 vide for the phase-in of such services for all eligible
19 persons within 5 years;

20 (3) ensure that individuals participating in the
21 program have access to all medically necessary men-
22 tal health and substance abuse services;

23 (4) promote the linkage of mental health and
24 substance abuse services with primary and preven-
25 tive health care services; and

1 (5) meet such other requirements as the Sec-
2 retary may impose.

3 (b) EXCEPTION.—Nothing in this part shall be con-
4 strued as preventing States that have separate administra-
5 tive entities for mental health and for substance abuse
6 services from establishing separate comprehensive man-
7 aged care programs for such services and receiving assist-
8 ance under this part for either or both programs.

9 **SEC. 3532. PLAN REQUIREMENTS.**

10 In order to receive a grant under this part, a State
11 must have a plan for a comprehensive managed mental
12 health and substance abuse program which is approved
13 by the Secretary. Such plan shall—

14 (1) describe the management, access, and refer-
15 ral structure that the State will use to promote and
16 achieve integration of mental health and substance
17 abuse services with the health delivery system estab-
18 lished under this Act for eligible individuals in the
19 State;

20 (2) describe how the State will ensure that pro-
21 viders of specialized services will meet appropriate
22 standards and provide assurances that the State has
23 complied with section 1504 as it affects mental
24 health and substance abuse services;

1 (3) describe payment, utilization review, and
2 other mechanisms that the State will use to encour-
3 age appropriate service delivery and management of
4 costs;

5 (4) describe uniform patient placement criteria
6 that the State will use to ensure placement in appro-
7 priate substance abuse treatment programs;

8 (5) describe the processes the State will use to
9 ensure that individuals will continue to have access
10 to treatment through referrals from nonhealth public
11 entities, such as the juvenile or criminal justice sys-
12 tems, or social service systems;

13 (6) specify the methods the State will use to en-
14 sure that individuals receiving services under the
15 program have access to all medically necessary and
16 appropriate mental health and substance abuse serv-
17 ices;

18 (7) define terms that will be used by the State
19 in determining the eligibility of individuals for serv-
20 ices under the program;

21 (8) describe how health plans will use services
22 under the comprehensive managed mental health
23 and substance abuse programs established under
24 this part;

1 (9) describe the role of local government in fi-
2 nancing and managing the integrated mental illness
3 and substance abuse treatment system;

4 (10) describe the sources of funding, including
5 Medicaid and the block grants authorized by title
6 XIX of the Public Health Service Act, that will be
7 used by the State, other than the grant received
8 under this part, to operate the program, and provide
9 the status of any request for a Medicaid waiver
10 made by the State to the Secretary;

11 (11) describe how the State provided for broad-
12 based public input in the development of the plan,
13 and the mechanism that will be used for ongoing
14 public comment on and review of amendments to the
15 plan; and

16 (12) describe grievance procedures that will be
17 available for individuals dissatisfied with their health
18 plan's participation in the comprehensive managed
19 mental health and substance abuse program, and
20 mechanisms that will be available to review the per-
21 formance of health plans and fee-for-service arrange-
22 ments to ensure against under treatment.

23 **SEC. 3533. ADDITIONAL FEDERAL RESPONSIBILITIES.**

24 The Secretary shall, upon the submission of a State's
25 plan under section 3532, ensure the timely consideration

1 of any Medicaid waiver requests submitted by the State,
 2 affirm that section 1504 has been implemented, and en-
 3 sure the timely implementation of section 1641(b)(5).

4 **SEC. 3534. AUTHORIZATION OF APPROPRIATIONS.**

5 There are authorized to be appropriated for grants
 6 under this part, \$100,000,000 for each of the fiscal years
 7 1995 through 2000.

8 **Subtitle G—Comprehensive School**
 9 **Health Education; School-Relat-**
 10 **ed Health Services**

11 **PART 1—HEALTHY STUDENTS-HEALTHY**
 12 **SCHOOLS GRANTS FOR SCHOOL HEALTH**
 13 **EDUCATION**

14 **SEC. 3601. PURPOSES.**

15 It is the purpose of this part—

16 (1) to support the development and implemen-
 17 tation of comprehensive age appropriate health edu-
 18 cation programs in public schools for children and
 19 youth kindergarten through grade 12; and

20 (2) to increase access to preventive and primary
 21 health care services for children and youth through
 22 school-based or school-linked health service sites in
 23 accordance with locally determined needs.

1 **SEC. 3602. HEALTHY STUDENTS-HEALTHY SCHOOLS**
2 **GRANTS.**

3 (a) IN GENERAL.—The Secretary, in consultation
4 with the Secretary of Education, shall award grants to
5 State educational agencies in eligible States to integrate
6 comprehensive school health education in schools within
7 the State, with priority given within States to those com-
8 munities in greatest need as defined by section 3683(a).

9 (b) ELIGIBLE USES OF FUNDS.—Funds made avail-
10 able under this section shall be used—

11 (1) to implement comprehensive school health
12 education programs, as defined in subsection (f)(1)
13 through grants to local educational agencies;

14 (2) to provide staff development and technical
15 assistance to local educational agencies, schools,
16 local health agencies, and other community organiza-
17 tions involved in providing comprehensive school
18 health education programs;

19 (3) to evaluate and report to the Secretary on
20 the progress made towards attaining the goals and
21 objectives described under subsection (c)(1)(A); and

22 (4) to conduct such other activities to achieve
23 the objectives of this subpart as the Secretary may
24 require.

25 (c) APPLICATION.—An application for a grant under
26 subsection (a), shall be jointly developed by the State edu-

1 cational agency and the State health agencies of the State
2 involved, and shall contain—

3 (1) a State plan for comprehensive school
4 health education programs, that outlines—

5 (A) the goals and objectives of the State
6 for school health education programs, and the
7 manner in which the State will allocate funds to
8 local educational agencies in order to achieve
9 these goals and objectives;

10 (B) the manner in which the State will co-
11 ordinate programs under this part with other
12 Federal, State and local health education pro-
13 grams and resources, and school health serv-
14 ices;

15 (C) the manner in which comprehensive
16 school health education programs will be coordi-
17 nated with other Federal, State and local edu-
18 cation programs (such as programs under titles
19 I, II, and IV of the Elementary and Secondary
20 Education Act of 1965), with the school im-
21 provement plan of the State, if any, under title
22 III of the Goals 2000: Educate America Act,
23 and with any similar programs;

24 (D) the manner in which the State shall
25 work with State and local educational agencies

1 and with State and local health agencies to re-
2 duce barriers to implementing school health
3 education programs;

4 (E) the manner in which the State will
5 monitor the implementation of such programs
6 by local educational agencies and establish out-
7 come criteria by which to evaluate their effec-
8 tiveness in achieving progress towards the goals
9 and objectives described in subparagraph (A);

10 (F) the manner in which the State will
11 provide staff development and technical assist-
12 ance to local educational agencies, and build ca-
13 pacity for professional development of health
14 educators; and

15 (G) the manner in which such school
16 health education programs will be, to the extent
17 practicable, culturally competent and linguis-
18 tically appropriate and responsive to the diverse
19 needs of the students served;

20 (2) a description of the respective roles of the
21 State educational agency, local educational agencies,
22 the State health agency and local health agencies in
23 developing and implementing the State's school
24 health education plan and resulting programs;

1 (3) a description of the input of the local com-
2 munity (including students and parents) in the de-
3 velopment and operation of comprehensive school
4 health education programs;

5 (4) an assurance that communities identified in
6 section 3683(a) receive priority as locations for com-
7 prehensive school health education programs for all
8 grades to the extent that a State does not implement
9 a statewide program; and

10 (5) an assurance that grants to local edu-
11 cational agencies under subsection (b)(1) are contin-
12 gent upon submission by such agencies of a plan
13 consistent with the requirements for the State plan
14 as required under this subsection.

15 (d) WAIVERS OF STATUTORY AND REGULATORY RE-
16 QUIREMENTS.—

17 (1) WAIVERS.— Except as provided in para-
18 graph (4), upon the request of an entity and under
19 a relevant program described in paragraph (2), the
20 Secretary of Health and Human Services and the
21 Secretary of Education may grant to the entity a
22 waiver of any requirement of such program regard-
23 ing the use of funds, or of the regulations issued for
24 the program by the Secretary involved, if the follow-
25 ing conditions are met with respect to such program:

1 (A) The Secretary involved determines that
2 the requirements of such program impede the
3 ability of the State educational agency to
4 achieve more effectively the purposes described
5 in section 3601.

6 (B) The Secretary involved determines
7 that, with respect to the use of funds under
8 such program, the requested use of the funds
9 by the entity would be consistent with the pur-
10 poses described in section 3601.

11 (C) The State educational agency provides
12 all interested local educational agencies in the
13 State with notice and an opportunity to com-
14 ment on the proposal and makes these com-
15 ments available to the Secretary.

16 (2) RELEVANT PROGRAMS.—For purposes of
17 paragraph (1), the programs described in this sub-
18 paragraph are the following:

19 (A) In the case of programs administered
20 by the Secretary of Health and Human Serv-
21 ices, the following:

22 (i) The program known as the Preven-
23 tion, Treatment, and Rehabilitation Model
24 Projects for High Risk Youth, carried out

1 under section 517 of the Public Health
2 Service Act.

3 (ii) The program known as the State
4 and Local Comprehensive School Health
5 Programs to Prevent Important Health
6 Problems and Improve Educational Out-
7 comes, carried out under such Act.

8 (B) In the case of programs administered
9 by the Secretary of Education, any program
10 carried out under part B of the Drug-Free
11 Schools and Communities Act of 1986, except
12 that a component of such comprehensive school
13 health education must be consistent with the
14 statutory intent and purposes of such Act.

15 (3) WAIVER PERIOD.—A waiver under this
16 paragraph shall be for a period not to exceed 3
17 years, unless the Secretary involved determines
18 that—

19 (A) the waiver has been effective in ena-
20 bling the State to carry out the activities for
21 which it was requested and has contributed to
22 improved performance of comprehensive health
23 education programs; and

24 (B) such extension is in the public interest;

1 (4) WAIVERS NOT AUTHORIZED.—The Sec-
2 retary involved under paragraph (1), may not waive,
3 under this section, any statutory or regulatory re-
4 quirements relating to—

5 (A) comparability of services;

6 (B) maintenance of effort;

7 (C) parental participation and involvement;

8 (D) the distribution of funds to States or
9 to local educational agencies or other recipients
10 of funds under the programs described in para-
11 graph (2);

12 (E) maintenance of records;

13 (F) applicable civil rights requirements; or

14 (G) the requirements of sections 438 and
15 439 of the General Education Provisions Act.

16 (5) TERMINATION OF WAIVER.—The Secretary
17 involved under paragraph (1) shall terminate a waiv-
18 er under this subsection if the Secretary determines
19 that the performance of the State affected by the
20 waiver has been inadequate to justify a continuation
21 of the waiver or if it is no longer necessary to
22 achieve its original purpose.

23 (e) DEFINITIONS.—As used in this section:

24 (1) COMPREHENSIVE SCHOOL HEALTH EDU-
25 CATION.—The term “comprehensive school health

1 education” means a planned, sequential program of
2 health education that addresses the physical, emo-
3 tional and social dimensions of student health in
4 kindergarten through grade 12. Such program
5 shall—

6 (A) be designed to assist students in devel-
7 oping the knowledge and behavioral skills need-
8 ed to make positive health choices and maintain
9 and improve their health, prevent disease and
10 injuries, and reduce risk behaviors which ad-
11 versely impact health;

12 (B) be comprehensive and include a variety
13 of components addressing personal health, com-
14 munity and environmental health, injury pre-
15 vention and safety, nutritional health, the ef-
16 fects of substance use and abuse, consumer
17 health regarding the benefits and appropriate
18 use of medical services including immunizations
19 and other clinical preventive services, and other
20 components deemed appropriate by the local
21 educational agencies;

22 (C) be designed to be linguistically and cul-
23 turally competent and responsive to the needs
24 of the students served; and

1 (D) address locally relevant priorities as
2 determined by parents, students, teachers, and
3 school administrators and health officials.

4 (2) ELIGIBLE STATE.—The term “eligible
5 State” means a State with a memorandum of under-
6 standing or a written cooperative agreement entered
7 into by the agencies responsible for health and edu-
8 cation concerning the planning and implementation
9 of comprehensive school health education programs.
10 Among these States a priority shall be given to
11 qualified States as defined in section 3682(c).

12 (3) STATE EDUCATIONAL AGENCY.—The term
13 “State educational agency” means the officer or
14 agency primarily responsible for the State super-
15 vision of public elementary and secondary schools.

16 (4) LOCAL EDUCATIONAL AGENCY.—The term
17 “local educational agency” means a public board of
18 education or other public authority legally con-
19 stituted within a State for either administrative con-
20 trol or direction of, or to perform a service function
21 for, public elementary or secondary schools in a city,
22 county, township, school district, or other political
23 subdivision of a State, or such combination of school
24 districts or counties as are recognized in a State as
25 an administrative agency for its public elementary or

1 secondary schools. Such term includes any other
2 public institution or agency having administrative
3 control and direction of a public elementary or sec-
4 ondary school.

5 (f) AUTHORIZED FUNDING.—For the purpose of car-
6 rying out this section, out of the funds available under
7 section 3695(b)(2), there are made available, not to exceed
8 \$15,000,000 for fiscal year 1995, \$20,000,000 for fiscal
9 year 1996, \$25,000,000 for fiscal year 1997, \$30,000,000
10 for fiscal year 1998, \$40,000,000 for fiscal year 1999, and
11 \$50,000,000 for fiscal year 2000.

12 **SEC. 3603. HEALTHY STUDENTS-HEALTHY SCHOOLS INTER-**
13 **AGENCY TASK FORCE.**

14 (a) ESTABLISHMENT.—Not later than 120 days after
15 the date of enactment of this Act, the Secretary shall es-
16 tablish a Healthy Students-Healthy Schools Interagency
17 Task Force to be composed of representatives of the Office
18 of Disease Prevention and Health Promotion, the National
19 Institutes of Health, the Centers for Disease Control and
20 Prevention, the Health Resources and Services Adminis-
21 tration, the Office of School Health Education within the
22 Department of Education, and other Federal agencies and
23 departments which have responsibility for components of
24 school health and education.

1 (b) CO-CHAIRPERSONS.—The Assistant Secretary for
2 Health and the Assistant Secretary for Elementary and
3 Secondary Education shall serve as co-chairpersons of the
4 task force established under subsection (a).

5 (c) FUNCTIONS AND ACTIVITIES.—The task force es-
6 tablished under subsection (a) shall—

7 (1) review and coordinate all Federal efforts in
8 school health education and health services;

9 (2) provide scientific and technical advice con-
10 cerning the development and implementation of
11 model comprehensive school health education pro-
12 grams and curricula;

13 (3) develop model student learning objectives
14 and assessment instruments that shall be made
15 available to all States;

16 (4) develop a uniform grant application form (a
17 form that serves as the principal document contain-
18 ing the core information concerning a particular en-
19 tity) and procedures that may be used with respect
20 to all school health education-related programs (in-
21 cluding supplementary information procedures to be
22 implemented when an entity that has already sub-
23 mitted an application form is applying for additional
24 assistance) that require the submission of an appli-
25 cation; and

1 (5) recommend to the Secretary, for inclusion
2 in the biennial report required by section 3604(2),
3 methods for effectively linking school health edu-
4 cation and health services research findings at the
5 Federal level with implementation at the State and
6 local levels.

7 (d) CONSOLIDATION OF INITIATIVES.—Not later
8 than 12 months after the date of enactment of this Act,
9 the task force established under subsection (a) shall pre-
10 pare and submit to the Congress a report containing the
11 recommendations of the task force for the consolidation
12 of Federal school health education initiatives.

13 **SEC. 3604. DUTIES OF THE SECRETARY.**

14 The Secretary shall—

15 (1) establish and maintain a national clearing-
16 house, using advanced technologies to the maximum
17 extent practicable, and mechanisms for the diverse
18 dissemination of school health education material,
19 including written, audio-visual, and electronically
20 conveyed information to educators, schools, health
21 care providers, and other individuals, organizations,
22 and governmental entities;

23 (2) submit a biennial report to the Committee
24 on Labor and Human Resources of the Senate and
25 the appropriate committees of the House of Rep-

1 representatives on the implementation and contribution
2 of comprehensive school health education programs
3 funded under this part toward achieving relevant
4 National Healthy People 2000 objectives established
5 by the Secretary; and

6 (3) encourage coordination among Federal
7 agencies, State and local governments, educators,
8 school health providers, community-based organiza-
9 tions, and private sector entities to support develop-
10 ment of comprehensive school health education pro-
11 grams and school health services.

12 **PART 5—SCHOOL-RELATED HEALTH SERVICES**

13 **Subpart A—Development and Operation**

14 **SEC. 3681. AUTHORIZATION OF APPROPRIATIONS.**

15 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
16 ICES.—For the purpose of carrying out this subpart, there
17 are authorized to be appropriated \$100,000,000 for fiscal
18 year 1995, \$200,000,000 for fiscal year 1996,
19 \$325,000,000 for fiscal year 1997, \$450,000,000 for fis-
20 cal year 1998, \$575,000,000 for fiscal year 1999, and
21 \$700,000,000 for fiscal year 2000.

22 (b) FUNDING FOR PLANNING AND DEVELOPMENT
23 GRANTS.—Of amounts made available under this section,
24 not to exceed \$10,000,000 for each of fiscal years 1995
25 and 1996 may be utilized to carry out section 3684.

1 **SEC. 3682. ELIGIBILITY FOR GRANTS.**

2 (a) IN GENERAL.—

3 (1) PLANNING AND DEVELOPMENT GRANTS.—

4 Entities eligible to apply for and receive grants
5 under section 3684 are—

6 (A) State health agencies that apply on be-
7 half of local community partnerships; or

8 (B) local community partnerships in States
9 in which health agencies have not successfully
10 applied.

11 (2) OPERATIONAL GRANTS.—Entities eligible to
12 apply for and receive grants under section 3685
13 are—

14 (A) a qualified State as designated under
15 subsection (c) that apply on behalf of local com-
16 munity partnerships; or

17 (B) local community partnerships in States
18 that are not designated under subparagraph
19 (A).

20 (b) LOCAL COMMUNITY PARTNERSHIPS.—

21 (1) IN GENERAL.—A local community partner-
22 ship under subsection (a)(1)(B) and (a)(2)(B) is an
23 entity that, at a minimum includes—

24 (A) a local health care provider, which may
25 be a local public health department, with expe-

1 rience in delivering services to children and
2 youth or medically underserved populations;

3 (B) local educational agency on behalf of
4 one or more public schools; and

5 (C) one community-based organization lo-
6 cated in the community to be served that has
7 a history of providing services to at-risk chil-
8 dren and youth.

9 (2) RURAL COMMUNITIES.—In rural commu-
10 nities, local partnerships should seek to include, to
11 the fullest extent practicable, providers and commu-
12 nity-based organizations with experience in serving
13 the target population.

14 (3) PARENT AND COMMUNITY PARTICIPA-
15 TION.—An applicant described in subsection (a)
16 shall, to the maximum extent feasible, involve broad-
17 based community participation (including parents of
18 the youth to be served).

19 (c) QUALIFIED STATE.—A qualified State under sub-
20 section (a)(2)(A) is a State that, at a minimum—

21 (1) demonstrates an organizational commitment
22 (including a strategic plan) to providing a broad
23 range of health, health education and support serv-
24 ices to at-risk youth; and

1 (2) has a memorandum of understanding or co-
2 operative agreement jointly entered into by the State
3 agencies responsible for health and education re-
4 garding the planned delivery of health and support
5 services in school-based or school-linked centers.

6 **SEC. 3683. PREFERENCES.**

7 In making grants under sections 3684 and 3685, the
8 Secretary shall give priority to applicants whose-commu-
9 nities to be served show the most substantial level of need
10 for health services among children and youth.

11 **SEC. 3684. PLANNING AND DEVELOPMENT GRANTS.**

12 (a) IN GENERAL.—The Secretary may make grants
13 during fiscal years 1995 and 1996 to entities eligible
14 under section 3862 to develop school-based or school-
15 linked health service sites.

16 (b) USE OF FUNDS.—Amounts provided under a
17 grant under this section may be used for the following:

18 (1) Planning for the provision of school health
19 services, including—

20 (A) an assessment of the need for health
21 services among youth in the communities to be
22 served;

23 (B) the health services to be provided and
24 how new services will be integrated with exist-
25 ing services;

1 (C) assessing and planning for the mod-
2 ernization and expansion of existing facilities
3 and equipment to accommodate such services;
4 and

5 (D) an affiliation with relevant health
6 plans.

7 (2) recruitment and training of staff for the ad-
8 ministration and delivery of school health services;

9 (3) the establishment of local community part-
10 nerships as described in section 3682 (b);

11 (4) in the case of States, the development of
12 memorandums of understanding or cooperative
13 agreements for the coordinated delivery of health
14 and support services through school health service
15 sites; and

16 (5) other activities necessary to assume oper-
17 ational status.

18 (c) APPLICATION FOR GRANTS.—To be eligible to re-
19 ceive a grant under this section an entity described in sec-
20 tion 3682 (a) shall submit an application in a form and
21 manner prescribed by the Secretary.

22 (d) NUMBER OF GRANTS.—Not more than one plan-
23 ning grant may be made to a single applicant. A planning
24 grant may not exceed 2 years in duration.

1 (e) AMOUNT AVAILABLE FOR DEVELOPMENT
2 GRANT.—The Secretary may award not to exceed—

3 (1) \$150,000 to entities under section
4 3682(a)(1)(A) and to localities planning for a city-
5 wide or countywide school health services delivery
6 system; and

7 (2) \$50,000 to entities under section
8 3682(a)(1)(B).

9 **SEC. 3685. GRANTS FOR OPERATION OF SCHOOL HEALTH**
10 **SERVICES.**

11 (a) IN GENERAL.—The Secretary may make grants
12 to eligible entities described in section 3682(a)(2) that
13 submit applications consistent with the requirements of
14 this section, to pay the cost of operating school-based or
15 school-linked health service sites.

16 (b) USE OF GRANT.—Amounts provided under a
17 grant under this section may be used for the following—

18 (1) health services, including diagnosis and
19 treatment of simple illnesses and minor injuries;

20 (2) preventive health services, including health
21 screenings follow-up health care, mental health, and
22 preventive health education;

23 (3) enabling services, as defined in section
24 3461(b), and other necessary support services;

1 (4) training, recruitment, and compensation of
2 health professionals and other staff necessary for the
3 administration and delivery of school health services;
4 and

5 (5) referral services, including the linkage of in-
6 dividuals to health plans, and community-based
7 health and social service providers.

8 (c) APPLICATION FOR GRANT.—To be eligible to re-
9 ceive a grant under this section an entity described in sec-
10 tion 3682(a)(2) shall submit an application in a form and
11 manner prescribed by the Secretary. In order to receive
12 a grant under this section, an applicant must include in
13 the application the following information—

14 (1) a description of the services to be furnished
15 by the applicant;

16 (2) the amounts and sources of funding that
17 the applicant will expend, including estimates of the
18 amount of payments the applicant will receive from
19 health plans and other sources;

20 (3) a description of local community partner-
21 ships, including parent and community participation;

22 (4) a description of the linkages with other
23 health and social service providers; and

24 (5) such other information as the Secretary de-
25 termines to be appropriate.

1 (d) ASSURANCES.—In order to receive a grant under
2 this section, an applicant must meet the following condi-
3 tions—

4 (1) school health service sites will, directly or
5 indirectly, provide a broad range of health services,
6 in accordance with the determinations of the local
7 community partnership, that may include—

8 (A) diagnosis and treatment of simple ill-
9 nesses and minor injuries;

10 (B) preventive health services, including
11 health screenings and follow-up health care,
12 mental health and preventive health education;

13 (C) enabling services, as defined in section
14 3461(b);

15 (D) referrals (including referrals regarding
16 mental health and substance abuse) with follow-
17 up to ensure that needed services are received;

18 (2) the applicant provides services rec-
19 ommended by the health provider, in consultation
20 with the local community partnership, and with the
21 approval of the local education agency;

22 (3) the applicant provides the services under
23 this subsection to adolescents, and other school age
24 children and their families as deemed appropriate by
25 the local partnership;

1 (4) the applicant maintains agreements with
2 community-based health care providers with a his-
3 tory of providing services to such populations for the
4 provision of health care services not otherwise pro-
5 vided directly or during the hours when school
6 health services are unavailable;

7 (5) the applicant establishes an affiliation with
8 relevant health plans and will establish reimburse-
9 ment procedures and will make every reasonable ef-
10 fort to collect appropriate reimbursement for serv-
11 ices provided; and

12 (6) the applicant agrees to supplement and not
13 supplant the level of State or local funds under the
14 direct control of the applying State or participating
15 local education or health authority expended for
16 school health services as defined by this Act;

17 (7) services funded under this Act will be co-
18 ordinated with existing school health services pro-
19 vided at a participating school; and

20 (8) for applicants in rural areas, the assurances
21 required under paragraph (4) shall be fulfilled to the
22 maximum extent possible.

23 (e) STATE LAWS.—Notwithstanding any other provi-
24 sion in this part, no school based health clinic may provide
25 services, to any minor, when to do so is a violation of State

1 laws or regulations pertaining to informed consent for
2 medical services to minors.

3 (f) LIMITATION ON ADMINISTRATIVE FUNDS.—In
4 the case of a State applying on behalf of local educational
5 partnerships, the applicant may retain not more than 5
6 percent of grants awarded under this subpart for adminis-
7 trative costs.

8 (g) DURATION OF GRANT.—A grant under this sec-
9 tion shall be for a period determined appropriate by the
10 Secretary.

11 (h) AMOUNT OF GRANT.—The annual amount of a
12 grant awarded under this section shall not be more than
13 \$200,000 per school-based or school-linked health service
14 site.

15 (i) FEDERAL SHARE.—

16 (1) IN GENERAL.—Subject to paragraph (3), a
17 grant for services awarded under this section may
18 not exceed—

19 (A) 90 percent of the non-reimbursed cost
20 of the activities to be funded under the program
21 for the first 2 fiscal years for which the pro-
22 gram receives assistance under this section; and

23 (B) 75 percent of the non-reimbursed cost
24 of such activities for subsequent years for which

1 the program receives assistance under this sec-
2 tion.

3 The remainder of such costs shall be made available as
4 provided in paragraph (2).

5 (2) FORM OF NON-FEDERAL SHARE.—The non-
6 Federal share required by paragraph (1) may be in
7 cash or in-kind, fairly evaluated, including facilities,
8 equipment, personnel, or services, but may not in-
9 clude amounts provided by the Federal Government.
10 In-kind contributions may include space within a
11 school facilities, school personnel, program use of
12 school transportation systems, outposted health per-
13 sonnel, and extension of health provider medical li-
14 ability insurance.

15 (3) WAIVER.—The Secretary may waive the re-
16 quirements of paragraph (1) for any year in accord-
17 ance with criteria established by regulation. Such
18 criteria shall include a documented need for the
19 services provided under this section and an inability
20 of the grantee to meet the requirements of para-
21 graph (1) despite a good faith effort.

22 (j) TRAINING AND TECHNICAL ASSISTANCE.—Enti-
23 ties that receive assistance under this section may use not
24 to exceed 10 percent of the amount of such assistance to
25 provide staff training and to secure necessary technical as-

1 sistance. To the maximum extent feasible, technical assist-
2 ance should be sought through local community-based en-
3 tities. The limitation contained in this subsection shall
4 apply to individuals employed to assist in obtaining funds
5 under this part. Staff training should include the training
6 of teachers and other school personnel necessary to ensure
7 appropriate referral and utilization of services, and appro-
8 priate linkages between class-room activities and services
9 offered.

10 (k) REPORT AND MONITORING.—The Secretary will
11 submit to the Committee on Labor and Human Resources
12 in the Senate and the Committee on Energy and Com-
13 merce in the House of Representatives a biennial report
14 on the activities funded under this Act, consistent with
15 the ongoing monitoring activities of the Department. Such
16 reports are intended to advise the relevant Committees of
17 the availability and utilization of services, and other rel-
18 evant information about program activities.

19 **Subpart B—Capital Costs of Developing Projects**

20 **SEC. 3691. FUNDING.**

21 Amounts available to the Secretary under section
22 3412 for the purpose of carrying out subparts B and C
23 of part 2 of subtitle E are, in addition to such purpose,
24 available to the Secretary for the purpose of carrying out
25 this subpart.

1 **Subtitle H—Public Health Service**
2 **Initiative**

3 **SEC. 3695. PUBLIC HEALTH SERVICE INITIATIVE.**

4 (a) IN GENERAL.—Subject to subsection (c), the Sec-
5 retary of Health and Human Services shall pay, from
6 funds in the Treasury not otherwise appropriated, individ-
7 uals and entities that are eligible to receive assistance pur-
8 suant to the provisions referred to in paragraphs (1)
9 through (13) of subsection (b), to the extent of the
10 amounts specified under subsection (b).

11 (b) AMOUNTS SPECIFIED.—The amounts specified in
12 subsection (a) with respect to a fiscal year shall be—

13 (1) with respect to the health services research
14 activities authorized under the amendments made by
15 section 3202, \$150,000,000 for fiscal year 1995,
16 \$400,000,000 for fiscal year 1996, \$500,000,000 for
17 fiscal year 1997, and \$600,000,000 for each of the
18 fiscal years 1998 through 2000;

19 (2) with respect to the core functions of public
20 health programs authorized under part 2 of subtitle
21 D of title III, \$150,000,000 for fiscal year 1995,
22 \$225,000,000 for fiscal year 1996, \$325,000,000 for
23 fiscal year 1997, \$425,000,000 for fiscal year 1998,
24 \$500,000,000 for fiscal year 1999, and
25 \$625,000,000 for fiscal year 2000;

1 (3) with respect to the national initiatives re-
2 garding health promotion and disease prevention
3 under part 3 of subtitle D of title III, \$125,000,000
4 for each of the fiscal years 1996 through 1998, and
5 \$150,000,000 for each of the fiscal years 1999 and
6 2000;

7 (4) with respect to occupational injury and ill-
8 ness prevention under section 3903, \$150,000,000
9 for each of the fiscal years 1995 through 2000;

10 (5) with respect to activities for the develop-
11 ment of plans and networks under subpart B of part
12 2 of subtitle E of title III—

13 (A) \$52,500,000 for fiscal year 1995,
14 \$122,500,000 for fiscal year 1996,
15 \$192,500,000 for fiscal year 1997,
16 \$157,500,000 for fiscal year 1998,
17 \$122,500,000 for fiscal year 1999, and
18 \$52,500,000 for fiscal year 2000; and

19 (B) with respect to awards to federally
20 qualified health centers (as defined in section
21 1861(aa)(4) of the Social Security Act) under
22 such subpart, \$97,500,000 for fiscal year 1995,
23 \$227,500,000 for fiscal year 1996,
24 \$357,500,000 for fiscal year 1997,
25 \$292,500,000 for fiscal year 1998,

1 \$227,500,000 for fiscal year 1999, and
2 \$97,500,000 for fiscal year 2000;

3 (6) with respect to capital costs under subpart
4 C of part 2 of subtitle E of title III, \$50,000,000
5 for each of the fiscal years 1995 through 2000;

6 (7) with respect to enabling services under sub-
7 part D of part 2 of subtitle E of title III—

8 (A) \$35,000,000 for fiscal year 1996,
9 \$140,000,000 for each of the fiscal years 1997
10 through 1999, and \$175,000,000 for fiscal year
11 2000; and

12 (B) with respect to awards to federally
13 qualified health centers (as defined in section
14 1861(aa)(4) of the Social Security Act) under
15 such subpart, \$65,000,000 for fiscal year 1996,
16 \$260,000,000 for each of the fiscal years 1997
17 through 1999, and \$325,000,000 for fiscal year
18 2000;

19 (8) with respect to supplemental services under
20 subpart D of part 1 of subtitle E of title III,
21 \$100,000,000 for fiscal year 1995, \$150,000,000 for
22 fiscal year 1996, and \$250,000,000 for each of the
23 fiscal years 1997 through 2000;

24 (9) with respect to the National Health Service
25 Corps program referred to under section 3471,

1 \$150,000,000 for each of the fiscal years 1996 and
2 1997, and \$250,000,000 for each of the fiscal years
3 1998 through 2000;

4 (10) with respect to school-related health serv-
5 ice programs under subpart A of part 5 of subtitle
6 G of title III, \$100,000,000 for fiscal year 1995,
7 \$200,000,000 for fiscal year 1996, \$325,000,000 for
8 fiscal year 1997, and \$450,000,000 for fiscal year
9 1998, \$575,000,000 for fiscal year 1999, and
10 \$700,000,000 for fiscal year 2000;

11 (11) with respect to the development and oper-
12 ation of comprehensive managed mental health and
13 substance abuse programs under section 3534,
14 \$100,000,000 for each of the fiscal years 1995
15 through 2000;

16 (12) with respect to programs of the Secretary
17 of Health and Human Services under section 3081,
18 \$100,000,000 for each of the fiscal years 1995 and
19 1996, and \$150,000,000 for each of the fiscal years
20 1997 through 2000; and

21 (13) with respect to programs of the Secretary
22 of Labor under section 3082, \$200,000,000 for each
23 of the fiscal years 1995 through 2000.

24 (c) AUTHORITY TO TRANSFER FUNDS.—The Com-
25 mittee on Appropriations of the House of Representatives

1 and the Committee on Appropriations of the Senate, act-
2 ing through appropriations Acts, may transfer the
3 amounts specified under subsection (b) in each fiscal year
4 among the programs referred to in such subsection.

5 **Subtitle I—Additional Provisions**
6 **Regarding Public Health**

7 **SEC. 3901. CURRICULUM DEVELOPMENT AND IMPLEMEN-**
8 **TATION REGARDING DOMESTIC VIOLENCE**
9 **AND WOMEN'S HEALTH.**

10 (a) IN GENERAL.—The Secretary shall make grants
11 to eligible entities for the purpose of implementing and
12 developing for trainees a curriculum that includes training
13 in identification, treatment and referral of victims of do-
14 mestic violence and women's health needs.

15 (b) ELIGIBLE ENTITIES.—For purposes of sub-
16 section (a), eligible entities are any school of medicine,
17 school of osteopathic medicine, school of public health,
18 graduate program in mental health practice, school of
19 nursing as defined in section 853 of the Public Health
20 Service Act, a program to train physician assistants, a
21 program for training allied health professionals, and a
22 program for training of family medicine physicians, gen-
23 eral internists, general pediatricians, geriatricians, and ob-
24 stetrician/gynecologists.

1 (c) CURRICULUM.—A curriculum developed under
2 this section shall include—

3 (1) identification of victims of domestic violence
4 and maintaining complete medical records that in-
5 clude documentation of the examination, treatment
6 provided, and referral made and recording the loca-
7 tion and nature of the victim’s injuries;

8 (2) examining and treating such victims within
9 the scope of the health professional’s discipline,
10 training, and practice, including at a minimum pro-
11 viding medical advice regarding the dynamics and
12 nature of domestic violence;

13 (3) referring the victims to public and nonprofit
14 entities that provide support services for such vic-
15 tims;

16 (4) training in the identification and diagnosis
17 of diseases afflicting women and other medical dis-
18 orders as they affect women;

19 (5) training in the treatment of such diseases
20 and disorders with emphasis on the unique needs of
21 women; and

22 (6) research into the causes of such diseases
23 and disorders, including determination of appro-
24 priate means of prevention.

1 (d) ALLOCATION OF APPROPRIATIONS.—Of the
2 amounts made available under section 3301(b) for a fiscal
3 year, the Secretary shall reserve not to exceed
4 \$20,000,000 for a fiscal year for carrying out this section.

5 **Subtitle J—Occupational Safety**
6 **and Health**

7 **SEC. 3903. OCCUPATIONAL INJURY AND ILLNESS PREVEN-**
8 **TION.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services and the Secretary of Labor shall work
11 together to develop and implement a comprehensive pro-
12 gram to expand and coordinate initiatives to prevent occu-
13 pational injuries and illnesses.

14 (b) SECRETARY OF LABOR.—The Secretary of Labor
15 after consultation with the Secretary of Health and
16 Human Services shall directly or by grants or contracts—

17 (1) provide for training and education programs
18 for employees and employers in the recognition and
19 control of workplace hazards and methods and meas-
20 ures to prevent occupational injuries and illnesses;

21 (2) develop model educational materials for
22 training and educating employees and employers on
23 the recognition and control of workplace hazards, in-
24 cluding a core curriculum for general safety and

1 health training and materials related to specific safe-
2 ty and health hazards; and

3 (3) provide programs and services for technical
4 assistance to employers and employees on the rec-
5 ognition and control of workplace safety and health
6 hazards including programs for onsite consultation.

7 Technical assistance and consultative services under para-
8 graph (3) shall be provided in a manner that is separate
9 from the enforcement programs conducted by the Sec-
10 retary of Labor.

11 (c) SECRETARY OF HEALTH AND HUMAN SERV-
12 ICES.—The Secretary of Health and Human Services after
13 consultation with the Secretary of Labor shall directly or
14 by grants or contracts—

15 (1) provide education programs for training oc-
16 cupational safety and health professionals including
17 professionals in the fields of occupational medicine,
18 occupational health nursing, industrial hygiene, safe-
19 ty engineering, toxicology and epidemiology;

20 (2) provide education programs for other health
21 professionals and health care providers and the pub-
22 lic to improve the recognition, treatment and preven-
23 tion of occupationally related injuries and illnesses;

24 (3) conduct surveillance programs to identify
25 patterns and to determine the prevalence of occupa-

1 tional illnesses, injuries and deaths related to expo-
2 sure to particular safety and health hazards;

3 (4) conduct investigations and evaluations to
4 determine if workplace exposures to toxic chemicals,
5 harmful physical agents or potentially hazardous
6 conditions pose a risk to exposed employees; and

7 (5) conduct research, demonstrations and ex-
8 periments relating to occupational safety and health
9 to identify the causes of and major factors contribut-
10 ing to occupational illnesses and injuries.

11 (d) NATIONAL ADVISORY BOARD.—

12 (1) ESTABLISHMENT.—There is established a
13 National Advisory Board for Occupational Injury
14 and Illness Prevention to provide oversight, advice
15 and direction on the occupational injury and illness
16 prevention programs and initiatives conducted by the
17 Secretary of Labor and Secretary of Health and
18 Human Services.

19 (2) COMPOSITION.—The Board shall be com-
20 posed of 10 members appointed by the Secretary of
21 Labor, 5 of whom are to be designated by the Sec-
22 retary of Health and Human Services. Such mem-
23 bers shall be composed of representatives of employ-
24 ers, employees, and occupational safety and health
25 professionals.

1 (e) DIRECTOR OF NIOSH.—The responsibilities of
2 the Secretary of Health and Human Services established
3 under this section shall be carried out by the Director of
4 the National Institute for Occupational Safety and Health.

5 (f) AUTHORIZATION OF APPROPRIATIONS.—For the
6 purposes of carrying out this section there are authorized
7 to be appropriated \$150,000,000 for each of the fiscal
8 years 1995 through 2000

9 **Subtitle K—Full Funding for WIC**

10 **SEC. 3905. FULL FUNDING FOR WIC.**

11 Section 17 of the Child Nutrition Act of 1966 (42
12 U.S.C. 1786) is amended—

13 (1) in the second sentence of subsection (a)—

14 (A) by striking “authorized” and inserting
15 “established”; and

16 (B) by striking “, up to the authorization
17 levels set forth in subsection (g) of this sec-
18 tion,” and inserting “, up to the levels made
19 available under this section,”;

20 (2) in subsection (c)—

21 (A) in the first sentence of paragraph (1),
22 by striking “may” and inserting “shall”;

23 (B) in paragraph (2), by striking “appro-
24 priated” and inserting “made available”;

25 (3) in subsection (g)—

1 (A) by striking paragraph (1) and insert-
2 ing the following new paragraph:

3 “(1)(A) There are authorized to be—

4 “(i) appropriated to carry out this section such
5 amounts as are necessary for each of fiscal years
6 1995 through 2000; and

7 “(ii) made available such amounts as are nec-
8 essary for the Secretary of the Treasury to fulfill the
9 requirements of subparagraph (B).

10 “(B)(i) Out of any money in the Treasury not other-
11 wise appropriated, the Secretary of the Treasury shall pro-
12 vide to the Secretary of Agriculture, on January 1 of each
13 fiscal year, to carry out this subsection—

14 “(I) \$254,000,000 for fiscal year 1996;

15 “(II) \$407,000,000 for fiscal year 1997;

16 “(III) \$384,000,000 for fiscal year 1998;

17 “(IV) \$398,000,000 for fiscal year 1999; and

18 “(V) \$411,000,000 for fiscal year 2000.

19 “(ii) The Secretary of Agriculture shall be entitled
20 to receive the funds and shall accept the funds.

21 “(C) In lieu of obligating the funds made available
22 under subparagraph (B) to carry out this subsection, if
23 the amount appropriated (in addition to the amount ap-
24 propriated under subparagraph (B)(i)) to carry out this
25 subsection for—

1 “(i) fiscal year 1996 is less than
2 \$3,660,000,000, the amount referred to in subpara-
3 graph (B)(i)(I) shall be obligated by the Secretary,
4 during the period beginning December 31, 1995,
5 and ending June 30, 1996, to increase the special
6 assistance factor prescribed under section 11(a) of
7 the National School Lunch Act (42 U.S.C.
8 1759a(a)) for free lunches served under the school
9 lunch program (as established under section 4 of
10 such Act (42 U.S.C. 1753));

11 “(ii) fiscal year 1997 is less than
12 \$3,759,000,000, the amount referred to in subpara-
13 graph (B)(i)(II) shall be obligated by the Secretary,
14 during the period beginning December 31, 1996,
15 and ending June 30, 1997, to increase the special
16 assistance factor prescribed under section 11(a) of
17 such Act for free lunches served under the school
18 lunch program (as established under section 4 of
19 such Act);

20 “(iii) fiscal year 1998 is less than
21 \$3,861,000,000, the amount referred to in subpara-
22 graph (B)(i)(III) shall be obligated by the Secretary,
23 during the period beginning December 31, 1997,
24 and ending June 30, 1998, to increase the special
25 assistance factor prescribed under section 11(a) of

1 such Act for free lunches served under the school
2 lunch program (as established under section 4 of
3 such Act);

4 “(iv) fiscal year 1999 is less than
5 \$3,996,000,000, the amount referred to in subpara-
6 graph (B)(i)(IV) shall be obligated by the Secretary,
7 during the period beginning December 31, 1998,
8 and ending June 30, 1999, to increase the special
9 assistance factor prescribed under section 11(a) of
10 such Act for free lunches served under the school
11 lunch program (as established under section 4 of
12 such Act); and

13 “(v) fiscal year 2000 is less than
14 \$4,136,000,000, the amount referred to in subpara-
15 graph (B)(i)(V) shall be obligated by the Secretary,
16 during the period beginning December 31, 1999,
17 and ending June 30, 2000, to increase the special
18 assistance factor prescribed under section 11(a) of
19 such Act for free lunches served under the school
20 lunch program (as established under section 4 of
21 such Act).

22 “(D) Any increase in the special assistance factor
23 prescribed under section 11(a) of such Act as a result of
24 subparagraph (C) shall not affect any annual adjustment
25 in the factor under section 11(a)(3) of such Act.”;

1 (B) in the first sentence of paragraph (4),
2 by striking “appropriated” and inserting “made
3 available”; and

4 (C) in paragraph (5), by striking “appro-
5 priated” and inserting “made available”;

6 (4) in subsection (h)—

7 (A) in paragraph (1)—

8 (i) in subparagraph (A), by striking
9 “appropriated” both places it appears and
10 inserting “made available”; and

11 (ii) in subparagraph (C), by striking
12 “appropriated” both places it appears and
13 inserting “made available”; and

14 (B) in the first sentence of paragraph
15 (2)(A), by striking “1990, 1991, 1992, 1993
16 and 1994” and inserting “1990 through 2000”;
17 and

18 (5) in subsection (l), by striking “funds appro-
19 priated” and inserting “funds made available”.

20 **Subtitle L—Border Health**
21 **Improvement**

22 **SEC. 3908. BORDER HEALTH COMMISSION.**

23 (a) ESTABLISHMENT.—The President is authorized
24 and encouraged to conclude an agreement with Mexico to

1 establish a binational commission to be known as the Unit-
2 ed States-Mexico Border Health Commission.

3 (b) DUTIES.—It should be the duty of the Commis-
4 sion—

5 (1) to conduct a comprehensive needs assess-
6 ment in the United States-Mexico Border Area for
7 the purposes of identifying, evaluating, preventing,
8 and resolving health problems and potential health
9 problems that affect the general population of the
10 area;

11 (2) to develop and implement a comprehensive
12 plan for carrying out the actions recommended by
13 the needs assessment through—

14 (A) assisting in the coordination of public
15 and private efforts to prevent potential health
16 problems and resolve existing health problems;

17 (B) assisting in the coordination of public
18 and private efforts to educate the population, in
19 a culturally competent manner, concerning such
20 potential and existing health problems; and

21 (C) developing and implementing culturally
22 competent programs to prevent and resolve
23 such health problems and to educate the popu-
24 lation, in a culturally competent manner, con-
25 cerning such health problems where a new pro-

1 gram is necessary to meet a need that is not
2 being met through other public or private ef-
3 forts; and

4 (3) to formulate recommendations to the Gov-
5 ernments of the United States and Mexico concern-
6 ing a fair and reasonable method by which the gov-
7 ernment of one country could reimburse a public or
8 private person in the other country for the cost of
9 a health care service that such person furnishes to
10 a citizen or resident alien of the first country who
11 is unable, through insurance or otherwise, to pay for
12 the service.

13 (c) OTHER AUTHORIZED FUNCTIONS.—In addition
14 to the duties described in subsection (b), the Commission
15 should be authorized to perform the following functions
16 as the Commission determines to be appropriate—

17 (1) to conduct or support investigations, re-
18 search, or studies designed to identify, study, and
19 monitor, on an on-going basis, health problems that
20 affect the general population in the United States-
21 Mexico Border Area;

22 (2) to conduct or support a binational, public-
23 private effort to establish a comprehensive and co-
24 ordinated system, which uses advanced technologies
25 to the maximum extent possible, for gathering

1 health-related data and monitoring health problems
2 in the United States-Mexico Border Area; and

3 (3) to provide financial, technical, or adminis-
4 trative assistance to public or private persons who
5 act to prevent or resolve such problems or who edu-
6 cate the population concerning such health problems.

7 (d) MEMBERSHIP.—

8 (1) NUMBER AND APPOINTMENT OF UNITED
9 STATES SECTION.—The United States section of the
10 Commission should be composed of 13 members.

11 The section should consist of the following members:

12 (A) The Secretary of Health and Human
13 Services or the Secretary's delegate.

14 (B) The commissioners of health or chief
15 health officer from the States of Texas, New
16 Mexico, Arizona, and California or such com-
17 missioners' delegates.

18 (C) Two individuals residing in United
19 States-Mexico Border Area in each of the
20 States of Texas, New Mexico, Arizona, and
21 California who are nominated by the chief exec-
22 utive officer of the respective States and ap-
23 pointed by the President from among individ-
24 uals—

1 (i) who have a demonstrated interest
2 or expertise in health issues of the United
3 States-Mexico Border Area; and

4 (ii) whose name appears on a list of
5 6 nominees submitted to the President by
6 the chief executive officer of the State
7 where the nominee resides.

8 (2) COMMISSIONER.—The Commissioner of the
9 United States section of the Commission should be
10 the Secretary of Health and Human Services or
11 such individual's delegate to the Commission. The
12 Commissioner should be the leader of the section.

13 (3) COMPENSATION.—Members of the United
14 States section of the Commission who are not em-
15 ployees of the United States—

16 (A) shall each receive compensation at a
17 rate of not to exceed the daily equivalent of the
18 annual rate of basic pay payable for positions
19 at GS-15 of the General Schedule under sec-
20 tion 5332 of title 5, United States Code, for
21 each day such member is engaged in the actual
22 performance of the duties of the Commission;
23 and

24 (B) shall be allowed travel expenses, in-
25 cluding per diem in lieu of subsistence at rates

1 authorized for employees of agencies under sub-
2 chapter I of chapter 57 of title 5, United States
3 Code, while away from their homes or regular
4 places of business in the performance of serv-
5 ices of the Commission.

6 (e) REGIONAL OFFICES.—The Commission should
7 designate or establish one border health office in each of
8 the States of Texas, New Mexico, Arizona, and California.
9 Such office should be located within the United States-
10 Mexico Border Area, and should be coordinated with—

11 (1) State border health offices; and

12 (2) local nonprofit organizations designated by
13 the State's governor and directly involved in border
14 health issues.

15 If feasible to avoid duplicative efforts, the Commission of-
16 fices should be located in existing State or local nonprofit
17 offices. The Commission should provide adequate com-
18 pensation for cooperative efforts and resources.

19 (f) REPORTS.—Not later than February 1 of each
20 year that occurs more than 1 year after the date of the
21 establishment of the Commission, the Commission should
22 submit an annual report to both the United States Gov-
23 ernment and the Government of Mexico regarding all ac-
24 tivities of the Commission during the preceding calendar
25 year.

1 (g) DEFINITIONS.—As used in this section:

2 (1) COMMISSION.—The term “Commission”
3 means the United States-Mexico Border Health
4 Commission.

5 (2) HEALTH PROBLEM.—The term “health
6 problem” means a disease or medical ailment or an
7 environmental condition that poses the risk of dis-
8 ease or medical ailment. Such term includes dis-
9 eases, ailments, or risks of disease or ailment caused
10 by or related to environmental factors, control of
11 animals and rabies, control of insect and rodent vec-
12 tors, disposal of solid and hazardous waste, and con-
13 trol and monitoring of air quality.

14 (3) RESIDENT ALIEN.—The term “resident
15 alien”, when used in reference to a country, means
16 an alien lawfully admitted for permanent residence
17 to the United States or otherwise permanently resid-
18 ing in the United States under color of law (includ-
19 ing residence as an asylee, refugee, or parolee).

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

22 (5) UNITED STATES-MEXICO BORDER AREA.—
23 The term “United States-Mexico Border Area”
24 means the area located in the United States and

1 Mexico within 100 kilometers of the border between
 2 the United States and Mexico.

3 **TITLE V—QUALITY AND**
 4 **CONSUMER PROTECTION**

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4 **SEC. 5001. NATIONAL QUALITY COUNCIL.**

5 (a) ESTABLISHMENT.—Not later than 1 year after
 6 the date of enactment of this Act, the National Health
 7 Board shall establish a council to be known as the Na-
 8 tional Quality Council to oversee a performance based pro-
 9 gram of quality management and improvement designed
 10 to enhance the quality, appropriateness, and effectiveness
 11 of health care services and access to such services.

12 (b) APPOINTMENT.—The National Quality Council
 13 shall consist of 15 members appointed by the President,
 14 with the advice and consent of the Senate, who are broadly
 15 representative of the population of the United States and
 16 shall include—

1 (1) individuals and health care providers distin-
2 guished in the fields of medicine, public health,
3 health care quality, and related fields of health serv-
4 ices research. Such members shall constitute at least
5 one-third of the Council's membership;

6 (2) individuals representing consumers of health
7 care services. Such members shall constitute at least
8 one-third of the Council's membership; and

9 (3) other individuals representing purchasers of
10 health care; health plans; States; and nationally rec-
11 ognized health care accreditation organizations.

12 (c) DUTIES.—The National Quality Council shall:

13 (1) develop national goals and performance
14 measures of quality;

15 (2) develop uniform quality goals and perform-
16 ance measures for plans;

17 (3) design and oversee national surveys of plans
18 and consumers;

19 (4) design and oversee the production of
20 Consumer Report Cards;

21 (5) establish and oversee State-based Quality
22 Improvement Foundations; and

23 (6) evaluate the impact of the implementation
24 of this Act on the quality of health care services in

1 the United States and the access of consumers to
2 such services.

3 (d) CONSULTATION.—In carrying out these duties,
4 the National Quality Council shall establish a process of
5 consultation with appropriate interested parties.

6 (e) TERMS.—

7 (1) IN GENERAL.—Except as provided in para-
8 graph (2), members of the Council shall serve for a
9 term of 4 years.

10 (2) STAGGERED ROTATION.—Of the members
11 first appointed to the Council under subsection (b),
12 the President shall appoint members to serve for a
13 term of between 1 and 4 years so that no more than
14 one third of the Council seats are vacated each year.

15 (3) SERVICE BEYOND TERM.—A member of the
16 Council may continue to serve after the expiration of
17 the term of the member until a successor is ap-
18 pointed.

19 (f) VACANCIES.—If a member of the Council does not
20 serve the full term applicable under subsection (e), the in-
21 dividual appointed to fill the resulting vacancy shall be ap-
22 pointed for the remainder of the term of the predecessor
23 of the individual.

24 (g) CHAIR.—The President shall designate an indi-
25 vidual to serve as the chair of the Council.

1 (h) MEETINGS.—The Council shall meet not less than
2 once during each 4-month period and shall otherwise meet
3 at the call of the President or the chair.

4 (i) COMPENSATION AND REIMBURSEMENT OF EX-
5 PENSES.—Members of the Council shall receive compensa-
6 tion for each day (including travel time) engaged in carry-
7 ing out the duties of the Council. Such compensation may
8 not be in an amount in excess of the maximum rate of
9 basic pay payable for level IV of the Executive Schedule
10 under section 5315 of title 5, United States Code.

11 (j) CONFLICTS OF INTEREST.—Members of the
12 Council shall disclose upon appointment to the Council or
13 at any subsequent time that it may occur, conflicts of in-
14 terest.

15 (k) STAFF.—The National Health Board shall pro-
16 vide to the Council such staff, information, and other as-
17 sistance as may be necessary to carry out the duties of
18 the Council.

19 (l) HEALTH CARE PROVIDER.—For purposes of this
20 subtitle, the term “health care provider” means an individ-
21 ual who, or entity that, provides an item or service to an
22 individual that is covered under the health plan (as de-
23 fined in section 1500) in which the individual is enrolled.

1 **SEC. 5002. NATIONAL GOALS AND PERFORMANCE MEAS-**
2 **URES OF QUALITY.**

3 (a) IN GENERAL.—The National Quality Council
4 shall develop a set of national goals and performance
5 measures of quality for both the general population and
6 for population subgroups defined by demographic charac-
7 teristics and health status. The goals and measures shall
8 incorporate standards identified by the Secretary of
9 Health and Human Services for meeting public health ob-
10 jectives utilizing, but not limited to, goals delineated in
11 Healthy People 2000.

12 (b) SUBJECT OF MEASURES.—National measures of
13 quality performance shall be selected in a manner that
14 provides statistical and other information on at least the
15 following subjects:

16 (1) Outcomes of health care services and proce-
17 dures.

18 (2) Health promotion.

19 (3) Prevention of diseases, disorders, and other
20 health conditions.

21 (4) Access to care and appropriateness of care.

22 **SEC. 5003. STANDARDS AND PERFORMANCE MEASURES**
23 **FOR HEALTH PLANS.**

24 (a) IN GENERAL.—The National Quality Council
25 shall establish national standards and performance meas-
26 ures for health plans, which may be used to assess the

1 provision of health care services and access to such serv-
2 ices, both for the general population and population
3 subgroups defined by demographic characteristics and
4 health status. In subject matter areas with which the Na-
5 tional Quality Council determines that sufficient informa-
6 tion and consensus exist, the Council shall establish goals
7 for performance by health plans consistent with the na-
8 tional goals and performance measures established under
9 section 5002. These quality measures shall relate to, at
10 a minimum:

11 (1) Access to health care services by consumers,
12 including provider to patient ratios, waiting times
13 for appointments, travel distances, and community
14 involvement and outreach.

15 (2) Appropriateness of health care services, in-
16 cluding failure to provide appropriate services and
17 continuity of care.

18 (3) Consumer satisfaction with care and compli-
19 ance with members rights, including disenrollment,
20 referral, patterns of claims denials and out-of-net-
21 work utilization patterns.

22 (4) Quality improvement and accountability, in-
23 cluding showing that the plan can continuously mon-
24 itor and improve the quality of health care provided.

25 (5) Provider credentialing and competency.

1 (6) Management of clinical, and administrative
2 and financial information.

3 (7) Utilization management including criteria
4 for monitoring underutilization, techniques and pro-
5 vider feedback to minimize interference with the pro-
6 vider-patient relationship, and supervision of utiliza-
7 tion determinations by qualified medical profes-
8 sionals.

9 (b) CERTIFICATION OF PLANS.—The National Qual-
10 ity Council shall provide information and technical assist-
11 ance to the Board and the States on the use of national
12 standards and performance measures in this section for
13 State certification of health plans.

14 **SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.**

15 (a) IN GENERAL.—The National Quality Council
16 shall conduct (either directly or through contract) periodic
17 surveys of health care consumers and plans to gather in-
18 formation concerning the quality measures established in
19 sections 5002 and 5003. The surveys shall monitor
20 consumer reaction to the implementation of this Act and,
21 in coordination with relevant data from health plans and
22 other sources, be designed to assess the impact of this Act
23 both for the general population of the United States and
24 for populations vulnerable to discrimination or to receiving

1 inadequate care due to health status, demographic charac-
2 teristics, or geographic location.

3 (b) SURVEY ADMINISTRATION AND DATA ANALY-
4 SIS.—The National Quality Council shall approve a stand-
5 ard design for the consumer surveys and sampling of rel-
6 evant plan data which shall be administered by the Admin-
7 istrator for Health Care Policy and Research or such other
8 appropriate entity the Council shall designate on a plan-
9 by-plan and State-by-State basis. Sufficient consumer sur-
10 vey and plan data shall be collected and verified to provide
11 for reliable and valid analysis. A State may add survey
12 questions on quality measures of local interest to surveys
13 conducted in the State. The plan-level survey shall include
14 a subset of consumer survey responses related to consumer
15 satisfaction, perceived health status, access, and such
16 other survey items designated by the Council.

17 (c) SAMPLING STRATEGIES.—The National Quality
18 Council shall approve sampling strategies that ensure that
19 appropriate survey samples adequately measure popu-
20 lations that are considered to be at risk of receiving inad-
21 equate health care or may be difficult to reach through
22 consumer-sampling methods, including individuals who—

- 23 (1) fail to enroll in a health plan;
24 (2) resign from a plan; or

1 (2) CONSUMER REPORT CARDS.—The health
2 plan reports shall be summarized in a consumer re-
3 port card as specified by the National Quality Coun-
4 cil and made available by the State to all individuals
5 in the State.

6 (3) QUALITY REPORTS.—The National Quality
7 Council annually shall provide recommendations to
8 the Congress, the National Health Board, and the
9 Secretary a summary report that—

10 (A) outlines in a standard format the per-
11 formance of each State;

12 (B) discusses State-level and national
13 trends relating to health care quality; and

14 (C) presents data for each State from
15 health plan reports and consumer surveys that
16 were conducted during the year that is the sub-
17 ject of the report.

18 (4) STATE REPORTS.—The National Quality
19 Council annually shall provide to each State a sum-
20 mary report that—

21 (A) outlines in a standard format the per-
22 formance of each health plan;

23 (B) discusses State-level and national
24 trends relating to health care quality; and

1 (C) presents data for each health plan
2 from health plan reports and consumer surveys
3 that were conducted during the year that is the
4 subject of the report.

5 (b) PUBLIC AVAILABILITY OF INFORMATION IN NA-
6 TIONAL PRACTITIONER DATA BANK ON DEFENDANTS,
7 AWARDS, AND SETTLEMENTS.—

8 (1) IN GENERAL.—Section 427(a) of the Health
9 Care Quality Improvement Act (42 U.S.C. 11137
10 (a)) is amended by adding at the end the following
11 new sentence: “Not later than January 1, 1996, the
12 Secretary shall promulgate regulations under which
13 individuals seeking to enroll in health plans under
14 the Health Security Act shall be able to obtain infor-
15 mation reported under this part with respect to phy-
16 sicians and other licensed health practitioners par-
17 ticipating in such plans for whom information has
18 been reported under this part on repeated occa-
19 sions.”.

20 (2) ACCESS TO DATA BANK FOR POINT-OF-
21 SERVICE CONTRACTORS UNDER MEDICARE.—Section
22 427(a) of such Act (42 U.S.C. 11137(a)) is amend-
23 ed—

1 (A) by inserting “to sponsors of point-of-
2 service networks under section 1990 of the So-
3 cial Security Act,”, and

4 (B) in the heading, by inserting “RELAT-
5 ED” after “CARE”.

6 **SEC. 5006. DEVELOPMENT AND DISSEMINATION OF PRAC-**
7 **TICE GUIDELINES.**

8 (a) DEVELOPMENT OF GUIDELINES.—The National
9 Quality Council may advise the Secretary and the Admin-
10 istrator for Health Care Policy and Research on priorities
11 for the development and periodic review and updating of
12 clinically relevant guidelines established under section 912
13 of the Public Health Service Act.

14 (b) HEALTH SERVICE UTILIZATION PROTOCOLS.—
15 The National Quality Council shall establish standards
16 and procedures for evaluating the clinical appropriateness
17 of protocols used to manage health service utilization.

18 **SEC. 5007. RESEARCH ON HEALTH CARE QUALITY.**

19 The National Quality Council may make rec-
20 ommendations to the Secretary and the Administrator for
21 Agency for Health Care Policy and Research concerning
22 priorities for research with respect to the quality, appro-
23 priateness, and effectiveness of health care.

1 **SEC. 5008. QUALITY IMPROVEMENT FOUNDATIONS.**

2 (a) ESTABLISHMENT.—The National Quality Council
3 shall oversee the operation of quality improvement founda-
4 tions to perform the duties specified in subsection (c).

5 (b) STRUCTURE AND MEMBERSHIP.—

6 (1) GRANT PROCESS.—The Secretary, in con-
7 sultation with the States and the Council, shall se-
8 lect a number of regional foundations through a
9 competitive grantmaking process. The Secretary
10 shall allow for foundations to serve only one State
11 if the State so requests.

12 (2) ELIGIBLE APPLICANTS.—Eligible applicants
13 shall meet the following conditions:

14 (A) The entity shall be a not-for-profit en-
15 tity.

16 (B) The entity shall have a board which
17 includes—

18 (i) representatives of health care pro-
19 viders from throughout the State, includ-
20 ing both practicing providers and experts
21 in the field of quality measurement and
22 improvement, which together shall com-
23 prise at least one-fourth of the advisory
24 board's membership;

25 (ii) at least one representative of Aca-
26 demic Health Centers or schools defined in

1 section 799 of the Public Health Service
2 Act, which shall comprise up to one-fourth
3 of the membership;

4 (iii) representatives of consumers, who
5 shall comprise one-fourth of the member-
6 ship; and

7 (iv) representatives of purchasers of
8 health care, health plans, the State, and
9 other interested parties.

10 (C) STAFFING.—Each entity shall have
11 sufficient, competent staff of experts possessing
12 the skills and knowledge necessary to enable the
13 foundation perform its duties.

14 (c) DUTIES.—

15 (1) IN GENERAL.—Each quality improvement
16 foundation shall carry out the duties described in
17 paragraph (2) for the region in which the foundation
18 is located. The foundation shall establish a program
19 of activities incorporating such duties and shall be
20 able to demonstrate the involvement of a broad
21 cross-section of the providers and health care insti-
22 tutions throughout the region. A foundation may
23 apply for and conduct research described in section
24 5007.

1 (2) DUTIES DESCRIBED.—The duties described
2 in this paragraph include the following:

3 (A) Collaboration with and technical assist-
4 ance to providers and health plans in ongoing
5 efforts to improve the quality of health care
6 provided to individuals in the State.

7 (B) Population-based monitoring of prac-
8 tice patterns and patient outcomes, and audit-
9 ing samples of such data to assure its validity.

10 (C) Developing programs in lifetime learn-
11 ing for health professionals to improve the qual-
12 ity of health care by ensuring that health pro-
13 fessionals remain abreast of new knowledge, ac-
14 quire new skills, and adopt new roles as tech-
15 nology and societal demands change.

16 (D) Disseminating information about suc-
17 cessful quality improvement programs, practice
18 guidelines, and research findings, including in-
19 formation on innovative staffing of health pro-
20 fessionals.

21 (E) Assist in developing innovative patient
22 education systems that enhance patient involve-
23 ment in decisions relating to their health care.

24 (F) Issuing a report to the public regard-
25 ing the foundation's activities for the previous

1 year including areas of success during the pre-
2 vious year and areas for opportunities in im-
3 proving health outcomes for the community,
4 and the adoption of guidelines.

5 (G) Providing notice to the State or appro-
6 priate entity if the foundation finds, after rea-
7 sonable opportunities for improvement, that a
8 provider or plan appears unwilling or unable to
9 successfully engage in quality improvement ac-
10 tivities related to the services described.

11 **SEC. 5009. AUTHORIZATION OF APPROPRIATIONS.**

12 For the purposes of carrying out this subtitle, there
13 are authorized to be appropriated such sums as may be
14 necessary for fiscal years 1995 through 2000.

15 **SEC. 5010. ROLE OF STATES IN QUALITY ASSURANCE.**

16 Each State shall—

17 (1) disseminate to consumers information relat-
18 ed to quality and access to aid in their selection of
19 plans in accordance with section 1206;

20 (2) disseminate information on the quality of
21 health plans and health care providers contained in
22 reports of the National Quality Council under sec-
23 tion 5005;

1 (B) measure the quality of health care fur-
2 nished to enrollees under the plan by all health
3 care providers of the plan.

4 **SEC. 5012. INFORMATION ON HEALTH CARE PROVIDERS.**

5 Each State shall make available to consumers, upon
6 request, information concerning providers of health care
7 services or supplies. Such information shall include—

8 (1) the identity of any provider that has been
9 convicted, under Federal or State law, of a criminal
10 offense relating to fraud, corruption, breach of fidu-
11 ciary responsibility, or other financial misconduct in
12 connection with the delivery of a health care service
13 or supply;

14 (2) the identity of any provider that has been
15 convicted, under Federal or State law, of a criminal
16 offense relating to neglect or abuse of patients in
17 connection with the delivery of a health care service
18 or supply;

19 (3) the identity of any provider that has been
20 convicted, under Federal or State law, of a criminal
21 offense relating to the unlawful manufacture, dis-
22 tribution, prescription, or dispensing of a controlled
23 substance; and

24 (4) the identity of any provider whose license to
25 provide health care services or supplies has been re-

1 voked, suspended, restricted, or not renewed, by a
2 State licensing authority for reasons relating to the
3 provider’s professional competence, professional per-
4 formance, or financial integrity, or any provider who
5 surrendered such a license while a formal discipli-
6 nary proceeding was pending before such an author-
7 ity, if the proceeding concerned the provider’s pro-
8 fessional competence, professional performance, or
9 financial integrity.

10 **SEC. 5013. CONFORMING AMENDMENTS TO PUBLIC**
11 **HEALTH SERVICE ACT.**

12 Title IX of the Public Health Service Act is amend-
13 ed—

14 (1) in section 903(a)(4) (42 U.S.C. 299a-
15 1(a)(4)), by inserting “and Quality Improvement
16 Foundations” after “health agencies”;

17 (2) in section 904(c)(1) (42 U.S.C. 299a-
18 2(c)(1)), by inserting “the National Quality Council
19 and” after “in consultation with”;

20 (3) in section 912(b)(4) (42 U.S.C. 299b-
21 1(b)(4))—

22 (A) by inserting “outcomes,” before
23 “risks”; and

1 (B) by inserting before the semicolon “to
2 the extent feasible given the availability of unbi-
3 ased, reliable, and valid data”;

4 (4) in section 914 (42 U.S.C. 299b-3)—

5 (A) in subsection (a)(2)(B)—

6 (i) by inserting “the National Quality
7 Council,” after “shall consult with”; and

8 (ii) by inserting before the period
9 “and relevant sections of the Health Secu-
10 rity Act”;

11 (B) in subsection (c), by inserting “Quality
12 Improvement Foundations and other” after
13 “carried out through”; and

14 (C) in subsection (f)—

15 (i) by striking “TO ADMINISTRATOR”
16 in the subsection heading;

17 (ii) by striking “Administrator” and
18 inserting “National Quality Council and
19 the”; and

20 (5) in section 927 (42 U.S.C. 299c-6), by add-
21 ing at the end thereof the following new paragraphs:

22 “(5) The term ‘National Quality Council’ means
23 the Council established under section 5001 of the
24 Health Security Act.

1 “(6) The term “Quality Improvement Founda-
2 tions” means the Foundations established under sec-
3 tion 5008 of the Health Security Act.”.

4 **Subtitle B—Information Systems,**
5 **Privacy, and Administrative**
6 **Simplification**

7 **PART 1—NATIONAL HEALTH CARE DATA**

8 **NETWORK**

9 **Subpart A—Purpose and Definitions**

10 **SEC. 5101. PURPOSE.**

11 It is the purpose of this part to improve the efficiency
12 and effectiveness of the health care system by requiring
13 health plans and health care providers in the health care
14 system to—

15 (1) standardize certain health care transactions
16 and data in a manner established by the Board;

17 (2) transmit standard index markers with re-
18 spect to such standardized data to entities that are
19 certified by the Board; and

20 (3) make standardized data electronically avail-
21 able for disclosure as authorized under this subtitle.

22 **SEC. 5102. DEFINITIONS.**

23 For purposes of this part:

24 (1) CERTIFIED CLEARINGHOUSE.—

1 (A) IN GENERAL.—The term “certified
2 clearinghouse” means a clearinghouse that is
3 certified under section 5109.

4 (B) CLEARINGHOUSE.—The term “clear-
5 inghouse” means a public or private entity that
6 has the ability to—

7 (i) process nonstandard health care
8 data into standard health care data; or

9 (ii) store standard health care data
10 and make such data available to another
11 entity.

12 (2) CERTIFIED INDEXING SYSTEM.—

13 (A) IN GENERAL.—The term “certified in-
14 dexing system” means an indexing system that
15 is certified under section 5109.

16 (B) INDEXING SYSTEM.—The term “index-
17 ing system” means a public or private entity
18 that stores standard index markers and has the
19 ability to comply with section 5108(b).

20 (3) HEALTH CARE DATA NETWORK.—The term
21 “health care data network” means the health care
22 information system that is formed through the appli-
23 cation of the requirements under this part.

24 (4) HEALTH CARE PROVIDER.—The term
25 “health care provider” includes a provider of services

1 (as defined in section 1861(u) of the Social Security
2 Act), a physician, a laboratory (as defined in section
3 353(a) of the Public Health Service Act), a supplier,
4 and any other person furnishing health care.

5 (5) HEALTH INFORMATION PROTECTION ORGA-
6 NIZATION.—The term “health information protection
7 organization” means a private entity or an entity op-
8 erated by a State that has the capability to access
9 standard health care data through entities in the na-
10 tional health care data network and process such
11 data into data that is non-identifiable health infor-
12 mation.

13 (6) HEALTH PLAN.—The term “health plan”
14 has the meaning given such term in section 1500
15 and includes—

16 (A) workers compensation or similar insur-
17 ance insofar as it relates to workers compensa-
18 tion medical benefits (as defined by the Board);

19 (B) automobile medical insurance insofar
20 as it relates to automobile insurance medical
21 benefits (as defined by the Board); and

22 (C) a Federal, State, or local program that
23 pays for, or provides directly for, the provision
24 of health care.

1 (7) INDEX MARKER.—The term “index marker”
2 means data that indicate the location of specific
3 standard health care data, the unique identifier of
4 the holder of such data, and information necessary
5 to access such data.

6 (8) NON-IDENTIFIABLE HEALTH INFORMA-
7 TION.—The term “non-identifiable health informa-
8 tion” means health care data that is not protected
9 health information as defined in section 5163.

10 (9) PROTECTED HEALTH INFORMATION.—The
11 term “protected health information” has the mean-
12 ing given such term in section 5163.

13 (10) STANDARD.—The term “standard” when
14 referring to a transaction or to data means the
15 transaction or data meets any standard established
16 by the Board under subpart D that applies to such
17 transaction or data.

18 **Subpart B—Requirements on Health Care Providers**
19 **and Health Plans**

20 **SEC. 5103. REQUIREMENTS WITH RESPECT TO CERTAIN**
21 **TRANSACTIONS AND DATA.**

22 (a) ENROLLMENT AND DISENROLLMENT DATA.—
23 With respect to each enrollment and disenrollment trans-
24 action, a health plan shall be responsible for ensuring the
25 transmission of a standard index marker for the standard

1 enrollment and disenrollment data described in section
2 5114(a)(1) to a certified indexing system.

3 (b) FINANCIAL AND ADMINISTRATIVE TRANS-
4 ACTIONS AND DATA.—

5 (1) FINANCIAL AND ADMINISTRATIVE TRANS-
6 ACTIONS.—Any financial and administrative trans-
7 action described in section 5113 that is conducted by
8 a health care provider or a health plan shall be con-
9 ducted in accordance with standards established by
10 the Board under such section and the financial and
11 administrative data transmitted in connection with
12 such a financial and administrative transaction shall
13 be standard data.

14 (2) FINANCIAL AND ADMINISTRATIVE DATA.—

15 (A) IN GENERAL.—A health plan shall be
16 responsible for ensuring the transmission to a
17 certified indexing system of a standard index
18 marker for any standard financial and adminis-
19 trative data held by a health plan as a result
20 of a financial and administrative transaction.

21 (B) SPECIAL RULE FOR CERTAIN HEALTH
22 PLANS.—In the case of a health plan that does
23 not file claims, such plan shall be responsible
24 for ensuring the transmission to a certified in-
25 dexing system of a standard index marker for

1 the financial and administrative data deter-
2 mined appropriate by the Board.

3 (c) QUALITY-RELATED PATIENT MEDICAL RECORD
4 DATA.—

5 (1) IN GENERAL.—A health care provider (in-
6 cluding a health care provider that consists of a
7 health maintenance organization) shall be respon-
8 sible for ensuring the transmission to a certified in-
9 dexing system of a standard index marker for the
10 standard quality-related patient medical record data
11 described in section 5114(a)(3).

12 (2) TRANSMISSION TO HEALTH PLANS.—A
13 health care provider may satisfy the requirement
14 under paragraph (1) by transmitting standard qual-
15 ity-related patient medical record data to a health
16 plan. If a health care provider transmits data in ac-
17 cordance with the preceding sentence, the health
18 plan to which such data is transmitted shall be re-
19 sponsible for ensuring the transmission of a stand-
20 ard index marker for such data to a certified index-
21 ing system.

22 (3) REQUIREMENTS NOT APPLICABLE TO COM-
23 PLETE MEDICAL RECORDS.—Nothing in this section
24 shall be construed as preventing a health service
25 provider or health benefit plan from storing and

1 maintaining patient medical records in a form and
2 manner selected by such providers or plans (so long
3 as such providers and plans are able to comply with
4 the reporting requirements of this subtitle).

5 (d) GOVERNMENT REQUIRED DATA.—A health plan
6 or health care provider shall be responsible for ensuring
7 the transmission to a certified indexing system of a stand-
8 ard index marker for the standard Government required
9 data described in section 5114(a)(5).

10 (e) SATISFACTION OF REQUIREMENTS.—

11 (1) FINANCIAL AND ADMINISTRATIVE DATA.—A
12 health care provider or health plan may satisfy the
13 requirement imposed on such provider or plan under
14 subsection (b)(1) by—

15 (A) directly transmitting standard finan-
16 cial and administrative data; or

17 (B) submitting nonstandard financial and
18 administrative data to a certified clearinghouse
19 for processing into standard data and trans-
20 mission.

21 (2) INDEX MARKERS.—A health care provider
22 or health plan may satisfy a requirement imposed on
23 such provider or plan under subsection (a), (b)(2),
24 (c), or (d) by—

1 (A) transmitting a standard index marker
2 for standard data directly to a certified index-
3 ing system; or

4 (B) entering into a contract with a cer-
5 tified clearinghouse under which the clearing-
6 house transmits a standard index marker for
7 such data directly to a certified indexing sys-
8 tem.

9 (3) TIMELINESS.—A health care provider or
10 health plan shall be determined to have satisfied a
11 requirement imposed under subsection (a), (b), (c),
12 or (d) only if the action required under such sub-
13 section is completed in a timely manner, as deter-
14 mined by the Board.

15 (f) FORMS NOT TO INCLUDE PATIENT MEDICAL
16 RECORDS.—Nothing in this section shall be construed as
17 giving the National Health Board the authority to require
18 the disclosure and transmission of complete patient medi-
19 cal records without Congressional approval.

20 (g) ENFORCEMENT.—The National Health Board
21 shall ensure that the requirements of this part are satis-
22 fied.

1 **SEC. 5104. AVAILABILITY OF STANDARD HEALTH CARE**
2 **DATA.**

3 (a) IN GENERAL.—A health care provider or health
4 plan shall be capable of disclosing all standard health care
5 data with respect to which a standard index marker has
6 been transmitted to a certified indexing system under sec-
7 tion 5103 when such disclosure is authorized under part
8 2.

9 (b) SATISFACTION.—A health care provider or health
10 plan may satisfy the requirement imposed under sub-
11 section (a) by—

12 (1) being capable of disclosing standard health
13 care data directly; or

14 (2) entering into a contract with a certified
15 clearinghouse under which the clearinghouse is capa-
16 ble of disclosing such data.

17 (c) CONSTRUCTION.—Nothing in this section shall be
18 construed to require a health plan or health care provider
19 to disclose health care data under this section.

20 **SEC. 5105. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**
21 **MENTS.**

22 (a) INITIAL COMPLIANCE.—

23 (1) IN GENERAL.—Not later than 12 months
24 after the date on which standards are established
25 under subpart D with respect to a type of financial
26 and administrative transaction, a type of data, or

1 index markers for such data a health plan or health
2 care provider shall comply with the requirements of
3 this subpart with respect to such transaction, data,
4 or index marker.

5 (2) ADDITIONAL DATA.—Not later than 12
6 months after the date on which the Board makes an
7 addition to a set of health care data under subpart
8 D, a health plan or health care provider shall comply
9 with the requirements of this subpart with respect to
10 such data.

11 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

12 (1) IN GENERAL.—If the Board modifies a
13 standard established under subpart D, a health plan
14 or health care provider shall be required to transmit
15 or receive data in accordance with the modified
16 standard at such time as the Board determines ap-
17 propriate taking into account the time needed to
18 comply due to the nature and extent of the modifica-
19 tion.

20 (2) SPECIAL RULE.—In the case of modifica-
21 tions to standards that do not occur within the 12-
22 month period beginning on the date such standards
23 are established, the time determined appropriate by
24 the Board under paragraph (1) shall be no sooner
25 than the last day of the 90-day period beginning on

1 the date such modified standard is established and
2 no later than the last day of the 12-month period
3 beginning on the date such modified standard is es-
4 tablished.

5 **SEC. 5106. PREEMPTION OF STATE “QUILL PEN” LAWS.**

6 A requirement under this part or a standard estab-
7 lished by the Board under this part shall supersede any
8 contrary provision of State law, including a provision of
9 State law that requires medical or health plan records (in-
10 cluding billing information) to be maintained in written
11 rather than electronic form, except where the Board deter-
12 mines that the provision is necessary to prevent fraud and
13 abuse, with respect to controlled substances, or for other
14 purposes.

15 **Subpart C—Standards and Certification for Indexing**
16 **Systems and Clearinghouses**

17 **SEC. 5108. ESTABLISHMENT OF STANDARDS.**

18 (a) IN GENERAL.—The Board shall establish stand-
19 ards with respect to the operation of indexing systems and
20 clearinghouses, including standards ensuring that—

21 (1) such entities develop, operate, and cooperate
22 with one another to form a national health care data
23 network;

24 (2) such entities meet all of the requirements
25 under part 2 that are applicable to such entities;

1 (3) such entities make public information con-
2 cerning their performance, as measured by uniform
3 indicators such as accessibility, transaction respon-
4 siveness, administrative efficiency, reliability, de-
5 pendability, and any other indicator determined ap-
6 propriate by the Board;

7 (4) such entities have the highest security pro-
8 cedures that are practicable with respect to the proc-
9 essing of health care data; and

10 (5) indexing systems meet the additional re-
11 quirements for such systems described in subsection
12 (b).

13 (b) ADDITIONAL REQUIREMENTS FOR INDEXING
14 SYSTEMS.—The additional requirements for indexing sys-
15 tems that are referred to in subsection (a)(6) are as fol-
16 lows:

17 (1) INDEXING STANDARD HEALTH CARE
18 DATA.—An indexing system shall have the capability
19 to index the standard health care data that is made
20 available to the system.

21 (2) INTEROPERABILITY.—

22 (A) AVAILABILITY OF DATA.—An indexing
23 system shall make any index marker received by
24 such system pursuant to the requirements of
25 subpart B available to all other certified index-

1 ing systems operating in the national health
2 care data network.

3 (B) ABILITY TO ACCESS DATA.—An index-
4 ing system shall have the ability to receive
5 index markers from all other certified indexing
6 systems operating in the national health care
7 data network.

8 (3) RATES CHARGED.—The rate that an index-
9 ing system applies to a service performed for an-
10 other indexing system shall not exceed the amount
11 of the weighted average of the rates such system ap-
12 plies to the same service performed for health plans
13 or health care providers.

14 (c) TIMETABLE FOR ESTABLISHMENT.—The Board
15 shall establish standards under this section not later than
16 9 months after the date of the enactment of this part.

17 **SEC. 5109. CERTIFICATION PROCEDURE.**

18 (a) IN GENERAL.—Not later than 12 months after
19 the date of the enactment of this part, the Board shall
20 establish a certification procedure for indexing systems
21 and clearinghouses which ensures that certified entities
22 are qualified to meet the requirements of this subtitle.

23 (b) APPLICATION.—The procedure established by the
24 Board under subsection (a) shall provide that each entity
25 described in such subsection desiring to be certified as an

1 indexing system or clearinghouse shall apply to the Board
2 for certification in such form and in such manner as the
3 Board determines appropriate.

4 (c) AUDITS AND REPORTS.—The procedure estab-
5 lished under subsection (a) shall provide for audits by the
6 Board and reports by certified entities at such intervals
7 as the Board determines appropriate in order to monitor
8 compliance with the standards established under section
9 5108.

10 (d) RECERTIFICATION.—An indexing system or clear-
11 inghouse must be recertified under this section at least
12 every 3 years.

13 (e) LOSS OF CERTIFICATION.—

14 (1) MANDATORY TERMINATION.—If an indexing
15 system or clearinghouse violates a requirement im-
16 posed on such system or clearinghouse under part 2,
17 the entity's certification under this section shall be
18 terminated unless the Board determines that appro-
19 priate corrective action has been taken.

20 (2) DISCRETIONARY TERMINATION.—If an in-
21 dexing system or clearinghouse violates a require-
22 ment of this part and a penalty has been imposed
23 under section 5124 with respect to such violation,
24 the Board shall review the certification of such sys-

1 (1) require the use of data that are verifiable,
2 timely, accurate, reliable, useful, complete, and rel-
3 evant;

4 (2) establish standards that are consistent with
5 the objective of reducing the costs of providing and
6 paying for health care;

7 (3) incorporate standards in use and generally
8 accepted that are recommended by recognized public
9 or private standard setting or development groups,
10 including the American National Standard Insti-
11 tute's ASC X12, the Healthcare Informatics Stand-
12 ards Planning Panel, and the Department of Health
13 and Human Services; and

14 (4) promote the development of standards nec-
15 essary to fulfill the requirements of this Act.

16 The Board shall insure that new standards are developed
17 in collaboration with Federal health agencies, participat-
18 ing States, health plans, representatives of providers, em-
19 ployers and consumers, experts in public health, and na-
20 tionally recognized standard setting groups.

21 **SEC. 5113. FINANCIAL AND ADMINISTRATIVE TRANS-**
22 **ACTIONS.**

23 (a) IN GENERAL.—The Board shall establish the
24 standards necessary for health care providers and health

1 plans to conduct the following transactions relating to the
2 financing or administering of health care:

3 (1) Eligibility.

4 (2) Payment and remittance advice.

5 (3) Claims.

6 (4) Encounters.

7 (5) Claims status.

8 (6) Coordination of benefits.

9 (7) First report of injury.

10 (8) Claim attachments.

11 (9) Referrals, certification, and authorization.

12 (10) Any other transactions determined appro-
13 priate by the Board.

14 (b) SPECIAL RULE.—Any standards established by
15 the Board under subsection (a) that relate to coordination
16 of benefits shall be consistent with the rules and proce-
17 dures developed by the Board under section 5127.

18 **SEC. 5114. ELEMENTS OF HEALTH CARE DATA.**

19 (a) IN GENERAL.—The Board shall establish stand-
20 ards necessary to make the following health care data uni-
21 form and compatible for electronic transmission through
22 a national health care data network:

23 (1) enrollment and disenrollment data;

24 (2) financial and administrative data that the
25 Board determines is appropriate for transmission in

1 connection with a financial and administrative trans-
2 action described in section 5113;

3 (3) a set of quality-related patient medical
4 record data that the Board determines is necessary
5 in order to conduct meaningful quality measure-
6 ment;

7 (4) patient medical record data that is not in-
8 cluded in a set of quality-related patient medical
9 record data established by the Board under para-
10 graph (3);

11 (5) a set of health care data that is not de-
12 scribed in paragraphs (1) through (3) and that is re-
13 quired by the Board, a State, or the National Center
14 for Consumer Advocacy for such entity to perform
15 its functions under this Act.

16 (b) ADDITIONS.—The Board may make additions to
17 the sets of health care data established under paragraphs
18 (1), (2), (3), and (5) of subsection (a) as the Board deter-
19 mines appropriate.

20 (c) CERTAIN DATA ELEMENTS.—

21 (1) UNIQUE IDENTIFIERS.—The Board shall es-
22 tablish a system to provide for a unique identifier
23 for each individual, employer, health plan, and
24 health care provider.

1 (2) CODE SETS.—The Board shall select code
2 sets for any appropriate data elements from among
3 the code sets that are maintained by private and
4 public entities such as the American National Stand-
5 ards Institute, the National Uniform Billing Com-
6 mittee, or the Department of Health and Human
7 Services.

8 (d) FORMAT OF DATA ELEMENTS.—The Board shall
9 establish standards with respect to the format in which
10 data elements shall be transmitted.

11 (e) DEFINITIONS.—For purposes of this section:

12 (1) DEFINITION.—The term “code set” means
13 any set of codes used for encoding data elements, in-
14 cluding tables of terms, medical diagnostic codes, or
15 medical procedure codes.

16 (2) PATIENT MEDICAL RECORD DATA DE-
17 FINED.—The term “patient medical record data”
18 means health care data derived from a clinical en-
19 counter that relates to the physical or mental condi-
20 tion of an individual and that is not financial and
21 administrative data.

22 (3) QUALITY MEASUREMENT DEFINED.—The
23 term “quality measurement” means monitoring and
24 measuring the quality of health care consistent with

1 the measures established by the National Quality
2 Council under section 5002.

3 **SEC. 5115. INDEX MARKERS.**

4 The Board shall establish the standards necessary for
5 a health care provider or health plan to ensure the trans-
6 mission of an index marker with respect to standard
7 health care data to a certified indexing system.

8 **SEC. 5116. TIMETABLES FOR ESTABLISHMENT.**

9 (a) INITIAL STANDARDS.—The Board shall establish
10 standards relating to—

11 (1) financial and administrative transactions
12 not later than 9 months after the date of the enact-
13 ment of this part (except in the case of standards
14 for claims attachments which shall be established
15 not later than 24 months after the date of the enact-
16 ment of this part);

17 (2) the first set of enrollment data not later
18 than 9 months after the date of the enactment of
19 this part;

20 (3) financial and administrative data not later
21 than 9 months after the date of the enactment of
22 this part (except in the case of standards with re-
23 spect to data transmitted in connection with claims
24 attachments which shall be established not later

1 than 24 months after the date of the enactment of
2 this part);

3 (4) the first set of quality-related patient medi-
4 cal record data not later than 24 months after the
5 date of the enactment of this part;

6 (5) patient medical record data that is not in-
7 cluded in a set of quality-related patient medical
8 record data not later than 7 years after the date of
9 the enactment of this part;

10 (6) the first set of Government required data
11 not later than 9 months after the date of the enact-
12 ment of this part;

13 (7) index markers for standard data not later
14 than 9 months after the date of the enactment of
15 this part; and

16 (8) any addition to a set of health care data
17 under this part, in conjunction with making such an
18 addition.

19 (b) MODIFICATIONS TO STANDARDS.—

20 (1) IN GENERAL.—Except as provided in para-
21 graph (2), the Board shall review the standards es-
22 tablished under this subpart no more frequently
23 than every 6 months but at least every 12 months,
24 and shall modify such standards as determined ap-
25 propriate.

1 (2) SPECIAL RULES.—

2 (A) MODIFICATIONS DURING FIRST 12-
3 MONTH PERIOD.—The Board shall not modify
4 any standards established under this subpart
5 during the 12-month period beginning on the
6 date such standards are established unless the
7 Board determines that a modification is nec-
8 essary in order to permit health plans and
9 health care providers to comply with the re-
10 quirements of subpart B.

11 (B) CODE SETS.—

12 (i) RECOMMENDED MODIFICATIONS.—
13 The Board shall establish a procedure
14 under which an entity described in section
15 5114(b)(2)(A) may submit any modifica-
16 tion to a code set selected by the Board
17 that is determined appropriate by the en-
18 tity.

19 (ii) ADDITIONAL RULES.—A code set
20 selected by the Board may not be modified
21 more frequently than once annually unless
22 the Board determines that a modification
23 is necessary in order to permit health
24 plans and health care providers to comply
25 with the requirements of subpart B. If

1 such a code set is modified under the pre-
2 ceding sentence, the modified set shall in-
3 clude instructions on how data elements
4 that were encoded prior to such modifica-
5 tion are to be converted or translated so as
6 to preserve the value of the elements. Any
7 modification under this subparagraph shall
8 be implemented in a manner that mini-
9 mizes the disruption and cost to health
10 plans and health care providers of comply-
11 ing with such modification.

12 (C) EVALUATION OF STANDARDS.—The
13 Board may establish a process to measure or
14 verify the consistency of standards established
15 or modified under this subpart with the require-
16 ments of this Act. Such process may include
17 demonstration projects and analyses of the
18 costs of implementation of such standards and
19 modifications.

20 **Subpart E—Accessing Health Care Data**

21 **SEC. 5117. ACCESSING FINANCIAL AND ADMINISTRATIVE**
22 **DATA IN CONNECTION WITH A FINANCIAL**
23 **AND ADMINISTRATIVE TRANSACTION.**

24 The Board shall establish technical standards under
25 which a health care provider or health plan may access

1 financial and administrative data through entities in the
2 national health care data network in connection with a fi-
3 nancial and administrative transaction when such access
4 is authorized under part 2.

5 **SEC. 5118. ACCESSING DATA FOR AUTHORIZED PURPOSES.**

6 The Board shall establish technical standards that
7 shall apply to any request to access standard health care
8 data that is not described in section 5117, including
9 standards relating to access by enrollees, through entities
10 in the national health care data network. Such technical
11 standards shall provide any such request shall be satis-
12 fied—

13 (1) if the request is for data that is protected
14 health information and is authorized for disclosure
15 under part 2; or

16 (2) if the request is for data that is non-identi-
17 fiable health information, by obtaining such data
18 through a health information protection organization
19 certified under section 5119.

20 **SEC. 5119. HEALTH INFORMATION PROTECTION ORGANIZA-**
21 **TIONS.**

22 (a) RIGHT TO ACCESS DATA.—The Board shall es-
23 tablish standards under which a health information pro-
24 tection organization that is certified under subsection (d)

1 may access health care data through entities in the na-
2 tional health care data network.

3 (b) LIMITATION ON DISCLOSURE.—A health informa-
4 tion protection organization that is certified under sub-
5 section (d) may disclose health care data—

6 (1) if the data is non-identifiable health infor-
7 mation; or

8 (2) if the data is protected health care informa-
9 tion only when such disclosure is authorized under
10 part 2.

11 (c) STANDARDS FOR OPERATION.—The Board shall
12 establish standards with respect to the operation of health
13 information protection organizations, including standards
14 ensuring that such organizations have the highest security
15 procedures that are practicable with respect to processing
16 health care data.

17 (d) CERTIFICATION BY THE BOARD.—

18 (1) ESTABLISHMENT.—Not later than 12
19 months after the date of the enactment of this part,
20 the Board shall establish a certification procedure
21 for health information protection organizations
22 which ensures that certified organizations are quali-
23 fied to meet the requirements of this section.

24 (2) APPLICATION.—Each entity desiring to be
25 certified as a health information protection organiza-

1 tion shall apply to the Board for certification in a
2 form and manner determined appropriate by the
3 Board.

4 (3) AUDITS AND REPORTS.—The procedure es-
5 tablished under paragraph (1) shall provide for au-
6 dits by the Board and reports by an entity certified
7 under paragraph (2) at such intervals as the Board
8 determines appropriate in order to monitor such en-
9 tity’s compliance with the requirements of this sec-
10 tion and the standards established by the Board
11 under this section.

12 (4) RECERTIFICATION.—A health information
13 protection organization must be recertified under
14 this subsection at least every 3 years.

15 (e) LOSS OF CERTIFICATION.—

16 (1) MANDATORY TERMINATION.—If a health in-
17 formation protection organization violates a require-
18 ment imposed on such organization under part 2,
19 the organization’s certification under this section
20 shall be terminated unless the Board determines
21 that appropriate corrective action has been taken.

22 (2) DISCRETIONARY TERMINATION.—If a health
23 information protection organization violates a re-
24 quirement of this part, the Board shall review the

1 certification of such organization and may terminate
2 such certification.

3 **SEC. 5120. ACCESS BY THE BOARD AND OTHER FEDERAL**
4 **AGENCIES.**

5 (a) IN GENERAL.—The Board or any other Federal
6 agency may access health care data through entities in the
7 national health care data network only when authorized
8 under part 2.

9 (b) ACCESS THROUGH HEALTH INFORMATION PRO-
10 TECTION ORGANIZATIONS.—

11 (1) IN GENERAL.—Health information protec-
12 tion organizations certified under section 5119 shall
13 make available to the Board or another Federal
14 agency pursuant to a cost reimbursement contract
15 (as defined under the Federal Acquisition Regula-
16 tion), any health care information that is requested
17 by such agency.

18 (2) CERTAIN INFORMATION AVAILABLE TO
19 HEALTH INFORMATION PROTECTION ORGANIZATIONS
20 AT NO CHARGE.—If a health information protection
21 organization needs data from a health plan or health
22 care provider in order to comply with a request of
23 the Board or another a Federal agency under para-
24 graph (1) that relates to a requirement on such
25 agency under this Act, such plan or provider shall

1 make such data available to such organization at no
2 charge.

3 (c) DISCLOSURE.—

4 (1) IN GENERAL.—Health care data accessed
5 by the Board or another Federal agency under this
6 section shall be disclosed only as authorized under
7 the provisions of this Act.

8 (2) DISCLOSURE FOR PUBLIC USE FUNC-
9 TIONS.—The Board and any other Federal agency
10 shall make the non-identifiable health care informa-
11 tion accessed by such agency under this section
12 available to private, not-for-profit organizations for
13 public use functions (as determined by the Board
14 through regulations) in an affordable and timely
15 manner.

16 **SEC. 5121. ACCESS TO HEALTH CARE DATA BY THE STATES.**

17 (a) IN GENERAL.—The Board shall establish stand-
18 ards under which a State may access health care data
19 through entities in the national health care data network.

20 (b) ACCESS THROUGH HEALTH INFORMATION PRO-
21 TECTION ORGANIZATIONS.—Health information protec-
22 tion organizations certified under section 5119 shall make
23 health care data available to the States in accordance with
24 section 5119 pursuant to a cost reimbursement contract
25 (as defined under the Federal Acquisition Regulation).

1 **SEC. 5122. LENGTH OF TIME DATA SHOULD BE ACCES-**
2 **SIBLE.**

3 The Board shall establish standards with respect to
4 the length of time any specific standard health care data
5 should be accessible through the health care data network.

6 **SEC. 5123. TIMETABLES FOR ESTABLISHMENT AND COM-**
7 **PLIANCE.**

8 (a) INITIAL STANDARDS.—The Board shall establish
9 standards under this subpart not later than 9 months
10 after the date of the enactment of this part and such
11 standards shall be effective upon establishment.

12 (b) MODIFICATIONS TO STANDARDS.—

13 (1) IN GENERAL.—Except as provided in para-
14 graph (2), the Board shall review the standards es-
15 tablished under this subpart no more frequently
16 than every 6 months but at least every 12 months,
17 and shall modify such standards as determined ap-
18 propriate by the Board. Any modifications to stand-
19 ards established under this subpart shall be effective
20 upon establishment.

21 (2) SPECIAL RULE.—The Board shall not mod-
22 ify any standards established under this subpart
23 during the 12-month period beginning on the date
24 such standards are established unless the Board de-
25 termines that a modification is necessary in order to

1 permit compliance with the requirements of this sub-
2 part.

3 **Subpart F—Penalties**

4 **SEC. 5124. GENERAL PENALTY FOR FAILURE TO COMPLY**
5 **WITH REQUIREMENTS AND STANDARDS.**

6 (a) IN GENERAL.—Except as provided in section
7 5125, the Board shall impose on a health plan, health care
8 provider, indexing system, or clearinghouse that violates
9 a requirement or standard imposed under this part a pen-
10 alty of not more than \$1,000 for each violation. The provi-
11 sions of section 1128A of the Social Security Act (other
12 than subsections (a) and (b) and the second sentence of
13 subsection (f)) shall apply to the imposition of a civil
14 money penalty under this subsection in the same manner
15 as such provisions apply to the imposition of a penalty
16 under section 1128A of such Act.

17 (b) LIMITATIONS.—

18 (1) NONCOMPLIANCE NOT DISCOVERED EXER-
19 CISING REASONABLE DILIGENCE.—A penalty may
20 not be imposed under subsection (a) if it is estab-
21 lished to the satisfaction of the Board that the per-
22 son liable for the penalty did not know, and by exer-
23 cising reasonable diligence would not have known,
24 that such person failed to comply with the require-
25 ment or standard described in subsection (a).

1 (2) FAILURES DUE TO REASONABLE CAUSE.—

2 (A) IN GENERAL.—Except as provided in
3 subparagraphs (B) and (C), a penalty may not
4 be imposed under subsection (a) if—

5 (i) the failure to comply was due to
6 reasonable cause and not to willful neglect;
7 and

8 (ii) the failure to comply is corrected
9 during the 30-day period beginning on the
10 1st date the person liable for the penalty
11 knew, or by exercising reasonable diligence
12 would have known, that the failure to com-
13 ply occurred.

14 (B) PLANS AND PROVIDERS.—

15 (i) NO PENALTY.—If a health plan or
16 health care provider demonstrates to the
17 Board that a failure to comply occurred
18 because the plan or provider was unable to
19 comply, no penalty may be imposed under
20 subsection (a) until such time as the plan
21 or provider is able to comply.

22 (ii) ASSISTANCE.—The Board shall
23 provide technical assistance to a health
24 plan or health care provider described in
25 clause (i) to obtain compliance. Such as-

1 sistance shall be provided in any manner
2 determined appropriate by the Board.

3 (C) INDEXING SYSTEMS AND CLEARING-
4 HOUSES.—In the case of an indexing system or
5 clearinghouse, the period referred to in sub-
6 paragraph (A)(ii) may be extended as deter-
7 mined appropriate by the Board based on the
8 nature and extent of the failure to comply.

9 (3) REDUCTION.—In the case of a failure to
10 comply which is due to reasonable cause and not to
11 willful neglect, any penalty under subsection (a) that
12 is not entirely waived under paragraph (2) may be
13 waived to the extent that the payment of such pen-
14 alty would be excessive relative to the compliance
15 failure involved.

16 **SEC. 5125. PENALTIES RELATING TO ACCESSING DATA.**

17 A person who violates a standard established under
18 sections 5117, 5118, and 5119 shall—

19 (1) be fined not more than \$50,000, imprisoned
20 not more than 1 year, or both;

21 (2) if the offense is committed under false pre-
22 tenses, be fined not more than \$100,000, imprisoned
23 not more than 5 years, or both; and

24 (3) if the offense is committed with intent to
25 sell, transfer, or use health care data for commercial

1 advantage, personal gain, or malicious harm, fined
2 not more than \$250,000, imprisoned not more than
3 10 years, or both.

4 **Subpart G—Miscellaneous**

5 **SEC. 5126. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

6 (a) IN GENERAL.—A health plan or health care pro-
7 vider may not impose a standard on another plan or pro-
8 vider that is in addition to the standards established by
9 the Board under this part unless—

10 (1) such plan or provider voluntarily agrees to
11 such standard; or

12 (2) a waiver is granted under subsection (b) to
13 establish such standard.

14 (b) CONDITIONS FOR WAIVERS.—

15 (1) IN GENERAL.—A health plan or health care
16 provider may request a waiver from the Board in
17 order to require another plan or provider to comply
18 with a standard that is in addition to the standards
19 imposed by the Board under this part.

20 (2) CONSIDERATION OF WAIVER REQUESTS.—

21 In determining whether to grant a waiver under this
22 subsection the Board shall consider the value of the
23 data to be exchanged for research or other purposes
24 determined appropriate by the Board, the adminis-
25 trative cost of the additional standard, the burden of

1 the additional standard, and the burden of the tim-
2 ing of the imposition of the additional standard.

3 (3) ANONYMOUS REPORTING.—If a health plan
4 or health care provider attempts to impose a stand-
5 ard in addition to the standards imposed under this
6 part, the plan or provider on which such additional
7 standard is being imposed may contact the Board.
8 The Board shall develop a procedure under which
9 the contacting plan or provider shall remain anony-
10 mous. The Board shall notify the plan or provider
11 imposing the additional standard that the additional
12 standard may not be imposed unless the other plan
13 or provider voluntarily agrees to such standard or a
14 waiver is obtained under this subsection.

15 **SEC. 5127. RULES REGARDING COORDINATION OF BENE-**
16 **FITS.**

17 Not later than 9 months after the date of the enact-
18 ment of this part, the Board shall develop rules and proce-
19 dures for determining and coordinating the financial obli-
20 gations of health plans when health care benefits are pay-
21 able under 2 or more health plans.

22 **SEC. 5128. EFFECT ON STATE LAW.**

23 (a) IN GENERAL.—Except as provided in subsection
24 (b), the provisions of this part shall supersede any provi-

1 sions of the law of any State to the extent that the provi-
2 sions of this part conflict with such provisions of law.

3 (b) EXCEPTION.—Nothing in this part shall super-
4 sede any provision of State law that requires health plans
5 or health care providers to use an indexing system or a
6 clearinghouse that is certified under section 5109 and that
7 is operated by the State to satisfy the requirements im-
8 posed on such plan or provider under subpart B.

9 **SEC. 5129. HEALTH CARE DATA CONTINUITY.**

10 (a) DATA HELD BY HEALTH PLANS AND PROVID-
11 ERS.—Any health care data held by a health plan or
12 health care provider that ceases to function shall be ob-
13 tained by the State in connection with the execution of
14 the State’s responsibilities under section 1204. The State
15 shall ensure that such health care data is transferred to
16 a health plan or health care provider under procedures de-
17 veloped by the Board.

18 (b) DATA HELD BY INDEXING SYSTEMS AND CLEAR-
19 INGHOUSES.—If an indexing system or clearinghouse is
20 decertified or ceases to function in a manner that would
21 threaten the continued existence of health care data or
22 index markers held by such system or clearinghouse, such
23 data or index markers shall be transferred to a certified
24 indexing system or clearinghouse designated by the Board.

1 **SEC. 5130. PROTECTION OF COMMERCIAL INFORMATION.**

2 In establishing standards under this part, the Board
3 shall ensure that the trade secrets and confidential com-
4 mercial information of entities operating in the health care
5 data network is protected from—

6 (1) use other than as described in this title; and

7 (2) release to or access by third parties.

8 **SEC. 5131. AUTHORIZATION OF APPROPRIATIONS.**

9 There are authorized to be appropriated such sums
10 as may be necessary for each of the fiscal years 1995
11 through 2000, to carry out the purposes of this subtitle.

12 **Subpart H—Assistance to the Board**

13 **SEC. 5132. GENERAL REQUIREMENT ON BOARD.**

14 In complying with any requirements imposed under
15 this part, the Board shall rely on recommendations of the
16 Health Care Data Advisory Panel established under sec-
17 tion 5133 and shall consult with appropriate Federal
18 agencies.

19 **SEC. 5133. HEALTH CARE DATA ADVISORY PANEL.**

20 (a) ESTABLISHMENT.—There is established a panel
21 to be known as the Health Care Data Advisory Panel.

22 (b) DUTY.—The panel shall provide assistance to the
23 Board in complying with the requirements imposed on the
24 Board under this part and part 2. In performing such
25 duty, the Panel shall receive technical assistance from ap-
26 propriate Federal agencies.

1 (c) MEMBERSHIP.—

2 (1) IN GENERAL.—The Panel shall consist of
3 15 members to be appointed by the President not
4 later than 60 days after the date of the enactment
5 of this part. The Panel shall designate 1 member as
6 the Chair.

7 (2) EXPERTISE.—The membership of the Panel
8 shall consist of individuals who are of recognized
9 standing and distinction and who possess the dem-
10 onstrated capacity to discharge the duties imposed
11 on the Panel.

12 (3) TERMS.—Each member of the Panel shall
13 be appointed for a term of 5 years, except that the
14 members first appointed shall serve staggered terms
15 such that the terms of no more than 3 members ex-
16 pire at one time.

17 (4) VACANCIES.—

18 (A) IN GENERAL.—A vacancy on the Panel
19 shall be filled in the manner in which the origi-
20 nal appointment was made and shall be subject
21 to any conditions which applied with respect to
22 the original appointment.

23 (B) FILLING UNEXPIRED TERM.—An indi-
24 vidual chosen to fill a vacancy shall be ap-

1 pointed for the unexpired term of the member
2 replaced.

3 (C) EXPIRATION OF TERMS.—The term of
4 any member shall not expire before the date on
5 which the member's successor takes office.

6 (5) CONFLICTS OF INTEREST.—Members of the
7 Panel shall disclose upon appointment to the Panel
8 or at any subsequent time that it may occur, con-
9 flicts of interest.

10 (d) MEETINGS.—

11 (1) IN GENERAL.—Except as provided in para-
12 graph (2), the Panel shall meet at the call of the
13 Chair.

14 (2) INITIAL MEETING.—Not later than 30 days
15 after the date on which all members of the Panel
16 have been appointed, the Panel shall hold its first
17 meeting.

18 (3) QUORUM.—A majority of the members of
19 the Panel shall constitute a quorum, but a lesser
20 number of members may hold hearings.

21 (e) POWER TO HOLD HEARINGS.—The Panel may
22 hold such hearings, sit and act at such times and places,
23 take such testimony, and receive such evidence as the
24 Panel considers advisable to carry out the purposes of this
25 section.

1 (f) OTHER ADMINISTRATIVE PROVISIONS.—Subpara-
2 graphs (C), (D), and (H) of section 1886(e)(6) of the So-
3 cial Security Act shall apply to the Panel in the same man-
4 ner as they apply to the Prospective Payment Assessment
5 Commission.

6 (g) REPORTS.—

7 (1) IN GENERAL.—The Panel shall annually
8 prepare and submit to Congress and the Board a re-
9 port on—

10 (A) the status of the national health care
11 data network established pursuant to this part,
12 including—

13 (i) whether the network is fulfilling
14 the purpose described in section 5101; and

15 (ii) information relating to the cost
16 and quality of health care rendered by
17 health care providers;

18 (B) the savings and costs of the network;

19 and

20 (C) any legislative recommendations relat-
21 ed to the network.

22 (2) AVAILABILITY TO THE PUBLIC.—Any infor-
23 mation in the report submitted to Congress under
24 paragraph (1) shall be made available to the public
25 unless such information may not be disclosed by law.

1 (h) DURATION.—Notwithstanding section 14(a) of
2 the Federal Advisory Committee Act, the Panel shall con-
3 tinue in existence until otherwise provided by law.

4 (i) AUTHORIZATION OF APPROPRIATIONS.—

5 (1) IN GENERAL.—There are authorized to be
6 appropriated such sums as may be necessary to
7 carry out the purposes of this section.

8 (2) AVAILABILITY.—Any sums appropriated
9 under the authorization contained in this subsection
10 shall remain available, without fiscal year limitation,
11 until expended.

12 **Subpart I—Demonstration Projects for Community-**
13 **Based Clinical Information Systems**

14 **SEC. 5135. GRANTS FOR DEMONSTRATION PROJECTS.**

15 (a) IN GENERAL.—The Board may make grants for
16 demonstration projects to promote the development and
17 use of electronically integrated community-based clinical
18 information systems and computerized patient medical
19 records.

20 (b) APPLICATIONS.—

21 (1) SUBMISSION.—To apply for a grant under
22 this subpart for any fiscal year, an applicant shall
23 submit an application to the Board in accordance
24 with the procedures established by the Board.

1 (2) CRITERIA FOR APPROVAL.—The Board may
2 not approve an application submitted under para-
3 graph (1) unless the application includes assurances
4 satisfactory to the Board regarding the following:

5 (A) USE OF EXISTING TECHNOLOGY.—

6 Funds received under this subpart will be used
7 to apply telecommunications and information
8 systems technology that is in existence on the
9 date the application is submitted in a manner
10 that improves the quality of health care, re-
11 duces the costs of such care, and protects the
12 privacy and confidentiality of information relat-
13 ing to the physical or mental condition of an in-
14 dividual.

15 (B) USE OF EXISTING INFORMATION SYS-

16 TEMS.—Funds received under this subpart will
17 be used—

18 (i) to enhance telecommunications or
19 information systems that are operating on
20 the date the application is submitted;

21 (ii) to integrate telecommunications or
22 information systems that are operating on
23 the date the application is submitted; or

24 (iii) to connect additional users to
25 telecommunications or information net-

1 works or systems that are operating on the
2 date the application is submitted.

3 (C) MATCHING FUNDS.—The applicant will
4 make available funds for the demonstration
5 project in an amount that equals at least 50
6 percent of the cost of the project.

7 (c) GEOGRAPHIC DIVERSITY.—In making any grants
8 under this subpart, the Board shall, to the extent prac-
9 ticable, make grants to persons representing different geo-
10 graphic areas of the United States, including urban and
11 rural areas.

12 (d) REVIEW AND SANCTIONS.—The Board shall re-
13 view at least annually the compliance of a person receiving
14 a grant under this subpart with the provisions of this sub-
15 part. The Board shall establish a procedure for determin-
16 ing whether such a person has failed to comply substan-
17 tially within the provisions of this subpart and the sanc-
18 tions to be imposed for any such noncompliance.

19 (e) ANNUAL REPORT.—The Board shall include in
20 the annual report under section 1705 of the Public Health
21 Service Act (42 U.S.C. 300u-4) a description of the activi-
22 ties carried out under this subpart.

1 **Subpart J—Health Security Cards**

2 **SEC. 5136. HEALTH SECURITY CARDS.**

3 (a) PERMISSIBLE USES OF CARD.—A health security
4 card that is issued to an eligible individual under section
5 1001(b) may be used by an individual or entity, in accord-
6 ance with regulations promulgated by the Board, only for
7 the purpose of providing or assisting the eligible individual
8 in obtaining an item or service that is covered under—

9 (1) the applicable health plan in which the indi-
10 vidual is enrolled (as defined in section 1902);

11 (2) a policy consisting of a supplemental health
12 policy (described in part 2 of subtitle E of title I),
13 a cost sharing policy (described in such part), or
14 both;

15 (3) a FEHBP supplemental plan (described in
16 subtitle C of title VIII);

17 (4) a FEHBP medicare supplemental plan (de-
18 scribed in such subtitle); or

19 (5) such other programs as the Board may
20 specify.

21 (b) FORM OF CARD AND ENCODED INFORMATION.—

22 The Board shall establish standards respecting the form
23 of health security cards and the information to be encoded
24 in electronic form on the cards. Such information shall
25 include—

1 (1) the identity of the individual to whom the
2 card is issued;

3 (2) the applicable health plan in which the indi-
4 vidual is enrolled;

5 (3) any policy described in paragraph (2), (3),
6 or (4) of subsection (a) in which the individual is en-
7 rolled; and

8 (4) any other information that the Board deter-
9 mines to be necessary in order for the card to serve
10 the purpose described in subsection (a).

11 (c) UNIQUE IDENTIFIER NUMBERS.—The unique
12 identifier number system developed by the Board under
13 section 5114(b) shall be used in encoding the information
14 described in subsection (b).

15 (d) TRADEMARK REGISTRATION.—The Board shall
16 take appropriate steps to ensure the registration of health
17 security cards and other indicia relating to such cards as
18 trademarks or service marks (as appropriate) under the
19 Trademark Act of 1946. For purposes of this subsection,
20 the “Trademark Act of 1946” refers to the Act entitled
21 “An Act to provide for the registration and protection of
22 trademarks used in commerce, to carry out the provisions
23 of international conventions, and for other purposes”, ap-
24 proved July 5, 1946 (15 U.S.C. et seq.).

1 **PART 2—PRIVACY OF INFORMATION**

2 **Subpart A—Short Title; Findings and Purposes**

3 **SEC. 5160. SHORT TITLE.**

4 This part may be cited as the “Health Care Privacy
5 Protection Act”.

6 **SEC. 5161. FINDINGS AND PURPOSES.**

7 (a) FINDINGS.—The Congress finds as follows:

8 (1) The improper disclosure of personally iden-
9 tifiable health care information may cause signifi-
10 cant harm to a person’s interests in privacy, health
11 care, and reputation and may unfairly affect the
12 ability of a person to obtain employment, education,
13 insurance, and credit.

14 (2) The movement of people and health care-re-
15 lated information across State lines, availability of
16 access to and exchange of health care-related infor-
17 mation from automated data banks and networks,
18 and emergence of multistate health care providers
19 and payors create a need for uniform Federal law
20 governing the disclosure of health care information.

21 (b) PURPOSE.—The purpose of this Act is to estab-
22 lish effective mechanisms to protect the privacy of persons
23 with respect to personally identifiable health care informa-
24 tion that is created or maintained as part of health treat-
25 ment, enrollment, payment, testing, or research processes.

1 **Subpart B—Judicial Proceedings**

2 **SEC. 5162. PRIVACY OF PERSONALLY IDENTIFIABLE**
 3 **HEALTH CARE INFORMATION.**

4 (a) OFFENSE.—Part I of title 18, United States
 5 Code, is amended by inserting after chapter 84, the follow-
 6 ing new chapter:

7 **“CHAPTER 84A—PRIVACY OF PERSON-**
 8 **ALLY IDENTIFIABLE HEALTH CARE IN-**
 9 **FORMATION**

“Sec.

“1755. Wrongful disclosure of personally identifiable health care information.

“1756. Misuse of health security card or unique identifier.

10 **“§ 1755. Wrongful disclosure of protected health in-**
 11 **formation**

12 “(a) DEFINITION.—The term ‘protected health infor-
 13 mation’ shall have the meaning given such term under sec-
 14 tion 5163 of the Health Security Act.

15 “(b) OFFENSE.—A person who knowingly—

16 “(1) obtains protected health information relat-
 17 ing to an individual in violation of subpart C of the
 18 Health Care Privacy Protection Act; or

19 “(2) discloses protected health information to
 20 another person in violation of subpart C of the
 21 Health Care Privacy Protection Act,
 22 shall be punished as provided in subsection (c).

1 “(c) PENALTIES.—A person who violates subsection
2 (b) shall—

3 “(1) be fined not more than \$50,000, impris-
4 oned not more than 1 year, or both;

5 “(2) if the offense is committed under false pre-
6 tenses, be fined not more than \$100,000, imprisoned
7 not more than 5 years, or both; and

8 “(3) if the offense is committed with intent to
9 sell, transfer, or use protected health information for
10 commercial advantage, personal gain, or malicious
11 harm, fined not more than \$250,000, imprisoned not
12 more than 10 years, or both.

13 **“§1756. Misuse of health security card or unique**
14 **identifier**

15 “A person who—

16 “(1) requires the display of, requires the use of,
17 or uses a health security card that is issued under
18 the Health Security Act for any purpose other than
19 obtaining or paying for health care; or

20 “(2) requires the disclosure of, requires the use
21 of, or uses a unique identifier number for any pur-
22 pose that is not authorized by the National Health
23 Board,

24 shall be fined not more than \$25,000, imprisoned not
25 more than 2 years, or both.”.

1 (b) TECHNICAL AMENDMENT.—The part analysis for
 2 part I of title 18, United States Code, is amended by in-
 3 serting after the item related to chapter 84, the following
 4 new item:

“84A. Privacy of personally identifiable health care information 1755.”.

5 **Subpart C—Limitations on Disclosure of Protected**
 6 **Health Information**

7 **SEC. 5163. DEFINITIONS.**

8 In this subpart:

9 (1) ENROLLEE.—The term “enrollee” means
 10 an individual who is covered under a health plan.
 11 The term includes a deceased individual who was
 12 covered under a health plan.

13 (2) ENROLLEE REPRESENTATIVE.—The term
 14 “enrollee representative” means any individual le-
 15 gally empowered to make decisions concerning the
 16 provision of health care to an enrollee (where the en-
 17 rollee lacks the legal capacity under State law to
 18 make such decisions) or the administrator or execu-
 19 tor of the estate of a deceased enrollee.

20 (3) HEALTH CARE.—The term “health care”—

21 (A) means—

22 (i) a preventative, diagnostic, thera-
 23 peutic, rehabilitative, maintenance, or pal-
 24 liative care, counseling, service, or proce-
 25 dure—

1 (I) with respect to the physical or
2 mental condition of an individual; or

3 (II) affecting the structure or
4 function of the human body or any
5 part of the human body; or

6 (ii) any sale or dispensing of a drug,
7 device, equipment, or other item to an indi-
8 vidual, or for the use of an individual, pur-
9 suant to a prescription; but

10 (B) does not include any item or service
11 that is not furnished for the purpose of examin-
12 ing, maintaining, or improving the health of an
13 individual.

14 (4) HEALTH CARE PROVIDER.—The term
15 “health care provider” means a person who is li-
16 censed, certified, registered, or otherwise authorized
17 by law to provide an item or service that constitutes
18 health care in the ordinary course of business or
19 practice of a profession.

20 (5) HEALTH INFORMATION TRUSTEE.—The
21 term “health information trustee” means—

22 (A) a health care provider, health plan,
23 health oversight agency, certified indexing sys-
24 tem, certified clearinghouse, certified health in-
25 formation protection organization, or employer,

1 insofar as it creates, receives, maintains, uses,
2 or transmits protected health information; and

3 (B) any person who obtains protected
4 health information under section 5169, 5170,
5 5171, 5172, 5173, 5174, or 5177.

6 (6) HEALTH OVERSIGHT AGENCY.—The term
7 “health oversight agency” means a person that—

8 (A) performs or oversees the performance
9 of an assessment, evaluation, determination, or
10 investigation relating to the licensing, accredita-
11 tion, or certification of health care
12 providers; or

13 (B)(i) performs or oversees the perform-
14 ance of an assessment, evaluation, determina-
15 tion, or investigation relating to the effective-
16 ness of, compliance with, or applicability of
17 legal, fiscal, medical, or scientific standards or
18 aspects of performance related to the delivery
19 of, or payment for, health care or relating to
20 health care fraud or fraudulent claims for pay-
21 ment regarding health; and

22 (ii) is a public agency, acting on behalf of
23 a public agency, acting pursuant to a require-
24 ment of a public agency, or carrying out activi-
25 ties under a Federal or State statute governing

1 the assessment, evaluation, determination, or
2 investigation.

3 (7) HEALTH PLAN.—The term “health plan”
4 shall have the meaning given such term under sec-
5 tion 5102(6).

6 (8) HEALTH RESEARCHER.—The term “health
7 researcher” means a person who conducts a bio-
8 medical, public health, health services or health sta-
9 tistics research project or a research project on so-
10 cial and behavioral factors relating to health, that
11 has been approved by—

12 (A) an institutional review board for the
13 organization sponsoring the project;

14 (B) an institutional review board for each
15 health information trustee that maintains pro-
16 tected health information intended to be used in
17 the project; or

18 (C) an institutional review board estab-
19 lished or designated by the Board.

20 (9) INSTITUTIONAL REVIEW BOARD.—The term
21 “institutional review board” means—

22 (A) a board established in accordance with
23 regulations of the Board under section 491(a)
24 of the Public Health Service Act (42 U.S.C.
25 289);

1 (B) a similar board established by the
2 Board for the protection of human subjects in
3 research conducted by the Board; or

4 (C) a similar board established under regu-
5 lations of a Federal Government authority other
6 than the Board.

7 (10) LAW ENFORCEMENT INQUIRY.—The term
8 “law enforcement inquiry” means an investigation or
9 official proceeding inquiring into whether there is a
10 violation of, or failure to comply with, any criminal
11 or civil statute or any regulation, rule, or order is-
12 sued pursuant to such a statute.

13 (11) PERSON.—The term “person” includes an
14 authority of the United States, a State, or a political
15 subdivision of a State.

16 (12) PROTECTED HEALTH INFORMATION.—The
17 term “protected health information” means any in-
18 formation, whether oral or recorded in any form or
19 medium, that—

20 (A)(i) is created or received by a health
21 care provider, health plan, health oversight
22 agency, public health authority, certified index-
23 ing system, certified clearinghouse, or certified
24 health information protection organization; or

1 (ii) is created or received by an employer
2 through the process of testing, screening, or as-
3 sisting applicants or employees; and

4 (B) relates to the past, present, or future
5 physical or mental health or condition of an en-
6 rollee, the provision of health care to an en-
7 rollee, past, present, or future payment for the
8 provision of health care to an enrollee, or demo-
9 graphic data collected from the enrollee and—

10 (i) identifies an individual; or

11 (ii) with respect to which there is a
12 reasonable basis to believe that the infor-
13 mation can be used to identify an individ-
14 ual.

15 (12) PUBLIC HEALTH AUTHORITY.—The term
16 “public health authority” means an authority or in-
17 strumentality of the United States, a State, or a po-
18 litical subdivision of a State that is (A) responsible
19 for public health matters; and (B) engaged in such
20 activities as injury reporting, public health surveil-
21 lance, and public health investigation or interven-
22 tion.

23 (13) REFERENCES TO CERTAIN CERTIFIED EN-
24 TITIES.—

1 (A) CERTIFIED INDEXING SYSTEM.—The
2 term “certified indexing system” shall have the
3 meaning given such term under section 5102.

4 (B) CERTIFIED CLEARINGHOUSE.—The
5 term “certified clearinghouse” shall have the
6 meaning given such term under section 5102.

7 (C) CERTIFIED HEALTH INFORMATION
8 PROTECTION ORGANIZATION.—The term “cer-
9 tified health information protection organiza-
10 tion” means a health information protection or-
11 ganization (as defined in section 5102(5)) that
12 is certified under section 5119.

13 **SEC. 5164. GENERAL LIMITATIONS ON DISCLOSURE.**

14 (a) IN GENERAL.—

15 (1) DISCLOSURE WITHIN A TRUSTEE.—A
16 health information trustee may disclose protected
17 health information to an officer, employee, or agent
18 of the trustee only for a purpose that is compatible
19 with and related to the purpose for which the infor-
20 mation—

21 (A) was collected; or

22 (B) was received by that trustee.

23 (2) DISCLOSURE OUTSIDE A TRUSTEE.—A
24 health information trustee may disclose protected
25 health information to a person other than an officer,

1 employee, or agent of the trustee only for a purpose
2 that is authorized under this Act.

3 (3) SCOPE OF DISCLOSURE.—

4 (A) IN GENERAL.—Every disclosure of pro-
5 tected health information by a health informa-
6 tion trustee shall be limited to the minimum
7 amount of information necessary to accomplish
8 the purpose for which the information is dis-
9 closed.

10 (B) GUIDELINES.—Not later than July 1,
11 1996, the Board, after notice and opportunity
12 for public comment, shall issue guidelines to im-
13 plement subparagraph (A), which shall take
14 into account the technical capabilities of the
15 record systems used to maintain protected
16 health information and the costs of limiting dis-
17 closure.

18 (4) IDENTIFICATION OF DISCLOSED INFORMA-
19 TION AS PROTECTED INFORMATION.—Except with
20 respect to protected health information that is dis-
21 closed under section 5179, and except as provided in
22 paragraph (5), a health information trustee may not
23 disclose protected health information unless such in-
24 formation is clearly identified as protected health in-
25 formation that is subject to this section.

1 (5) ROUTINE DISCLOSURES SUBJECT TO WRIT-
2 TEN AGREEMENT.—A health information trustee
3 who routinely discloses protected health information
4 to a person may satisfy the identification require-
5 ment in paragraph (4) through a written agreement
6 between the trustee and the person with respect to
7 the protected health information.

8 (6) AGREEMENT TO LIMIT DISCLOSURE.—A
9 health information trustee who receives protected
10 health information from any person pursuant to a
11 written agreement to restrict disclosure of the infor-
12 mation to a greater extent than would otherwise be
13 required under this section shall comply with the
14 terms of the agreement, except in circumstances in
15 which disclosure of the information is required by
16 law notwithstanding the agreement.

17 (7) NO GENERAL REQUIREMENT TO DIS-
18 CLOSE.—Except as provided in the section 5179 re-
19 lating to inspection, nothing in this section shall be
20 construed to require a health information trustee to
21 disclose protected health information not otherwise
22 required to be disclosed by law.

23 (b) DISCLOSURE BY OFFICER, EMPLOYEE, OR
24 AGENT.—No officer, employee, or agent of a health infor-
25 mation trustee may disclose protected health information,

1 except insofar as the health information trustee is per-
2 mitted to disclose such information for a purpose that is
3 authorized under this Act.

4 **SEC. 5165. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**
5 **TECTED HEALTH INFORMATION.**

6 (a) WRITTEN AUTHORIZATIONS.—A health care pro-
7 vider and health plan may disclose protected health infor-
8 mation pursuant to an authorization executed by the en-
9 rollee who is the subject of the information, if each of the
10 following requirements is met:

11 (1) WRITING.—The authorization is in writing,
12 signed by the enrollee who is the subject of the in-
13 formation, and dated on the date of such signature.

14 (2) SEPARATE FORM.—The authorization is not
15 on a form used to authorize or facilitate the provi-
16 sion of, or payment for, health care.

17 (3) TRUSTEE DESCRIBED.—The trustee is spe-
18 cifically named or generically described in the au-
19 thorization as authorized to disclose such informa-
20 tion.

21 (4) RECIPIENT DESCRIBED.—The person to
22 whom the information is to be disclosed is specifi-
23 cally named or generically described in the author-
24 ization as a person to whom such information may
25 be disclosed.

1 (5) STATEMENT OF INTENDED DISCLOSURES.—

2 The authorization contains an acknowledgment that
3 the enrollee who is the subject of the information
4 has received a statement of the disclosures that the
5 person to receive the protected health information
6 intends to make, which statement shall be in writ-
7 ing, on a form that is distinct from the authorization
8 for disclosure, and which statement must be received
9 by the enrollee authorizing the disclosure on or be-
10 fore such authorization is executed.

11 (6) INFORMATION DESCRIBED.—The informa-
12 tion to be disclosed is described in the authorization.

13 (7) AUTHORIZATION TIMELY RECEIVED.—The
14 authorization is received by the trustee during a pe-
15 riod described in subsection (c)(1).

16 (8) DISCLOSURE TIMELY MADE.—The disclo-
17 sure occurs during a period described in subsection
18 (c)(2).

19 (b) AUTHORIZATIONS REQUESTED IN CONNECTION
20 WITH PROVISION OF HEALTH CARE.—

21 (1) IN GENERAL.—A health information trustee
22 may not request that an individual person provide to
23 any other person an authorization described in sub-
24 section (a) on a day on which—

1 (A) the trustee provides health care to the
2 individual requested to provide the authoriza-
3 tion; or

4 (B) in the case of a trustee that is a health
5 facility, the individual is admitted into the facil-
6 ity as a resident or inpatient in order to receive
7 health care.

8 (2) EXCEPTION.—Paragraph (1) does not apply
9 if a health information trustee requests that an indi-
10 vidual provide an authorization described in sub-
11 section (a) for the purpose of assisting the individual
12 in obtaining counseling or social services from a per-
13 son other than the trustee.

14 (c) TIME LIMITATIONS ON AUTHORIZATIONS.—

15 (1) RECEIPT BY TRUSTEE.—For purposes of
16 subsection (a)(7), an authorization is timely received
17 if it is received by the trustee during—

18 (A) the 1-year period beginning on the
19 date on which the authorization is signed under
20 subsection (a)(1), if the authorization permits
21 the disclosure of protected health information to
22 a person who provides health counseling or so-
23 cial services to individuals; or

24 (B) the 30-day period beginning on the
25 date on which the authorization is signed under

1 subsection (a)(1), if the authorization permits
2 the disclosure of protected health information to
3 a person other than a person described in sub-
4 paragraph (A).

5 (2) DISCLOSURE BY TRUSTEE.—For purposes
6 of subsection (a)(8), a disclosure is timely made if
7 it occurs before—

8 (A) the date or event (if any) specified in
9 the authorization upon which the authorization
10 expires; and

11 (B) the expiration of the 6-month period
12 beginning on the date on which the trustee re-
13 ceives the authorization.

14 (d) REVOCATION OR AMENDMENT OF AUTHORIZA-
15 TION.—

16 (1) IN GENERAL.—An individual may in writing
17 revoke or amend an authorization described in sub-
18 section (a), in whole or in part, at any time, except
19 when—

20 (A) disclosure of protected health informa-
21 tion has been authorized to permit validation of
22 expenditures for health care; or

23 (B) action has been taken in reliance on
24 the authorization.

1 (2) NOTICE OF REVOCATION.—A health infor-
2 mation trustee who discloses protected health infor-
3 mation pursuant to an authorization that has been
4 revoked shall not be subject to any liability or pen-
5 alty under this subpart if—

6 (A) the reliance was in good faith;

7 (B) the trustee had no notice of the rev-
8 ocation; and

9 (C) the disclosure was otherwise in accord-
10 ance with the requirements of this subpart.

11 (e) DECEASED INDIVIDUAL.—The Board shall de-
12 velop and establish through regulation a procedure for ob-
13 taining protected health information relating to a deceased
14 individual when there is no administrator or executor of
15 such individual's estate.

16 (f) MODEL AUTHORIZATIONS.—The Board, after no-
17 tice and opportunity for public comment, shall develop and
18 disseminate model written authorizations of the type de-
19 scribed in subsection (a) and model statements of intended
20 disclosures of the type described in paragraph (a)(5).

21 (g) EFFECT OF AUTHORIZATION ON PRIVILEGES.—
22 The execution by an individual of an authorization that
23 meets the requirements of this section for the purpose of
24 receiving health care or providing for the payment for
25 health care shall not be construed to affect any privilege

1 that the individual may have under common or statutory
2 law in a court of a State or the United States.

3 (h) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A
4 health information trustee may impose requirements for
5 an authorization that are in addition to the requirements
6 in this subsection.

7 (i) COPY.—A health information trustee who dis-
8 closes protected health information pursuant to an author-
9 ization under this section shall maintain a copy of the au-
10 thorization as part of the information.

11 (j) RULE OF CONSTRUCTION.—This section shall not
12 be construed—

13 (1) to require a health information trustee to
14 disclose protected health information; or

15 (2) to limit the right of a health information
16 trustee to charge a fee for the disclosure or repro-
17 duction of protected health information.

18 (k) SUBPOENAS.—If a health information trustee dis-
19 closes protected health information pursuant to an author-
20 ization in order to comply with a subpoena, the authoriza-
21 tion—

22 (1) shall specifically authorize the disclosure for
23 the purpose of permitting the trustee to comply with
24 the subpoena; and

1 (2) shall otherwise meet the requirements in
2 this subsection.

3 **SEC. 5166. TREATMENT; FINANCIAL AND ADMINISTRATIVE**
4 **TRANSACTIONS.**

5 (a) DISCLOSURE OF INFORMATION.—

6 (1) IN GENERAL.—A health care provider,
7 health plan, or employer may disclose protected
8 health information to a health care provider for the
9 purpose of providing health care to an enrollee if the
10 enrollee who is the subject of the information has
11 not previously objected to the disclosure in writing.

12 (2) PROVIDING FOR PAYMENT.—A health care
13 provider, health plan, employer, or certified indexing
14 system may disclose protected health information to
15 a health plan for the purpose of providing for the
16 payment for health care furnished to an enrollee.

17 (3) COOPERATIVE.—A health care provider or
18 health plan may disclose protected health informa-
19 tion to a consumer purchasing cooperative estab-
20 lished under subtitle D of title I in connection with
21 a financial and administrative transaction described
22 in section 5113.

23 (4) INDEXING SYSTEMS.—A health care pro-
24 vider or health plan may disclose protected health
25 information to a certified indexing system or cer-

1 tified clearinghouse for the purpose of carrying out
2 the functions of such system or clearinghouse under
3 part 1.

4 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
5 tected health information under this section shall be lim-
6 ited to the minimum amount necessary to accomplish the
7 purpose for which the disclosure is authorized.

8 **SEC. 5167. OVERSIGHT.**

9 (a) IN GENERAL.—A health information trustee may
10 disclose protected health information to a health oversight
11 agency for a purpose authorized by law.

12 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
13 tected health information under this section shall be lim-
14 ited to the minimum amount necessary to accomplish the
15 purpose for which the disclosure is authorized.

16 (c) USE IN ACTION AGAINST ENROLLEES.—Pro-
17 tected health information about an enrollee that is dis-
18 closed under this section may not be used in, or disclosed
19 to any person for use in, any administrative, civil, or crimi-
20 nal action or investigation directed against the enrollee
21 who is the subject of the information, except in an action
22 or investigation arising out of and directly related to re-
23 ceipt of health care or payment for health care or an ac-
24 tion involving a fraudulent claim related to health.

1 **SEC. 5168. NEXT OF KIN AND DIRECTORY INFORMATION.**

2 (a) NEXT OF KIN.—A health care provider or person
3 that receives protected health information under section
4 5170 may disclose protected health information to the
5 next of kin or enrollee representative of the enrollee who
6 is the subject of the information or to an individual with
7 whom that enrollee has a personal relationship if—

8 (1) the enrollee who is the subject of the infor-
9 mation has not previously objected to the disclosure
10 after being notified of the right to object; and

11 (2) the information disclosed relates to health
12 care currently being provided to that enrollee.

13 (b) DIRECTORY INFORMATION.—A health care pro-
14 vider and a person receiving protected health information
15 under section 5170 may disclose information to any per-
16 son if—

17 (1) the information does not reveal specific in-
18 formation about the physical or mental condition of
19 the enrollee who is the subject of the information or
20 health care provided to that person;

21 (2) the enrollee who is the subject of the infor-
22 mation has not objected in writing to the disclosure
23 after being notified of the right to object; and

24 (3) the information consists only of 1 or more
25 of the following items:

1 (A) The name of the enrollee who is the
2 subject of the information.

3 (B) If the enrollee who is the subject of
4 the information is receiving health care from a
5 health care provider on a premises controlled by
6 the provider—

7 (i) the location of the enrollee on the
8 premises; and

9 (ii) the general health status of the
10 enrollee, described as critical, poor, fair,
11 stable, or satisfactory or in terms denoting
12 similar conditions.

13 (c) IDENTIFICATION OF DEAD PERSON.—A health
14 care provider, health plan, employer, certified indexing
15 system, or certified clearinghouse may disclose protected
16 health information if necessary to assist in the identifica-
17 tion of a dead person.

18 (d) MINIMUM DISCLOSURE.—The disclosure of pro-
19 tected health information under this section shall be lim-
20 ited to the minimum amount necessary to accomplish the
21 purpose for which the disclosure is authorized.

22 **SEC. 5169. PUBLIC HEALTH.**

23 (a) IN GENERAL.—A health care provider, health
24 plan, public health authority, employer, or person that re-
25 ceives protected health information under section 5170

1 may disclose protected health information to a public
2 health authority or other person authorized by law for use
3 in legally authorized—

4 (1) disease or injury reporting;

5 (2) public health surveillance; or

6 (3) public health investigation or intervention.

7 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
8 tected health information under this section shall be lim-
9 ited to the minimum amount necessary to accomplish the
10 purpose for which the disclosure is authorized.

11 **SEC. 5170. EMERGENCY CIRCUMSTANCES.**

12 (a) IN GENERAL.—A health care provider, health
13 plan, employer, certified indexing system, certified clear-
14 inghouse, or person that receives protected health informa-
15 tion under this section may disclose protected health infor-
16 mation in emergency circumstances when necessary to
17 protect the health or safety of an individual from immi-
18 nent harm.

19 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
20 tected health information under this section shall be lim-
21 ited to the minimum amount necessary to accomplish the
22 purpose for which the disclosure is permitted and shall
23 be limited to persons who need the information to take
24 action to protect the health or safety of the enrollee.

1 (c) USE IN ACTION AGAINST ENROLLEE.—Protected
2 health information about an enrollee that is disclosed
3 under this section may not be used in, or disclosed to any
4 person for use in, any administrative, civil, or criminal ac-
5 tion or investigation directed against the enrollee.

6 **SEC. 5171. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

7 (a) IN GENERAL.—A health care provider, health
8 plan, health oversight agency, or employer may disclose
9 protected health information—

10 (1) pursuant to the Federal Rules of Civil Pro-
11 cedure, the Federal Rules of Criminal Procedure, or
12 comparable rules of other courts or administrative
13 agencies in connection with litigation or proceedings
14 to which the enrollee who is the subject of the infor-
15 mation is a party and in which the enrollee has
16 placed the enrollee’s physical or mental condition in
17 issue;

18 (2) if ordered by a court in connection with an
19 examination of an enrollee; or

20 (3) pursuant to a law requiring the reporting of
21 specific medical information to law enforcement au-
22 thorities.

23 (b) SCOPE OF DISCLOSURE.—The disclosure of pro-
24 tected health information under this section shall be lim-

1 ited to the minimum amount necessary to accomplish the
2 purpose for which the disclosure is permitted.

3 (c) LIMIT ON ADDITIONAL DISCLOSURE.—A person
4 that receives protected health information under this sec-
5 tion may use the information and disclose such informa-
6 tion only for the purpose for which it was received.

7 **SEC. 5172. HEALTH RESEARCH.**

8 (a) IN GENERAL.—Subject to subsection (d), a health
9 information trustee may disclose protected health informa-
10 tion to a health researcher if an institutional review board
11 has determined that the research project engaged in by
12 the health researcher—

13 (1) requires use of the protected health infor-
14 mation for the effectiveness of the project; and

15 (2) is of sufficient importance to outweigh the
16 intrusion into the privacy of the enrollee who is the
17 subject of the information that would result from the
18 disclosure.

19 (b) OBLIGATIONS OF RECIPIENT.—A person who re-
20 ceives protected health information pursuant to subsection

21 (a)—

22 (1) shall remove or destroy, at the earliest op-
23 portunity consistent with the purposes of the project,
24 information that would enable an enrollee to be iden-
25 tified, unless—

1 (A) an institutional review board has de-
2 termined that there is a health or research jus-
3 tification for retention of such identifiers; and

4 (B) there is an adequate plan to protect
5 the identifiers from disclosure that is inconsis-
6 tent with this section; and

7 (2) shall use protected health information solely
8 for purposes of the health research project for which
9 disclosure was authorized under this section.

10 (c) SCOPE OF DISCLOSURE.—The disclosure of pro-
11 tected health information under this section shall be lim-
12 ited to the minimum amount necessary to accomplish the
13 research purpose for which the disclosure is authorized.

14 (d) RESEARCH REQUIRING DIRECT CONTACT.—Pro-
15 tected information may not be disclosed to a health re-
16 searcher for a research project that includes direct contact
17 with an enrollee who is the subject of protected health in-
18 formation unless the enrollee has been given notice by the
19 health information trustee that such contact is possible,
20 has been given the opportunity to object to the disclosure,
21 and has not objected.

22 **SEC. 5173. LAW ENFORCEMENT.**

23 (a) IN GENERAL.—A health care provider, health
24 plan, health oversight agency, employer, or other person
25 that receives protected health information under section

1 5170 may disclose protected health information to a law
2 enforcement agency (other than a health oversight agency
3 governed by section 5167) if the information is requested
4 for use—

5 (1) in an investigation or prosecution of a
6 health information trustee;

7 (2) in the identification of a victim or witness
8 in a law enforcement inquiry; or

9 (3) in connection with the investigation of
10 criminal activity committed against the trustee or on
11 premises controlled by the trustee.

12 (b) CERTIFICATION.—When a law enforcement agen-
13 cy (other than a health oversight agency) requests that
14 a health information trustee disclose protected health in-
15 formation under this subsection, the law enforcement
16 agency shall provide the trustee with a written certifi-
17 cation that—

18 (1) specifies the information requested;

19 (2) states that the information is needed for a
20 lawful purpose under this section; and

21 (3) is signed by a supervisory official of a rank
22 designated by the head of the agency.

23 (c) SCOPE OF DISCLOSURE.—The disclosure of pro-
24 tected health information under this section shall be lim-

1 ited to the minimum amount necessary to accomplish the
2 purposes for which the disclosure is permitted.

3 (d) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

4 Protected health information about an enrollee that is dis-
5 closed to a law enforcement agency under this section—

6 (1) may not be disclosed for, or used in, any
7 administrative, civil, or criminal action or investiga-
8 tion against the enrollee, except in an action or in-
9 vestigation arising out of and directly related to the
10 action or investigation for which the information was
11 obtained; and

12 (2) may not be otherwise used or disclosed by
13 the law enforcement agency, unless the use or disclo-
14 sure is necessary to fulfill the purpose for which the
15 information was obtained and is not otherwise pro-
16 hibited by law.

17 **SEC. 5174. SUBPOENAS AND WARRANTS.**

18 (a) IN GENERAL.—A health care provider, health
19 plan, health oversight agency, employer, or person that re-
20 ceives protected health information under section 5170
21 may disclose protected health information under this sec-
22 tion if the disclosure is pursuant to—

23 (1) a subpoena issued under the authority of a
24 grand jury, and the trustee is provided a written cer-
25 tification by the grand jury seeking the information

1 that the grand jury has complied with the applicable
2 access provisions of section 5175;

3 (2) an administrative subpoena or a judicial
4 subpoena or warrant, and the trustee is provided a
5 written certification by the person seeking the infor-
6 mation that the person has complied with the appli-
7 cable access provisions of section 5175 or 5176; or

8 (3) an administrative subpoena or a judicial
9 subpoena or warrant, and the disclosure otherwise
10 meets the conditions of section 5167, 5169, 5170,
11 5171, or 5173.

12 (b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—
13 Protected health information about an enrollee that is re-
14 ceived under—

15 (1) subsection (a) may not be disclosed for, or
16 used in, any administrative, civil, or criminal action
17 or investigation against the enrollee, except in an ac-
18 tion or investigation arising out of and directly relat-
19 ed to the inquiry for which the information was ob-
20 tained;

21 (2) subsection (a)(2) may not be otherwise dis-
22 closed by the recipient unless the disclosure is nec-
23 essary to fulfill the purpose for which the informa-
24 tion was obtained; and

1 (3) subsection (a)(3) may not be disclosed by
2 the recipient unless the recipient complies with the
3 conditions and restrictions on disclosure with which
4 the recipient would have been required to comply if
5 the disclosure had been made under section 5168,
6 5169, 5170, 5171, or 5173.

7 **SEC. 5175. ACCESS PROCEDURES FOR LAW ENFORCEMENT**
8 **SUBPOENAS AND WARRANTS.**

9 (a) PROBABLE CAUSE REQUIREMENT.—A govern-
10 ment authority may not obtain protected health informa-
11 tion about an enrollee under section 5174(a) (1) or (2)
12 for use in a law enforcement inquiry unless there is prob-
13 able cause to believe that the information is relevant to
14 a legitimate law enforcement inquiry being conducted by
15 the government authority.

16 (b) WARRANTS.—A government authority that ob-
17 tains protected health information about an enrollee under
18 circumstances described in subsection (a) and pursuant to
19 a warrant shall, not later than 30 days after the date the
20 warrant was executed, serve the enrollee with, or mail to
21 the last known address of the enrollee, a notice that pro-
22 tected health information about the enrollee was so ob-
23 tained.

24 (c) SUBPOENAS.—Except as provided in subsection
25 (d), a government authority may not obtain protected

1 health information about an enrollee under circumstances
2 described in subsection (a) and pursuant to a subpoena
3 unless a copy of the subpoena has been served on the en-
4 rollee on or before the date of return of the subpoena, to-
5 gether with a notice of the enrollee's right to challenge
6 the subpoena in accordance with section 5176, and—

7 (1) 30 days have passed from the date of serv-
8 ice on the enrollee and within that time period the
9 enrollee has not initiated a challenge in accordance
10 with section 5176; or

11 (2) disclosure is ordered by a court after chal-
12 lenge under section 5176.

13 (d) APPLICATION FOR DELAY.—

14 (1) IN GENERAL.—A government authority may
15 apply ex parte and under seal to an appropriate
16 court to delay (for an initial period of not longer
17 than 90 days) serving a copy of a subpoena or notice
18 required under subsection (b) or (c) with respect to
19 a law enforcement inquiry. The government author-
20 ity may apply to the court for extensions of the
21 delay.

22 (2) REASONS FOR DELAY.—An application for
23 a delay, or extension of a delay, under this sub-
24 section shall state, with reasonable specificity, the
25 reasons why the delay or extension is being sought.

1 (3) EX PARTE ORDER.—The court shall enter
2 an ex parte order delaying, or extending the delay
3 of, notice and an order prohibiting the disclosure of
4 the request for or disclosure of the protected health
5 information and an order requiring the disclosure of
6 the protected health information if the court finds
7 that—

8 (A) the inquiry being conducted is within
9 the lawful jurisdiction of the government au-
10 thority seeking the protected health informa-
11 tion;

12 (B) there is probable cause to believe that
13 the protected health information being sought is
14 relevant to a legitimate law enforcement in-
15 quiry;

16 (C) the government authority's need for
17 the information outweighs the privacy interest
18 of the enrollee who is the subject of the infor-
19 mation; and

20 (D) there is reasonable ground to believe
21 that receipt of notice by the enrollee will result
22 in—

23 (i) endangering the life or physical
24 safety of any individual;

25 (ii) flight from prosecution;

- 1 (iii) destruction of or tampering with
2 evidence or the information being sought;
3 or
4 (iv) intimidation of potential wit-
5 nesses.

6 **SEC. 5176. CHALLENGE PROCEDURES FOR LAW ENFORCE-**
7 **MENT SUBPOENAS.**

8 (a) MOTION TO QUASH SUBPOENA.—Within 30 days
9 after the date of service of a subpoena of a government
10 authority seeking protected health information about an
11 enrollee under section 5174 (a) (1) or (2), or notice that
12 protected health information has been obtained by a gov-
13 ernment authority, the enrollee may file a motion to quash
14 the subpoena—

15 (1) in the case of a State judicial subpoena, in
16 the court which issued the subpoena;

17 (2) in the case of a subpoena issued under the
18 authority of a State that is not a State judicial sub-
19 poena, in a court of competent jurisdiction;

20 (3) in the case of a subpoena issued under the
21 authority of a Federal court, in the United States
22 district court for the district in which the enrollee
23 resides or in which the subpoena was issued; or

24 (4) in the case of any other subpoena issued
25 under the authority of the United States, in the

1 United States district court for the district in which
2 the enrollee resides or in which the subpoena was is-
3 sued.

4 (b) COPY.—A copy of the motion shall be served by
5 the enrollee upon the government authority by registered
6 or certified mail.

7 (c) PROCEEDINGS.—The government authority may
8 file with the court such papers, including affidavits and
9 other sworn documents, as sustain the validity of the sub-
10 poena. The enrollee may file with the court reply papers
11 in response to the government authority's filing. The
12 court, upon the request of the enrollee or the government
13 authority or both, may proceed in camera. The court may
14 conduct such proceedings as it deems appropriate to rule
15 on the motion, but shall endeavor to expedite its deter-
16 mination.

17 (d) STANDARD FOR DECISION.—A court may deny
18 a motion under subsection (a) if it finds there is probable
19 cause to believe the protected health information being
20 sought is relevant to a legitimate law enforcement inquiry
21 being conducted by the government authority, unless the
22 court finds the enrollee's privacy interest outweighs the
23 government authority's need for the information. The en-
24 rollee shall have the burden of demonstrating that the en-

1 rollee's privacy interest outweighs the need established by
2 the government authority for the information.

3 (e) SPECIFIC CONSIDERATIONS WITH RESPECT TO
4 PRIVACY INTEREST.—In reaching its determination, the
5 court shall consider—

6 (1) the particular purpose for which the infor-
7 mation was collected;

8 (2) the degree to which disclosure of the infor-
9 mation will embarrass, injure, or invade the privacy
10 of the enrollee;

11 (3) the effect of the disclosure on the enrollee's
12 future health care;

13 (4) the importance of the inquiry being con-
14 ducted by the government authority, and the impor-
15 tance of the information to that inquiry; and

16 (5) any other factor deemed relevant by the
17 court.

18 (f) ATTORNEY'S FEES.—In the case of a motion
19 brought under subsection (a) in which the enrollee has
20 substantially prevailed, the court may assess against the
21 government authority a reasonable attorney's fee and
22 other litigation costs (including expert's fees) reasonably
23 incurred.

24 (g) NO INTERLOCUTORY APPEAL.—A ruling denying
25 a motion to quash under this section shall not be deemed

1 to be a final order, and no interlocutory appeal may be
2 taken therefrom by the enrollee. An appeal of such a rul-
3 ing may be taken by the enrollee within such period of
4 time as is provided by law as part of any appeal from a
5 final order in any legal proceeding initiated against the
6 enrollee arising out of or based upon the protected health
7 information disclosed.

8 **SEC. 5177. ACCESS AND CHALLENGE PROCEDURES FOR**
9 **SUBPOENAS OTHER THAN LAW ENFORCE-**
10 **MENT SUBPOENAS.**

11 (a) IN GENERAL.—A private party may not obtain
12 protected health information from a health care provider,
13 health plan, employer, or person that receives protected
14 health information under section 5170 pursuant to a sub-
15 poena unless—

16 (1) a copy of the subpoena together with a no-
17 tice of the enrollee's right to challenge the subpoena
18 by filing a motion to quash under subsection (b), has
19 been served upon the enrollee who is the subject of
20 the protected health information on or before the
21 date on which the subpoena was served; and

22 (2)(A) 30 days have passed since the date of
23 service, and within that time period the enrollee has
24 not filed a motion under subsection (b); or

1 (B) disclosure is ordered by a court under that
2 subsection.

3 (b) MOTION TO QUASH.—Within 30 days after serv-
4 ice of a subpoena seeking protected health information
5 under subsection (a), the enrollee who is the subject of
6 the protected health information may file in any court of
7 competent jurisdiction a motion to quash the subpoena,
8 with a copy served on the person seeking the information.
9 The enrollee may oppose or seek to limit the subpoena on
10 any ground that would be available if the enrollee were
11 in sole possession of the information, including privacy
12 and relevance.

13 (c) STANDARD FOR DECISION.—The court shall
14 grant a motion under subsection (b) unless the respondent
15 demonstrates that—

16 (1) there is reasonable ground to believe the in-
17 formation is relevant to a lawsuit or other judicial
18 or administrative proceeding; and

19 (2) the need of the respondent for the informa-
20 tion outweighs the privacy interest of the enrollee.

21 (d) SPECIFIC CONSIDERATIONS WITH RESPECT TO
22 PRIVACY INTEREST.—In determining under subsection (c)
23 whether the need of the respondent for the information
24 outweighs the privacy interest of the enrollee, the court
25 shall consider—

1 (1) the particular purpose for which the infor-
2 mation was collected;

3 (2) the degree to which disclosure of the infor-
4 mation would embarrass, injure, or invade the pri-
5 vacy of the enrollee;

6 (3) the effect of the disclosure on the enrollee's
7 future health care;

8 (4) the importance of the information to the
9 lawsuit or proceeding; and

10 (5) any other relevant factor.

11 (e) ATTORNEY'S FEES.—In the case of a motion
12 brought under subsection (b) in which the enrollee has
13 substantially prevailed, the court may assess against the
14 respondent a reasonable attorney's fee and other litigation
15 costs and expenses (including expert's fees) reasonably in-
16 curred.

17 **SEC. 5178. SECURITY.**

18 (a) IN GENERAL.—A health information trustee shall
19 establish and maintain appropriate administrative, tech-
20 nical, and physical safeguards—

21 (1) to ensure the integrity and confidentiality of
22 protected health information created or received by
23 the trustee; and

1 (2) to protect against any anticipated threats or
2 hazards to the security or integrity of such informa-
3 tion.

4 (b) SPECIFIC SECURITY MEASURES.—The security
5 measures adopted by a health information trustee shall in-
6 clude the following:

7 (1) officers, employees, and agents of the trust-
8 ee who have access to protected health information
9 created or received by the trustee shall be regularly
10 trained in the requirements governing such informa-
11 tion;

12 (2) complete, accurate, and readily available
13 documentation of security features shall be main-
14 tained, if the maintenance of such documentation is
15 practicable, taking into account the technical capa-
16 bilities of the system used to maintain protected
17 health information and the costs of such mainte-
18 nance; and

19 (3) appropriate signs and warnings shall be
20 posted to advise of the need to secure protected
21 health information.

22 (c) REGULATIONS.—The Board shall promulgate reg-
23 ulations regarding security measures for protected health
24 information.

1 **SEC. 5179. INSPECTION OF PROTECTED HEALTH INFORMA-**
2 **TION.**

3 (a) INSPECTION OF PROTECTED HEALTH INFORMA-
4 TION.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (3), a health care provider or health plan—

7 (A) shall permit an enrollee who is the
8 subject of protected health information to in-
9 spect any such information that the provider or
10 plan maintains;

11 (B) shall permit the enrollee to have a
12 copy of the information;

13 (C) shall permit a person who has been
14 designated in writing by the enrollee who is the
15 subject of the information to inspect, or to have
16 a copy of, the information on behalf of the en-
17 rollee or to accompany the enrollee during the
18 inspection; and

19 (D) may offer to explain or interpret infor-
20 mation that is inspected or copied under this
21 subsection.

22 (2) USE OF INDEXING SYSTEMS.—Except as
23 provided in paragraph (3), a health plan or health
24 care provider shall, upon written request of an en-
25 rollee—

1 (A) determine the identity of previous pro-
2 viders to the enrollee; and

3 (B) obtain protected health information re-
4 garding the enrollee.

5 The plan or provider may obtain such information
6 through use of a certified indexing system.

7 (3) EXCEPTIONS.—A health care provider or
8 health plan is not required by this section to permit
9 inspection or copying of protected health information
10 if any of the following conditions apply:

11 (A) MENTAL HEALTH TREATMENT
12 NOTES.—The information consists of psy-
13 chiatric, psychological, or mental health treat-
14 ment notes, and the provider or plan deter-
15 mines, based on reasonable medical judgment,
16 that inspection or copying of the notes would
17 cause sufficient harm to the enrollee who is the
18 subject of the notes so as to outweigh the desir-
19 ability of permitting access, and the provider or
20 plan has not disclosed the notes to any person
21 not directly engaged in treating the enrollee, ex-
22 cept with the authorization of the enrollee or
23 under compulsion of law.

24 (B) INFORMATION ABOUT OTHERS.—The
25 information relates to an individual other than

1 the enrollee seeking to inspect or have a copy
2 of the information and the provider or plan de-
3 termines, based on reasonable medical judg-
4 ment, that inspection or copying of the informa-
5 tion would cause sufficient harm to 1 or both
6 of the individuals so as to outweigh the desir-
7 ability of permitting access.

8 (C) ENDANGERMENT TO LIFE OR SAFE-
9 TY.—The provider or plan determines that dis-
10 closure of the information could reasonably be
11 expected to endanger the life or physical safety
12 of any individual.

13 (D) CONFIDENTIAL SOURCE.—The infor-
14 mation identifies or could reasonably lead to the
15 identification of a person (other than a health
16 care provider) who provided information under
17 a promise of confidentiality to a health care
18 provider concerning the enrollee who is the sub-
19 ject of the information.

20 (E) ADMINISTRATIVE PURPOSES.—The in-
21 formation—

22 (i) is used by the provider or plan
23 solely for administrative purposes and not
24 in the provision of health care to the en-

1 rollee who is the subject of the informa-
2 tion; and

3 (ii) has not been disclosed by the pro-
4 vider or plan to any other person.

5 (3) INSPECTION AND COPYING OF SEGREGABLE
6 PORTION.—A health care provider or health plan
7 shall permit inspection and copying under paragraph
8 (1) of any reasonably segregable portion of a record
9 after deletion of any portion that is exempt under
10 paragraph (2).

11 (4) CONDITIONS.—A health care provider or
12 health plan may—

13 (A) require a written request for the in-
14 spection and copying of protected health infor-
15 mation under this subsection; and

16 (B) charge a reasonable fee (not greater
17 than the actual cost) for—

18 (i) permitting inspection of informa-
19 tion under this subsection; and

20 (ii) providing a copy of protected
21 health information under this subsection.

22 (5) STATEMENT OF REASONS FOR DENIAL.—If
23 a health care provider or health plan denies a re-
24 quest for inspection or copying under this sub-
25 section, the provider or plan shall provide the en-

1 rollee who made the request (or the enrollee's des-
2 ignated representative) with a written statement of
3 the reasons for the denial.

4 (6) DEADLINE.—A health care provider or
5 health plan shall comply with or deny a request for
6 inspection or copying of protected health information
7 under this subsection within the 30-day period be-
8 ginning on the date on which the provider or plan
9 receives the request.

10 **SEC. 5180. AMENDMENT OF PROTECTED HEALTH INFORMA-**
11 **TION.**

12 (a) IN GENERAL.—A health care provider or health
13 plan that is required to comply with section 5179 shall,
14 within the 45-day period beginning on the date on which
15 the provider or plan receives from an enrollee a written
16 request that the provider or plan correct or amend the
17 information—

18 (1) make the correction or amendment re-
19 quested;

20 (2) inform the enrollee of the correction or
21 amendment that has been made;

22 (3) inform any certified indexing system or cer-
23 tified clearinghouse to which the uncorrected or
24 unamended portion of the information was pre-

1 viously disclosed, of the correction or amendment;
2 and

3 (4) inform any person who is identified by the
4 enrollee, who is not an officer, employee or agent of
5 the provider or plan, and to whom the uncorrected
6 or unamended portion of the information was pre-
7 viously disclosed, of the correction or amendment
8 that has been made.

9 (b) REFUSAL TO CORRECT.—If the provider or plan
10 refuses to make the corrections, the provider or plan shall
11 inform the enrollee of—

12 (1) the reasons for the refusal of the provider
13 or plan to make the correction or amendment;

14 (2) any procedures for further review of the re-
15 fusal; and

16 (3) the enrollee's right to file with the provider
17 or plan a concise statement setting forth the re-
18 quested correction or amendment and the enrollee's
19 reasons for disagreeing with the refusal of the pro-
20 vider or plan.

21 (c) BASES FOR REQUEST TO CORRECT OR
22 AMEND.—An enrollee may request correction or amend-
23 ment of protected health information about the enrollee
24 under paragraph (a) if the information is not timely, accu-
25 rate, relevant to the system of records, or complete.

1 (d) STATEMENT OF DISAGREEMENT.—After an en-
2 rollee has filed a statement of disagreement under para-
3 graph (b)(3), the provider or plan, in any subsequent dis-
4 closure of the disputed portion of the information—

5 (1) shall include a copy of the enrollee's state-
6 ment; and

7 (2) may include a concise statement of the rea-
8 sons of the provider or plan for not making the re-
9 quested correction or amendment.

10 (e) RULE OF CONSTRUCTION.—This section shall not
11 be construed to require a health care provider or health
12 plan to conduct a formal, informal, or other hearing or
13 proceeding concerning a request for a correction or
14 amendment to protected health information the provider
15 or plan maintains.

16 (f) CORRECTION.—For purposes of paragraph (a), a
17 correction is deemed to have been made to protected
18 health information when information that is not timely,
19 accurate, relevant to the system of records, or complete
20 is clearly marked as incorrect or when supplementary cor-
21 rect information is made part of the information.

22 (g) NOTICE OF INFORMATION PRACTICES.—

23 (1) PREPARATION OF WRITTEN NOTICE.—A
24 health care provider or health plan shall prepare a

1 written notice of information practices describing the
2 following:

3 (A) PERSONAL RIGHTS OF AN EN-
4 ROLLEE.—The rights under this section of an
5 enrollee who is the subject of protected health
6 information, including the right to inspect and
7 copy such information and the right to seek
8 amendments to such information, and the pro-
9 cedures for authorizing disclosures of protected
10 health information and for revoking such au-
11 thorizations.

12 (B) PROCEDURES OF PROVIDER OR
13 PLAN.—The procedures established by the pro-
14 vider or plan for the exercise of the rights of
15 enrollees about whom protected health informa-
16 tion is maintained.

17 (C) AUTHORIZED DISCLOSURES.—The dis-
18 closures of protected health information that
19 are authorized.

20 (2) DISSEMINATION OF NOTICE.—A health care
21 provider or health plan—

22 (A) shall, upon request, provide any en-
23 rollee with a copy of the notice of information
24 practices described in paragraph (1); and

1 (B) shall make reasonable efforts to inform
2 enrollees in a clear and conspicuous manner of
3 the existence and availability of the notice.

4 (3) MODEL NOTICE.—The Board, after notice
5 and opportunity for public comment, shall develop
6 and disseminate a model notice of information prac-
7 tices for use by health care providers and health
8 plans under this section.

9 **SEC. 5181. ACCOUNTING FOR DISCLOSURES.**

10 (a) IN GENERAL.—A health care provider or health
11 plan that is required to comply with sections 5179 and
12 5180 shall create and maintain, with respect to any pro-
13 tected health information disclosed, a record of—

14 (1) the date and purpose of the disclosure;

15 (2) the name of the person to whom or to which
16 the disclosure was made;

17 (3) the address of the person to whom or to
18 which the disclosure was made or the location to
19 which the disclosure was made; and

20 (4) the information disclosed, if the recording of
21 the information disclosed is practicable, taking into
22 account the technical capabilities of the system used
23 to maintain the record and the costs of such mainte-
24 nance.

1 (b) DISCLOSURE RECORD PART OF INFORMATION.—

2 A record created and maintained under paragraph (a)
3 shall be maintained as part of the protected health infor-
4 mation to which the record pertains, except for requests
5 from and disclosures to health oversight agencies.

6 (c) CERTIFIED INDEXING SYSTEMS AND CERTIFIED
7 CLEARINGHOUSES.—

8 (1) IN GENERAL.—Certified indexing systems
9 and certified clearinghouses shall account for disclo-
10 sures of protected health information in the manner
11 prescribed under subsection (a).

12 (2) SPECIAL RULE.—Paragraph (1) shall not
13 apply to disclosures made in connection with finan-
14 cial and administrative transactions and to health
15 information protection organizations (as such terms
16 are defined under part 1) for the creation of health
17 information that is non-identifiable health informa-
18 tion.

19 **SEC. 5182. STANDARDS FOR ELECTRONIC DOCUMENTS AND**
20 **COMMUNICATIONS.**

21 The Board, after notice and opportunity for public
22 comment, shall promulgate standards with respect to the
23 creation, transmission, receipt, and maintenance, in elec-
24 tronic form, of each written document required or author-
25 ized under this subpart. When a signature is required with

1 respect to a written document under any other provision
2 of this subpart, such standards shall provide for an elec-
3 tronic substitute that serves the functional equivalent of
4 a signature.

5 **SEC. 5183. RIGHTS OF INCOMPETENTS.**

6 (a) EFFECT OF DECLARATION OF INCOMPETENCE.—
7 Except as provided in section 5184, if an enrollee has been
8 declared to be incompetent by a court of competent juris-
9 diction, the rights of the enrollee under this subpart shall
10 be exercised and discharged in the best interests of the
11 enrollee through the enrollee's representative.

12 (b) NO COURT DECLARATION.—Except as provided
13 in section 5184, if a health care provider determines that
14 an enrollee, who has not been declared to be incompetent
15 by a court of competent jurisdiction, suffers from a medi-
16 cal condition that prevents the enrollee from acting know-
17 ingly or effectively on the enrollee's own behalf, the right
18 of the enrollee to authorize disclosure may be exercised
19 and discharged in the best interest of the enrollee by the
20 enrollee's next of kin.

21 **SEC. 5184. RIGHTS OF MINORS.**

22 (a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-
23 BLE.—In the case of an enrollee—

24 (1) who is 18 years of age or older, all rights
25 of the enrollee shall be exercised by the enrollee; or

1 (2) who, acting alone, has the legal right, as de-
2 termined by State law, to apply for and obtain a
3 type of medical examination, care, or treatment and
4 who has sought such examination, care, or treat-
5 ment, the enrollee shall exercise all rights of an en-
6 rollee under this subpart with respect to protected
7 health information relating to such examination,
8 care, or treatment.

9 (b) INDIVIDUALS UNDER 18.—Except as provided in
10 subsection (a)(2), in the case of an enrollee who is—

11 (1) under 14 years of age, all the enrollee's
12 rights under this subpart shall be exercised through
13 the parent or legal guardian of the enrollee; or

14 (2) 14, 15, 16, or 17 years of age, the rights
15 of inspection and amendment, and the right to au-
16 thorize disclosure of protected health information of
17 the enrollee may be exercised either by the enrollee
18 or by the parent or legal guardian of the enrollee.

19 **SEC. 5185. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.**

20 A health information trustee who makes a disclosure
21 of protected health information about an enrollee that is
22 permitted by this subpart shall not be liable to the enrollee
23 for the disclosure under common law.

1 **SEC. 5186. NO LIABILITY FOR INSTITUTIONAL REVIEW**
2 **BOARD DETERMINATIONS.**

3 If the members of an institutional review board make
4 a determination in good faith that—

5 (1) a health research project is of sufficient im-
6 portance to outweigh the intrusion into the privacy
7 of an enrollee; and

8 (2) the effectiveness of the project requires use
9 of protected health information,

10 the members, the board, and the parent institution of the
11 board shall not be liable to the enrollee as a result of the
12 determination.

13 **SEC. 5187. GOOD FAITH RELIANCE ON CERTIFICATION.**

14 A health information trustee who relies in good faith
15 on a certification by a government authority or other per-
16 son and discloses protected health information about an
17 enrollee in accordance with this subpart shall not be liable
18 to the enrollee for such disclosure.

19 **SEC. 5188. CIVIL PENALTY.**

20 (a) VIOLATION.—Any health information trustee who
21 the Board determines has substantially failed to comply
22 with this subpart shall be subject, in addition to any other
23 penalties that may be prescribed by law, to a civil penalty
24 of not more than \$10,000 for each such violation.

25 (b) PROCEDURES FOR IMPOSITION OF PENALTIES.—
26 Section 1128A of the Social Security Act (42 U.S.C.

1 1320a–7a), other than subsections (a) and (b) and the
2 second sentence of subsection (f) of that section, shall
3 apply to the imposition of a civil monetary penalty under
4 this section in the same manner as such provisions apply
5 with respect to the imposition of a penalty under section
6 1128A of that Act.

7 **SEC. 5189. CIVIL ACTION.**

8 (a) IN GENERAL.—An individual who is aggrieved by
9 conduct in violation of this subpart may bring a civil ac-
10 tion to recover—

11 (1) the greater of actual damages or liquidated
12 damages of \$5,000;

13 (2) punitive damages;

14 (3) a reasonable attorney’s fee and expenses of
15 litigation;

16 (4) costs of litigation; and

17 (5) such preliminary and equitable relief as the
18 court determines to be appropriate.

19 (b) LIMITATION.—No action may be commenced
20 under this section more than 3 years after the date on
21 which the violation was or should reasonably have been
22 discovered.

1 **SEC. 5190. RELATIONSHIP TO OTHER LAWS.**

2 (a) STATE LAW.—Except as provided in subsections
3 (b), (c), and (d), this subpart preempts any State law to
4 the extent that such law is inconsistent with this subpart.

5 (b) LAWS RELATING TO PUBLIC HEALTH.—Nothing
6 in this subpart is intended to preempt or operate to the
7 exclusion of any State public health law that prevents or
8 regulates disclosure of protected health information other-
9 wise allowed under this Act.

10 (c) PRIVILEGES.—Nothing in this subpart is intended
11 to preempt or modify State common or statutory law to
12 the extent such law concerns a privilege of a witness or
13 person in a court of the State. This subpart does not su-
14 percede or modify Federal common or statutory law to the
15 extent such law concerns a privilege of a witness or person
16 in a court of the United States.

17 (d) CERTAIN DUTIES UNDER STATE OR FEDERAL
18 LAW.—This subpart shall not be construed to preempt,
19 supersede, or modify the operation of—

20 (1) any law that provides for the reporting of
21 vital statistics such as birth or death information;

22 (2) any law requiring the reporting of abuse or
23 neglect information about any individual; or

24 (3) subpart II of part E of title XXVI of the
25 Public Health Service Act (relating to notifications

1 of emergency response employees of possible expo-
2 sure to infectious diseases); or

3 (4) any federal law that prevents or regulates
4 disclosure of protected health information.

5 **SEC. 5191. PRIOR WRITTEN CONSENT.**

6 Except as otherwise provided in this title, no individ-
7 ually identifiable health care information may be disclosed,
8 shared or otherwise transmitted without the prior, valid,
9 written consent of the individuals about whom the infor-
10 mation is maintained. Such consent may not be provided
11 on a form that is used to authorize or facilitate the provi-
12 sion of, or payment for, health care. A separate consent
13 shall be obtained for each proposed disclosure under this
14 section. With respect to minors or individuals deemed in-
15 capable of giving valid written consent, State law shall
16 apply as appropriate.

17 **SEC. 5192. PROVIDER IDENTIFIABLE DATA.**

18 The Board shall establish standards for the disclo-
19 sure and transmission of provider identifiable data.

20 **PART 3—INTERIM REQUIREMENTS FOR**
21 **ADMINISTRATIVE SIMPLIFICATION**

22 **SEC. 5195. STANDARD BENEFIT FORMS.**

23 (a) DEVELOPMENT.—Not later than 1 year after the
24 date of the enactment of this Act, the National Health
25 Board shall develop, promulgate, and publish in the Fed-

1 eral Register the following standard health care benefit
2 forms:

3 (1) An enrollment and disenrollment form to be
4 used to record enrollment and disenrollment in a
5 health benefit plan.

6 (2) A clinical encounter record to be used by
7 health benefit plans and health service providers.

8 (3) A claim form to be used in the submission
9 of claims for benefits or payment under a health
10 benefit plan.

11 (b) INSTRUCTIONS, DEFINITIONS, AND CODES.—
12 Each standard form developed under subsection (a) shall
13 include instructions for completing the form that—

14 (1) specifically define, to the extent practicable,
15 the data elements contained in the form; and

16 (2) standardize any codes or data sets to be
17 used in completing the form.

18 (c) REQUIREMENTS FOR ADOPTION OF FORMS.—

19 (1) HEALTH SERVICE PROVIDERS.—On or after
20 the date that is 270 days after the publication of the
21 standard forms developed under subsection (a), a
22 health service provider that furnishes items or serv-
23 ices in the United States for which payment may be
24 made under a health benefit plan may not—

1 (A) maintain records of clinical encounters
2 involving such items or services that are re-
3 quired to be maintained by the National Health
4 Board in a paper form that is not the clinical
5 encounter record promulgated by the Board; or

6 (B) submit any claim for benefits or pay-
7 ment for such services to such plan in a paper
8 form that is not the claim form promulgated by
9 the National Health Board.

10 (2) HEALTH BENEFIT PLANS.—On or after the
11 date that is 270 days after the publication of the
12 standard forms developed under subsection (a), a
13 health benefit plan may not—

14 (A) record enrollment and disenrollment in
15 a paper form that is not the enrollment and
16 disenrollment form promulgated by the Na-
17 tional Health Board;

18 (B) maintain records of clinical encounters
19 that are required to be maintained by the Na-
20 tional Health Board in a paper form that is not
21 the clinical encounter record promulgated by
22 the Board; or

23 (C) reject a claim for benefits or payment
24 under the plan on the basis of the form or me-
25 dium in which the claim is submitted if—

1 (i) the claim is submitted on the claim
2 form promulgated by the National Health
3 Board; and

4 (ii) the plan accepts claims submitted
5 in paper form.

6 (d) DEFINITIONS.—For purposes of this subtitle:

7 (1) HEALTH BENEFIT PLAN.—

8 (A) IN GENERAL.—The term “health bene-
9 fit plan” means, except as provided in subpara-
10 graphs (B) through (D), any public or private
11 entity or program that provides for payments
12 for health care services, including—

13 (i) a group health plan (as defined in
14 section 5000(b)(1) of the Internal Revenue
15 Code of 1986); and

16 (ii) any other health insurance ar-
17 rangement, including any arrangement
18 consisting of a hospital or medical expense
19 incurred policy or certificate, hospital or
20 medical service plan contract, or health
21 maintenance organization subscriber con-
22 tract.

23 (B) PLANS EXCLUDED.—Such term does
24 not include—

1 (i) accident-only, credit, or disability
2 income insurance;

3 (ii) coverage issued as a supplement
4 to liability insurance;

5 (iii) an individual making payment on
6 the individual's own behalf (or on behalf of
7 a relative or other individual) for
8 deductibles, coinsurance, or services not
9 covered under a health benefit plan; and

10 (iv) such other plans as the National
11 Health Board may determine, because of
12 the limitation of benefits to a single type
13 or kind of health care, such as dental serv-
14 ices or hospital indemnity plans, or other
15 reasons should not be subject to the re-
16 quirements of this section.

17 (C) PLANS INCLUDED.—Such term in-
18 cludes—

19 (i) workers compensation or similar
20 insurance insofar as it relates to workers
21 compensation medical benefits (as defined
22 in section 10000(3)) provided by or
23 through health plans; and

24 (ii) automobile medical insurance in-
25 sofar as it relates to automobile insurance

1 medical benefits (as defined in section
2 10100(2)) provided by or through health
3 plans.

4 (D) TREATMENT OF DIRECT PROVISION OF
5 SERVICES.—Such term does not include a Fed-
6 eral or State program that provides directly for
7 the provision of health services to beneficiaries.

8 (2) HEALTH SERVICE PROVIDER.—The term
9 “health service provider” includes a provider of serv-
10 ices (as defined in section 1861(u) of the Social Se-
11 curity Act), physician, supplier, and other person
12 furnishing health care services. Such term includes
13 a Federal or State program that provides directly
14 for the provision of health services to beneficiaries.

15 (e) INTERIM NATURE OF REQUIREMENTS.—Any re-
16 quirement with respect to a standard form imposed under
17 this part shall cease to be effective upon a determination
18 by the Board that the health care data network (as defined
19 in section 5102(3)) is operational.

1 **Subtitle C—Remedies and**
2 **Enforcement**

3 **PART 1—REVIEW OF BENEFIT DETERMINATIONS**
4 **FOR ENROLLED INDIVIDUALS**

5 **Subpart A—General Rules**

6 **SEC. 5201. HEALTH PLAN CLAIMS PROCEDURE.**

7 (a) DEFINITIONS.—For purposes of this section—

8 (1) CLAIM.—The term “claim” means a claim
9 for payment or provision of benefits under a health
10 plan, a request for preauthorization of items or serv-
11 ices which is submitted to a health plan prior to re-
12 ceipt of the items or services, or the denial, reduc-
13 tion or termination of any service or request for a
14 referral or reimbursement.

15 (2) INDIVIDUAL CLAIMANT.—The term “indi-
16 vidual claimant” with respect to a claim means any
17 individual who submits the claim to a health plan in
18 connection with the individual’s enrollment under
19 the plan, or on whose behalf the claim is submitted
20 to the plan by a provider.

21 (3) PROVIDER CLAIMANT.—The term “provider
22 claimant” with respect to a claim means any pro-
23 vider who submits the claim to a health plan with
24 respect to items or services provided to an individual
25 enrolled under the plan.

1 (b) GENERAL RULES GOVERNING TREATMENT OF
2 CLAIMS.—

3 (1) ADEQUATE NOTICE OF DISPOSITION OF
4 CLAIM.—In any case in which a claim is submitted
5 in complete form to a health plan, the plan shall
6 provide to the individual claimant and any provider
7 claimant with respect to the claim a written notice
8 of the plan's approval or denial of the claim within
9 15 days after the date of the submission of the
10 claim. The notice to the individual claimant shall be
11 written in language calculated to be understood by
12 the typical individual enrolled under the plan and in
13 a form which takes into account accessibility to the
14 information by individuals whose primary language
15 is not English. In the case of a denial of the claim,
16 the notice shall be provided within 5 days after the
17 date of the determination to deny the claim, and
18 shall set forth the specific reasons for the denial.
19 Such notice shall include an explanation of the spe-
20 cific reasons and facts underlying the decision to re-
21 duce or fail to provide services or pay the claim. The
22 notice of a denial shall clearly explain the right to
23 appeal the denial under paragraph (2) and a de-
24 scription of the process for appealing such decision
25 sufficient to allow the claimant to initiate an appeal

1 and submit evidence to the decision maker in sup-
2 port of the position of the claimant. Failure by any
3 plan to comply with the requirements of this para-
4 graph with respect to any claim submitted to the
5 plan shall be treated as approval by the plan of the
6 claim.

7 (2) PLAN'S DUTY TO REVIEW DENIALS UPON
8 TIMELY REQUEST.—The plan shall review its denial
9 of the claim if an individual claimant or provider
10 claimant with respect to the claim submits to the
11 plan a written request for reconsideration of the
12 claim after receipt of written notice from the plan of
13 the denial. The plan shall allow any such claimant
14 not less than 60 days, after receipt of written notice
15 from the plan of the denial, to submit the claimant's
16 request for reconsideration of the claim.

17 (3) TIME LIMIT FOR REVIEW.—The plan shall
18 complete any review required under paragraph (2),
19 and shall provide the individual claimant and any
20 provider claimant with respect to the claim written
21 notice of the plan's decision on the claim after re-
22 consideration pursuant to the review, within 30 days
23 after the date of the receipt of the request for recon-
24 sideration.

1 (4) DE NOVO REVIEWS.—Any review required
2 under paragraph (2)—

3 (A) shall be de novo,

4 (B) shall be conducted by an individual
5 who did not make the initial decision denying
6 the claim and who is authorized to approve the
7 claim, and

8 (C) shall include review by a qualified phy-
9 sician in the same speciality as the treating
10 physician if the resolution of any issues involved
11 requires medical expertise.

12 (c) TREATMENT OF URGENT REQUESTS TO PLANS
13 FOR PREAUTHORIZATION.—

14 (1) IN GENERAL.—This subsection applies in
15 the case of any claim submitted by an individual
16 claimant or a provider claimant consisting of a re-
17 quest for preauthorization of items or services (other
18 than emergency services which under section
19 1406(b) may not be subject to preauthorization)
20 which is accompanied by an attestation that—

21 (A) failure to immediately provide the
22 items or services could reasonably be expected
23 to result in—

24 (i) placing the health of the individual
25 claimant (or, with respect to an individual

1 claimant who is a pregnant woman, the
2 health of the woman or her unborn child)
3 in serious jeopardy,

4 (ii) serious impairment to bodily func-
5 tions, or

6 (iii) serious dysfunction of any bodily
7 organ or part,

8 or

9 (B) immediate provision of the items or
10 services is necessary because the individual
11 claimant has made or is at serious risk of mak-
12 ing an attempt to harm such individual claim-
13 ant or another individual.

14 (2) SHORTENED TIME LIMIT FOR CONSIDER-
15 ATION OF REQUESTS FOR PREAUTHORIZATION.—
16 Notwithstanding subsection (b)(1), a health plan
17 shall approve or deny any claim described in para-
18 graph (1) within 12 hours after submission of the
19 claim to the plan. Failure by the plan to comply with
20 the requirements of this paragraph with respect to
21 the claim shall be treated as approval by the plan of
22 the claim.

23 (3) EXPEDITED EXHAUSTION OF PLAN REM-
24 EDIES.—Any claim described in paragraph (1) which
25 is denied by the plan shall be treated as a claim with

1 respect to which all remedies under the plan pro-
2 vided pursuant to this section are exhausted, irre-
3 spective of any review provided under subsection
4 (b)(2).

5 (4) DENIAL OF PREVIOUSLY AUTHORIZED
6 CLAIMS NOT PERMITTED.—In any case in which a
7 health plan approves a claim described in paragraph
8 (1)—

9 (A) the plan may not subsequently deny
10 payment or provision of benefits pursuant to
11 the claim, unless the plan makes a showing of
12 an intentional misrepresentation of a material
13 fact by the individual claimant, and

14 (B) in the case of a violation of subpara-
15 graph (A) in connection with the claim, all rem-
16 edies under the plan provided pursuant to this
17 section with respect to the claim shall be treat-
18 ed as exhausted.

19 (d) TIME LIMIT FOR DETERMINATION OF INCOM-
20 PLETENESS OF CLAIM.—For purposes of this section—

21 (1) any claim submitted by an individual claim-
22 ant and accepted by a provider serving under con-
23 tract with a health plan and any claim described in
24 subsection (b)(1) shall be treated with respect to the

1 individual claimant as submitted in complete form,
2 and

3 (2) any other claim for benefits under the plan
4 shall be treated as filed in complete form as of 10
5 days after the date of the submission of the claim,
6 unless the plan provides to the individual claimant
7 and any provider claimant, within such period, a
8 written notice of any required matter remaining to
9 be filed in order to complete the claim.

10 Any filing by the individual claimant or the provider claim-
11 ant of additional matter requested by the plan pursuant
12 to paragraph (2) shall be treated for purposes of this sec-
13 tion as an initial filing of the claim.

14 (e) ADDITIONAL NOTICE AND DISCLOSURE RE-
15 QUIREMENTS FOR HEALTH PLANS.—In the case of a de-
16 nial of a claim for benefits under a health plan, the plan
17 shall include, together with the specific reasons provided
18 to the individual claimant and any provider claimant
19 under subsection (b)(1)—

20 (1) if the denial is based in whole or in part on
21 a determination that the claim is for an item or
22 service which is not covered by the comprehensive
23 benefit package or exceeds payment rates under the
24 applicable fee schedule, the factual basis for the de-
25 termination,

1 in consultation with the National Health Board,
2 each State shall establish and maintain a complaint
3 review office for each health care coverage area es-
4 tablished by such State. According to designations
5 which shall be made by each State under regulations
6 of the Secretary of Labor, in consultation with such
7 Board, the complaint review office for a health care
8 coverage area established by such State shall also
9 serve as the complaint review office for large group
10 sponsors operating in the State with respect to indi-
11 viduals who are enrolled under health plans main-
12 tained by such sponsors and who reside within the
13 area of the health care coverage area.

14 (2) HEALTH SYSTEMS NOT ESTABLISHED BY
15 STATES.—In the case of any health care system es-
16 tablished in any State by the Secretary of Health
17 and Human Services, the Secretary of Health and
18 Human Services shall assume all duties and obliga-
19 tions of such State under this part in accordance
20 with the applicable regulations of the Secretary of
21 Labor, in consultation with the National Health
22 Board, under this part.

23 (b) FILINGS OF COMPLAINTS BY AGGRIEVED PER-
24 SONS.—In the case of any person who is aggrieved by—

1 (1) any act or practice engaged in by any
2 health plan which consists of or results in denial of
3 payment or provision of benefits under the plan or
4 delay in the payment or provision of benefits, or

5 (2) any act or practice engaged in by any other
6 plan maintained in a health care coverage area or by
7 a large group sponsor which consists of or results in
8 denial of payment or provision of benefits under a
9 supplemental benefit policy described in section
10 1421(b)(1) or a cost sharing policy described in sec-
11 tion 1421(b)(2) or delay in the payment or provision
12 of the benefits,

13 if the denial or delay consists of a failure to comply with
14 the terms of the plan (including the provision of benefits
15 in full when due in accordance with the terms of the plan),
16 or with the applicable requirements of this Act, such per-
17 son may file a complaint with the appropriate complaint
18 review office.

19 (c) EXHAUSTION OF PLAN REMEDIES.—Any com-
20 plaint including a claim to which section 5201 applies may
21 not be filed until the complainant has exhausted all rem-
22 edies provided under the plan with respect to the claim
23 in accordance with such section.

24 (d) FORM OF COMPLAINT.—The complaint shall be
25 in writing under oath or affirmation, shall set forth the

1 complaint in a manner calculated to give notice of the na-
2 ture of the complaint, and shall contain such information
3 as may be prescribed in regulations of the Secretary of
4 Labor.

5 (e) NOTICE OF FILING.—The complaint review office
6 shall serve by certified mail a notice of the complaint (in-
7 cluding the date, place, and circumstances of the alleged
8 violation) on the person or persons alleged in the com-
9 plaint to have committed the violation within 10 days after
10 the filing of the complaint.

11 (f) TIME LIMITATION.—Complaints may not be
12 brought under this section with respect to any violation
13 later than one year after the date on which the complain-
14 ing party knows or should have reasonably known that a
15 violation has occurred. This subsection shall not prevent
16 the subsequent amending of a complaint.

17 **SEC. 5203. INITIAL PROCEEDINGS IN COMPLAINT REVIEW**
18 **OFFICES.**

19 (a) ELECTIONS.—Whenever a complaint is brought
20 to the complaint review office under section 5202(b), the
21 complaint review office shall provide the complainant with
22 an opportunity, in such form and manner as shall be pre-
23 scribed in regulations of the Secretary of Labor, to elect
24 one of the following:

1 (1) to forego further proceedings in the com-
2 plaint review office and rely on remedies available in
3 a court of competent jurisdiction, with respect to
4 any matter in the complaint,

5 (2) to submit the complaint as a dispute under
6 the Early Resolution Program established under
7 subpart B and thereby suspend further review pro-
8 ceedings under this section pending termination of
9 proceedings under the Program, or

10 (3) in any case in which an election under para-
11 graph (2) is not made, or such an election was made
12 but resolution of all matters in the complaint was
13 not obtained upon termination of proceedings pursu-
14 ant to the election by settlement agreement or other-
15 wise, to proceed with the complaint to a hearing in
16 the complaint review office under section 5204 re-
17 garding the unresolved matters.

18 (b) DUTY OF COMPLAINT REVIEW OFFICE.—The
19 complaint review office shall provide (in a linguistically ap-
20 propriate manner) an explanation to complainants bring-
21 ing complaints to the office concerning the legal and other
22 ramifications of each option available under this section.

23 (c) EFFECT OF PARTICIPATION IN EARLY RESOLU-
24 TION PROGRAM.—Any matter in a complaint brought to
25 the complaint review office which is included in a dispute

1 which is timely submitted to the Early Resolution Pro-
2 gram established under subpart B shall not be assigned
3 to a hearing under section 5204 unless the proceedings
4 under the Program with respect to the dispute are termi-
5 nated without settlement or resolution of the dispute with
6 respect to such matter. Upon termination of any proceed-
7 ings regarding a dispute submitted to the Program, the
8 applicability of this section to any matter in a complaint
9 which was included in the dispute shall not be affected
10 by participation in the proceedings, except to the extent
11 otherwise required under the terms of any settlement
12 agreement or other formal resolution obtained in the pro-
13 ceedings.

14 **SEC. 5204. HEARINGS BEFORE HEARING OFFICERS IN COM-**
15 **PLAINT REVIEW OFFICES.**

16 (a) HEARING PROCESS.—

17 (1) ASSIGNMENT OF COMPLAINTS TO HEARING
18 OFFICERS AND NOTICE TO PARTIES.—

19 (A) IN GENERAL.—In the case of an elec-
20 tion under section 5203(a)(3)—

21 (i) the complaint review office shall
22 assign the complaint, and each motion in
23 connection with the complaint, to a hearing
24 officer employed by the State in the office;
25 and

1 (ii) the hearing officer shall have the
2 power to issue and cause to be served upon
3 the plan named in the complaint a copy of
4 the complaint and a notice of hearing be-
5 fore the hearing officer at a place fixed in
6 the notice, not less than 5 days after the
7 serving of the complaint.

8 (B) QUALIFICATIONS FOR HEARING OFFI-
9 CERS.—No individual may serve in a complaint
10 review office as a hearing officer unless the in-
11 dividual meets standards which shall be pre-
12 scribed by the Secretary of Labor. Such stand-
13 ards shall include experience, training, ability to
14 communicate with the enrollee, affiliations, dili-
15 gence, absence of actual or potential conflicts of
16 interest, and other qualifications deemed rel-
17 evant by the Secretary of Labor. At no time
18 shall a hearing officer have any official, finan-
19 cial, or personal conflict of interest with respect
20 to issues in controversy before the hearing offi-
21 cer.

22 (2) AMENDMENT OF COMPLAINTS.—Any such
23 complaint may be amended by the hearing officer
24 conducting the hearing, upon the motion of the com-

1 plainant, in the hearing officer's discretion at any
2 time prior to the issuance of an order based thereon.

3 (3) ANSWERS.—The party against whom the
4 complaint is filed shall have the right to file an an-
5 swer to the original or amended complaint and to
6 appear in person or otherwise and give testimony at
7 the place and time fixed in the complaint.

8 (b) ADDITIONAL PARTIES.—In the discretion of the
9 hearing officer conducting the hearing, any other person
10 may be allowed to intervene in the proceeding and to
11 present testimony.

12 (c) HEARINGS.—

13 (1) DE NOVO HEARING.—Each hearing officer
14 shall hear complaints and motions de novo.

15 (2) TESTIMONY.—The testimony taken by the
16 hearing officer shall be reduced to writing. There-
17 after, the hearing officer, in his or her discretion,
18 upon notice may provide for the taking of further
19 testimony or hear argument.

20 (3) AUTHORITY OF HEARING OFFICERS.—The
21 hearing officer may compel by subpoena the attend-
22 ance of witnesses and the production of evidence at
23 any designated place or hearing. In case of contu-
24 macy or refusal to obey a subpoena lawfully issued
25 under this paragraph and upon application of the

1 hearing officer, an appropriate district court of the
2 United States may issue an order requiring compli-
3 ance with the subpoena and any failure to obey the
4 order may be punished by the court as a contempt
5 thereof. The hearing officer may also seek enforce-
6 ment of the subpoena in a State court of competent
7 jurisdiction.

8 (4) EXPEDITED HEARINGS.—Notwithstanding
9 section 5203 and the preceding provisions of this
10 section, upon receipt of a complaint containing a
11 claim described in section 5201(c)(1), the complaint
12 review office shall promptly provide the complainant
13 with the opportunity to make an election under sec-
14 tion 5203(a)(3) and assignment to a hearing on the
15 complaint before a hearing officer. The complaint re-
16 view office shall ensure that such a hearing com-
17 mences not later than 24 hours after receipt of the
18 complaint by the complaint hearing office and not
19 later than 3 days after the receipt of a complaint,
20 the Complaint Review Office shall provide a decision.

21 (d) DECISION OF HEARING OFFICER.—

22 (1) IN GENERAL.—Not later than 120 days
23 after the date on which a complaint is assigned
24 under this section, the hearing officer shall decide if
25 the preponderance of the evidence justifies the denial

1 of services and whether to decide in favor of the
2 complainant with respect to each alleged act or prac-
3 tice. Each such decision—

4 (A) shall include the hearing officer's find-
5 ings of fact, and

6 (B) shall constitute the hearing officer's
7 final disposition of the proceedings.

8 (2) DECISIONS FINDING IN FAVOR OF COM-
9 PLAINANT.—If the hearing officer's decision includes
10 a determination that any party named in the com-
11 plaint has engaged in or is engaged in an act or
12 practice described in section 5202(b), the hearing of-
13 ficer shall issue and cause to be served on such
14 party an order which requires such party—

15 (A) to cease and desist from such act or
16 practice,

17 (B) to provide the benefits due under the
18 terms of the plan and to otherwise comply with
19 the terms of the plan and the applicable re-
20 quirements of this Act,

21 (C) to pay to the complainant prejudgment
22 interest on the actual costs incurred in obtain-
23 ing the items and services at issue in the com-
24 plaint,

1 (D) to pay to the prevailing complainant a
2 reasonable attorney's fee, reasonable expert wit-
3 ness fees, and other reasonable costs relating to
4 the hearing on the charges on which the com-
5 plainant prevails, and

6 (E) to provide other appropriate relief.

7 (3) DECISIONS NOT IN FAVOR OF COMPLAIN-
8 ANT.—If the hearing officer's decision includes a de-
9 termination that the party named in the complaint
10 has not engaged in or is not engaged in an act or
11 practice referred to in section 5202(b), the hearing
12 officer—

13 (A) shall include in the decision a dismissal
14 of the charge in the complaint relating to the
15 act or practice, and

16 (B) upon a finding that such charge is
17 frivolous, shall issue and cause to be served on
18 the complainant an order which requires the
19 complainant to pay to such party a reasonable
20 attorney's fee, reasonable expert witness fees,
21 and other reasonable costs relating to the pro-
22 ceedings on such charge.

23 (4) SUBMISSION AND SERVICE OF DECISIONS.—
24 The hearing officer shall submit each decision to the
25 complaint review office at the conclusion of the pro-

1 proceedings and the office shall cause a copy of the de-
2 cision to be served on the parties to the proceedings.

3 (e) REVIEW.—

4 (1) IN GENERAL.—The decision of the hearing
5 officer shall be final and binding upon all parties.
6 Except as provided in paragraph (2), any party to
7 the complaint may, within 30 days after service of
8 the decision by the complaint review office, file an
9 appeal of the decision with the Federal Health Plan
10 Review Board under section 5205 in such form and
11 manner as may be prescribed by such Board.

12 (2) EXCEPTION.—The decision in the case of
13 an expedited hearing under subsection (c)(4) shall
14 not be subject to review.

15 (f) COURT ENFORCEMENT OF ORDERS.—

16 (1) IN GENERAL.—If a decision of the hearing
17 officer in favor of the complainant is not appealed
18 under section 5205, the complainant may petition
19 any court of competent jurisdiction for enforcement
20 of the order. In any such proceeding, the order of
21 the hearing officer shall not be subject to review.

22 (2) AWARDING OF COSTS.—In any action for
23 court enforcement under this subsection, a prevailing
24 complainant shall be entitled to a reasonable attor-

1 tion 5304, and shall provide for the orderly consideration
2 of arguments by any party to the hearing upon which the
3 hearing officer's decision is based. In the discretion of the
4 Review Board, any other person may be allowed to inter-
5 vene in the proceeding and to present written argument.
6 The National Health Board may intervene in the proceed-
7 ing as a matter of right.

8 (c) SCOPE OF REVIEW.—The Review Board shall re-
9 view the decision of the hearing officer from which the
10 appeal is made, except that the review shall be only for
11 the purposes of determining—

12 (1) whether the determination is supported by
13 substantial evidence on the record considered as a
14 whole,

15 (2) in the case of any interpretation by the
16 hearing officer of contractual terms (irrespective of
17 the extent to which extrinsic evidence was consid-
18 ered), whether the determination is supported by a
19 preponderance of the evidence,

20 (3) whether the determination is in excess of
21 statutory jurisdiction, authority, or limitations, or in
22 violation of a statutory right, or

23 (4) whether the determination is without ob-
24 servance of procedure required by law.

1 (d) DECISION OF REVIEW BOARD.—The decision of
2 the hearing officer as affirmed or modified by the Review
3 Board (or any reversal by the Review Board of the hearing
4 officer’s final disposition of the proceedings) shall become
5 the final order of the Review Board and binding on all
6 parties, subject to review under subsection (e). The Review
7 Board shall cause a copy of its decision to be served on
8 the parties to the proceedings not later than 5 days after
9 the date of the decision.

10 (e) REVIEW OF FINAL ORDERS.—

11 (1) IN GENERAL.—Not later than 60 days after
12 the entry of the final order, any person aggrieved by
13 any such final order under which the amount or
14 value in controversy exceeds \$10,000 may seek a re-
15 view of the order in the United States court of ap-
16 peals for the circuit in which the violation is alleged
17 to have occurred or in which the complainant re-
18 sides.

19 (2) FURTHER REVIEW.—Upon the filing of the
20 record with the court, the jurisdiction of the court
21 shall be exclusive and its judgment shall be final, ex-
22 cept that the judgment shall be subject to review by
23 the Supreme Court of the United States upon writ
24 of certiorari or certification as provided in section
25 1254 of title 28 of the United States Code.

1 (3) ENFORCEMENT DECREE IN ORIGINAL RE-
2 VIEW.—If, upon appeal of an order under paragraph
3 (1), the United States court of appeals does not re-
4 verse the order, the court shall have the jurisdiction
5 to make and enter a decree enforcing the order of
6 the Review Board.

7 (f) AWARDING OF ATTORNEYS' FEES AND OTHER
8 COSTS AND EXPENSES.—In any proceeding before the Re-
9 view Board under this section or any judicial proceeding
10 under subsection (e), the Review Board or the court (as
11 the case may be) shall award to a prevailing complainant
12 reasonable costs and expenses (including a reasonable at-
13 torney's fee) on the causes on which the complainant pre-
14 vails.

15 **SEC. 5206. CIVIL MONEY PENALTIES.**

16 (a) DENIAL OR DELAY IN PAYMENT OR PROVISION
17 OF BENEFITS.—

18 (1) IN GENERAL.—The Secretary of Labor, in
19 consultation with the National Health Board, may
20 assess a civil penalty against any health plan, or
21 against any other plan in connection with benefits
22 provided thereunder under a supplemental benefit
23 policy described in section 1421(b)(1) or a cost shar-
24 ing policy described in section 1421(b)(2), for unrea-

1 sonable denial or delay in the payment or provision
2 of benefits thereunder, in an amount not to exceed—

3 (A) \$25,000 per violation, or \$75,000 per
4 violation in the case of a finding of bad faith
5 on the part of the plan, and

6 (B) in the case of a finding of a pattern
7 or practice of such violations engaged in by the
8 plan, \$1,000,000 in addition to the total
9 amount of penalties assessed under subpara-
10 graph (A) with respect to such violations.

11 For purposes of subparagraph (A), each violation
12 with respect to any single individual shall be treated
13 as a separate violation.

14 (2) CIVIL ACTION TO ENFORCE CIVIL PEN-
15 ALTY.—The Secretary of Labor, in consultation with
16 the National Health Board, may commence a civil
17 action in any court of competent jurisdiction to en-
18 force a civil penalty assessed under paragraph (1).

19 (3) SUPPLEMENTAL PLANS.—Nothing in this
20 section shall be construed to limit the rights and
21 remedies available under State law with respect to
22 supplemental benefit plans.

23 (b) CIVIL PENALTIES FOR CERTAIN OTHER AC-
24 TIONS.—The Secretary of Labor, in consultation with the
25 National Health Board, may assess a civil penalty de-

1 scribed in section 5412(b)(1) against any experience-rated
2 health plan, or against any other plan sponsored by a large
3 group sponsor in connection with benefits provided there-
4 under under a cost sharing policy described in section
5 1421(b)(2), for any action described in section 5412(a).
6 The Secretary of Labor, in consultation with the National
7 Health Board, may initiate proceedings to impose such
8 penalty in the same manner as the Secretary of Health
9 and Human Services may initiate proceedings under sec-
10 tion 5412 with respect to actions described in section
11 5412(a).

12 **Subpart B—Early Resolution Programs**

13 **SEC. 5211. ESTABLISHMENT OF EARLY RESOLUTION PRO-**
14 **GRAMS IN COMPLAINT REVIEW OFFICES.**

15 (a) ESTABLISHMENT OF PROGRAMS.—Each State
16 shall establish and maintain an Early Resolution Program
17 in each complaint review office in such State. The Pro-
18 gram shall include—

19 (1) the establishment and maintenance of fo-
20 rums for mediation of disputes in accordance with
21 this subpart, and

22 (2) the establishment and maintenance of such
23 forums for other forms of alternative dispute resolu-
24 tion (including binding arbitration) as may be pre-

1 scribed in regulations of the Secretary of Labor, in
2 consultation with the National Health Board.

3 Each State shall ensure that the standards applied in
4 Early Resolution Programs administered in such State
5 which apply to any form of alternative dispute resolution
6 described in paragraph (2) and which relate to time re-
7 quirements, qualifications of facilitators, arbitrators, or
8 other mediators, and confidentiality are at least equivalent
9 to the standards which apply to mediation proceedings
10 under this subpart.

11 (b) DUTIES OF COMPLAINT REVIEW OFFICES.—
12 Each complaint review office in a State—

13 (1) shall administer its Early Resolution Pro-
14 gram in accordance with regulations of the Secretary
15 of Labor, in consultation with the National Health
16 Board,

17 (2) shall, pursuant to subsection (a)(1)—

18 (A) recruit and train individuals to serve
19 as facilitators for mediation proceedings under
20 the Early Resolution Program from attorneys
21 who have the requisite expertise for such serv-
22 ice, which shall be specified in regulations of
23 the Secretary of Labor, in consultation with the
24 National Health Board,

1 (B) provide meeting sites, maintain
2 records, and provide facilitators with adminis-
3 trative support staff, and

4 (C) establish and maintain attorney refer-
5 ral panels,

6 (3) shall ensure that, upon the filing of a com-
7 plaint with the office, the complainant is adequately
8 apprised of the complainant's options for review
9 under this part, and

10 (4) shall monitor and evaluate the Program on
11 an ongoing basis.

12 **SEC. 5212. INITIATION OF PARTICIPATION IN MEDIATION**
13 **PROCEEDINGS.**

14 (a) **ELIGIBILITY OF CASES FOR SUBMISSION TO**
15 **EARLY RESOLUTION PROGRAM.**—A dispute may be sub-
16 mitted to the Early Resolution Program only if the follow-
17 ing requirements are met with respect to the dispute:

18 (1) **NATURE OF DISPUTE.**—The dispute con-
19 sists of an assertion by an individual enrolled under
20 a health plan of one or more claims against the
21 health plan for payment or provision of benefits, or
22 against any other plan community-rated health plan
23 or large group sponsor sponsoring the health plan
24 with respect to benefits provided under a supple-
25 mental benefit policy described in section 1421(b)(1)

1 or a cost sharing policy described in section
2 1421(b)(2), based on alleged coverage under the
3 plan, and a denial of the claims, or a denial of ap-
4 propriate reimbursement based on the claims, by the
5 plan.

6 (2) NATURE OF DISPUTED CLAIM.—Each claim
7 consists of—

8 (A) a claim for payment or provision of
9 benefits under the plan; or

10 (B) a request for information or docu-
11 ments the disclosure of which is required under
12 this Act (including claims of entitlement to dis-
13 closure based on colorable claims to rights to
14 benefits under the plan).

15 (b) FILING OF ELECTION.—A complainant with a
16 dispute which is eligible for submission to the Early Reso-
17 lution Program may make the election under section
18 5203(a)(2) to submit the dispute to mediation proceedings
19 under the Program not later than 15 days after the date
20 the complaint is filed with the complaint review office
21 under section 5202(b).

22 (c) AGREEMENT TO PARTICIPATE.—

23 (1) ELECTION BY CLAIMANT.—A complainant
24 may elect participation in the mediation proceedings
25 only by entering into a written participation agree-

1 ment (including an agreement to comply with the
2 rules of the Program and consent for the complaint
3 review office to contact the health plan regarding the
4 agreement), and by releasing plan records to the
5 Program for the exclusive use of the facilitator as-
6 signed to the dispute.

7 (2) PARTICIPATION BY PLANS OR HEALTH BEN-
8 EFITS CONTRACTORS.—Each party whose participa-
9 tion in the mediation proceedings has been elected
10 by a claimant pursuant to paragraph (1) shall par-
11 ticipate in, and cooperate fully with, the proceedings.
12 The claims review office shall provide such party
13 with a copy of the participation agreement described
14 in paragraph (1), together with a written description
15 of the Program. Such party shall submit the copy of
16 the agreement, together with its authorized signa-
17 ture signifying receipt of notice of the agreement, to
18 the claims review office, and shall include in the sub-
19 mission to the claims review office a copy of the
20 written record of the plan claims procedure com-
21 pleted pursuant to section 5201 with respect to the
22 dispute and all relevant plan documents. The rel-
23 evant documents shall include all documents under
24 which the plan is or was administered or operated,
25 including copies of any insurance contracts under

1 which benefits are or were provided and any fee or
2 reimbursement schedules for health care providers.

3 **SEC. 5213. MEDIATION PROCEEDINGS.**

4 (a) **ROLE OF FACILITATOR.**—In the course of medi-
5 ation proceedings under the Early Resolution Program,
6 the facilitator assigned to the dispute shall prepare the
7 parties for a conference regarding the dispute and serve
8 as a neutral mediator at such conference, with the goal
9 of achieving settlement of the dispute.

10 (b) **PREPARATIONS FOR CONFERENCE.**—In advance
11 of convening the conference, after identifying the nec-
12 essary parties and confirming that the case is eligible for
13 the Program, the facilitator shall analyze the record of the
14 claims procedure conducted pursuant to section 5201 and
15 any position papers submitted by the parties to determine
16 if further case development is needed to clarify the legal
17 and factual issues in dispute, and whether there is any
18 need for additional information and documents.

19 (c) **CONFERENCE.**—Upon convening the conference,
20 the facilitator shall assist the parties in identifying undis-
21 puted issues and exploring settlement. If settlement is
22 reached, the facilitator shall assist in the preparation of
23 a written settlement agreement. If no settlement is
24 reached, the facilitator shall present the facilitator's eval-
25 uation, including an assessment of the parties' positions,

1 the likely outcome of further administrative action or liti-
2 gation, and suggestions for narrowing the issues in dis-
3 pute.

4 (d) TIME LIMIT.—The facilitator shall ensure that
5 mediation proceedings with respect to any dispute under
6 the Early Resolution Program shall be completed within
7 120 days after the election to participate. The parties may
8 agree to one extension of the proceedings by not more than
9 30 days if the proceedings are suspended to obtain an
10 agency ruling or to reconvene the conference in a subse-
11 quent session.

12 (e) INAPPLICABILITY OF FORMAL RULES.—Formal
13 rules of evidence shall not apply to mediation proceedings
14 under the Early Resolution Program. All statements made
15 and evidence presented in the proceedings shall be admis-
16 sible in the proceedings. The facilitator shall be the sole
17 judge of the proper weight to be afforded to each submis-
18 sion. The parties to mediation proceedings under the Pro-
19 gram shall not be required to make statements or present
20 evidence under oath.

21 (f) REPRESENTATION.—Parties may participate pro
22 se or be represented by attorneys throughout the proceed-
23 ings of the Early Resolution Program.

24 (g) CONFIDENTIALITY.—

1 (1) IN GENERAL.—Under regulations of the
2 Secretary of Labor, rules similar to the rules under
3 section 574 of title 5, United States Code (relating
4 to confidentiality in dispute resolution proceedings)
5 shall apply to the mediation proceedings under the
6 Early Resolution Program.

7 (2) CIVIL REMEDIES.—The Secretary of Labor
8 may assess a civil penalty against any person who
9 discloses information in violation of the regulations
10 prescribed pursuant to paragraph (1) in the amount
11 of three times the amount of the claim involved. The
12 Secretary of Labor may bring a civil action to en-
13 force such civil penalty in any court of competent ju-
14 risdiction.

15 **SEC. 5214. LEGAL EFFECT OF PARTICIPATION IN MEDI-**
16 **ATION PROCEEDINGS.**

17 (a) PROCESS NONBINDING.—Findings and conclu-
18 sions made in the mediation proceedings of the Early Res-
19 olution Program shall be treated as advisory in nature and
20 nonbinding. Except as provided in subsection (b), the
21 rights of the parties under subpart A shall not be affected
22 by participation in the Program.

23 (b) RESOLUTION THROUGH SETTLEMENT AGREE-
24 MENT.—If a case is settled through participation in medi-
25 ation proceedings under the Program, the facilitator shall

1 assist the parties in drawing up an agreement which shall
2 constitute, upon signature of the parties, a binding con-
3 tract between the parties, which shall be enforceable under
4 section 5215.

5 (c) PRESERVATION OF RIGHTS OF NON-PARTIES.—
6 The settlement agreement shall not have the effect of
7 waiving or otherwise affecting any rights to review under
8 subpart A, or any other right under this Act or the plan,
9 with respect to any person who is not a party to the settle-
10 ment agreement.

11 **SEC. 5215. ENFORCEMENT OF SETTLEMENT AGREEMENTS.**

12 (a) ENFORCEMENT.—Any party to a settlement
13 agreement entered pursuant to mediation proceedings
14 under this subpart may petition any court of competent
15 jurisdiction for the enforcement of the agreement, by filing
16 in the court a written petition praying that the agreement
17 be enforced. In such a proceeding, the order of the hearing
18 officer shall not be subject to review.

19 (b) COURT REVIEW.—It shall be the duty of the court
20 to advance on the docket and to expedite to the greatest
21 possible extent the disposition of any petition filed under
22 this section, with due deference to the role of settlement
23 agreements under this part in achieving prompt resolution
24 of disputes involving health plans.

1 (c) AWARDING OF ATTORNEY'S FEES AND OTHER
2 COSTS AND EXPENSES.—In any action by an individual
3 enrolled under a health plan for court enforcement under
4 this section, a prevailing plaintiff shall be entitled to rea-
5 sonable costs and expenses (including a reasonable attor-
6 ney's fee and reasonable expert witness fees) on the
7 charges on which the plaintiff prevails.

8 **SEC. 5216. DUE PROCESS FOR HEALTH CARE PROVIDERS.**

9 (a) PUBLICLY AVAILABLE STANDARDS AND PROC-
10 ESS.—Each health plan shall establish and utilize—

11 (1) publicly available standards for contracting
12 with health care providers; and

13 (2) a publicly available process for dismissing
14 such providers or failing to renew contracts with
15 such providers.

16 (b) NOTICE REQUIREMENT.—

17 (1) IN GENERAL.—The process established by a
18 health plan under subsection (a) shall include rea-
19 sonable notification to a health care provider of a
20 decision to dismiss such provider or not to renew a
21 contract with such provider before such decision
22 takes effect.

23 (2) EXCEPTION.—The notice required under
24 paragraph (1) shall not apply if failure to dismiss a

1 provider or renewing a provider's contract would ad-
2 versely affect the health or safety of a patient.

3 (3) CONTENTS OF NOTICE.—Each notice to a
4 health care provider under paragraph (1) shall con-
5 tain the reasons for the dismissal or failure to
6 renew. Such reasons shall be consistent with the
7 standards established under subsection (a).

8 (c) REVIEW.—The process established by a health
9 plan under subsection (a) shall include an opportunity for
10 review of the health plan's action by a health care provider
11 who is dismissed by a health plan or with respect to whom
12 a health plan fails to renew a contract. Such review shall
13 be conducted by—

14 (1) the provider's peers who have contracts
15 with, or are employed by, the health plan; and

16 (2) if there is mutual consent of the provider
17 and the health plan, one or more enrollees in the
18 health plan.

19 A health care provider may have an attorney present in
20 connection with any review under this subsection if the
21 provider notifies the health plan that an attorney will be
22 present in advance of the review proceeding.

23 (d) EFFECT ON OTHER LAWS.—The provisions of
24 this section shall not supersede any other provision of Fed-
25 eral or State law.

1 **PART 2—ADDITIONAL REMEDIES AND**

2 **ENFORCEMENT PROVISIONS**

3 **SEC. 5231. JUDICIAL REVIEW OF FEDERAL ACTION ON**
4 **STATE SYSTEMS.**

5 (a) IN GENERAL.—Any State that is aggrieved by a
6 determination by the National Health Board under sub-
7 part B of part 1 of subtitle F of title I shall be entitled
8 to judicial review of such determination in accordance with
9 this section.

10 (b) JUDICIAL REVIEW.—

11 (1) JURISDICTION.—The courts of appeals of
12 the United States (other than the United States
13 Court of Appeals for the Federal Circuit) shall have
14 jurisdiction to review a determination described in
15 subsection (a), to affirm the determination, or to set
16 it aside, in whole or in part. A judgment of a court
17 of appeals in such an action shall be subject to re-
18 view by the Supreme Court of the United States
19 upon certiorari or certification as provided in section
20 1254 of title 28, United States Code.

21 (2) PETITION FOR REVIEW.—A State that de-
22 sires judicial review of a determination described in
23 subsection (a) shall, within 30 days after it has been
24 notified of such determination, file with the United
25 States court of appeals for the circuit in which the
26 State is located a petition for review of such deter-

1 mination. A copy of the petition shall be transmitted
2 by the clerk of the court to the National Health
3 Board, and the Board shall file in the court the
4 record of the proceedings on which the determina-
5 tion or action was based, as provided in section 2112
6 of title 28, United States Code.

7 (3) SCOPE OF REVIEW.—The findings of fact of
8 the National Health Board, if supported by substan-
9 tial evidence, shall be conclusive; but the court, for
10 good cause shown, may remand the case to the
11 Board to take further evidence, and the Board may
12 make new or modified findings of fact and may mod-
13 ify its previous action, and shall certify to the court
14 the record of the further proceedings. Such new or
15 modified findings of fact shall likewise be conclusive
16 if supported by substantial evidence.

17 **SEC. 5232. ADMINISTRATIVE AND JUDICIAL REVIEW RELAT-**
18 **ING TO COST CONTAINMENT.**

19 There shall be no administrative or judicial review of
20 any determination by the National Health Board respect-
21 ing any matter under subtitle A of title VI.

22 **SEC. 5233. CIVIL ENFORCEMENT.**

23 Unless otherwise provided in this Act, the district
24 courts of the United States shall have jurisdiction of civil
25 actions brought by—

1 (1) the Secretary of Labor, in consultation with
2 the National Health Board, to enforce any final
3 order of such Secretary or to collect any civil mone-
4 tary penalty assessed by such Secretary under this
5 Act; and

6 (2) the Secretary of Health and Human Serv-
7 ices to enforce any final order of such Secretary or
8 to collect any civil monetary penalty assessed by
9 such Secretary under this Act.

10 **SEC. 5234. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.**

11 Section 507(a)(8) of title 11, United States Code, is
12 amended to read as follows:

13 “(8) Eighth, allowed unsecured claims—

14 “(A) based upon any commitment by the
15 debtor to the Federal Deposit Insurance Cor-
16 poration, the Resolution Trust Corporation, the
17 Director of the Office of Thrift Supervision, the
18 Comptroller of the Currency, or the Board of
19 Governors of the Federal Reserve System, or
20 their predecessors or successors, to maintain
21 the capital of an insured depository institution;

22 “(B) for payments under subtitle B of title
23 IV of the Health Security Act owed to a State
24 (as defined in section 1301 of such Act);

1 “(C) for payments owed to an experienced-
2 rated health plan under trusteeship of the Sec-
3 retary of Labor under section 1395 of the
4 Health Security Act; or

5 “(D) for assessments and related amounts
6 owed to the Secretary of Labor under section
7 1397 of the Health Security Act.”.

8 **SEC. 5235. PRIVATE RIGHT TO ENFORCE STATE RESPON-**
9 **SIBILITIES.**

10 The failure of a participating State to carry out a
11 responsibility applicable to participating States under this
12 Act constitutes a deprivation of rights secured by this Act
13 for the purposes of section 1977 of the Revised Statutes
14 of the United States (42 U.S.C. 1983). In an action
15 brought under such section, the court shall exercise juris-
16 diction without regard to whether the aggrieved person
17 has exhausted any administrative or other remedies that
18 may be provided by law.

19 **SEC. 5236. PRIVATE RIGHT TO ENFORCE FEDERAL RESPON-**
20 **SIBILITIES IN OPERATING A SYSTEM IN A**
21 **STATE.**

22 (a) IN GENERAL.—The failure of the Secretary of
23 Health and Human Services to carry out a responsibility
24 under section 1522 (relating to State participation) con-
25 fers an enforceable right of action on any person who is

1 aggrieved by such failure. Such a person may commence
2 a civil action against the Secretary in an appropriate State
3 court or district court of the United States.

4 (b) EXHAUSTION OF REMEDIES.—In an action under
5 subsection (a), the court shall exercise jurisdiction without
6 regard to whether the aggrieved person has exhausted any
7 administrative or other remedies that may be provided by
8 law.

9 (c) RELIEF.—In an action under subsection (a), if
10 the court finds that a failure described in such subsection
11 has occurred, the aggrieved person may recover compen-
12 satory damages and the court may award any other appro-
13 priate relief.

14 (d) ATTORNEY'S FEES.—In an action under sub-
15 section (a), the court, in its discretion, may allow the pre-
16 vailing party, other than the United States, a reasonable
17 attorney's fee (including expert fees) as part of the costs,
18 and the United States shall be liable for costs the same
19 as a private person.

20 **SEC. 5237. PRIVATE RIGHT TO ENFORCE RESPONSIBILITIES**
21 **OF COOPERATIVES.**

22 (a) IN GENERAL.—The failure of a consumer pur-
23 chasing cooperative, large group sponsor, or health plan
24 to carry out a responsibility applicable to the entity under
25 this Act confers an enforceable right of action on any per-

1 son who is aggrieved by such failure. Such a person may
2 commence a civil action against the cooperative, large
3 group sponsor or health plan in an appropriate State court
4 or district court of the United States.

5 (b) EXHAUSTION OF REMEDIES.—

6 (1) IN GENERAL.—Except as provided in para-
7 graph (2), in an action under subsection (a) the
8 court may not exercise jurisdiction until the ag-
9 grieved person has exhausted any administrative
10 remedies that may be provided by law.

11 (2) NO EXHAUSTION REQUIRED.—In an action
12 under subsection (a), the court shall exercise juris-
13 diction without regard to whether the aggrieved per-
14 son has exhausted any administrative or other reme-
15 dies that may be provided by law if the action re-
16 lates to—

17 (A) whether the person is an eligible indi-
18 vidual within the meaning of section 1001(c);

19 (B) whether the person is eligible for a
20 premium discount under subpart A of part 1 of
21 subtitle B of title VI;

22 (C) whether the person is eligible for a re-
23 duction in cost sharing under subpart D of part
24 3 of subtitle D of title I; or

1 (D) enrollment or disenrollment in a health
2 plan.

3 (c) RELIEF.—In an action under subsection (a), if
4 the court finds that a failure described in such subsection
5 has occurred, the court may award any appropriate relief.

6 (d) ATTORNEY'S FEES.—In any action under sub-
7 section (a), the court, in its discretion, may allow the pre-
8 vailing party, other than the United States, a reasonable
9 attorney's fee (including expert fees) as part of the costs,
10 and the United States shall be liable for costs the same
11 as a private person.

12 **SEC. 5237A. ENFORCEMENT OF CONSUMER PROTECTIONS.**

13 (a) COVERED VIOLATIONS.—The provisions of this
14 section shall apply with respect to a health plan that fails
15 to fulfill a duty imposed on the plan under section 1204
16 and subtitle A of this title.

17 (b) ADMINISTRATIVE ENFORCEMENT AND CIVIL
18 PENALTIES.—The penalties described in section
19 1867(d)(1) of the Social Security Act and the procedures
20 described in section 1128A of such Act (other than the
21 first two sentences of subsection (a) and subsection (b))
22 shall apply to health plans described in subsection (a). In
23 addition to such penalties, an amount not to exceed
24 \$1,000,000 may be assessed in the case of a finding of
25 a pattern or practice of such violations. The Secretary

1 shall establish procedures whereby, when a consumer has
2 disenrolled from a health plan violating the duties de-
3 scribed in subsection (a), successor health plans may re-
4 cover from the original health plan for health care costs
5 attributable to such violations.

6 (c) CORRECTION OF SUBSTANTIAL VIOLATIONS.—
7 Upon an administrative or judicial finding of a substantial
8 violation of the duties described in subsection (a), the
9 State or court may—

10 (1) inform all current enrollees of the plan of
11 the violation and that they may disenroll imme-
12 diately from that plan and enroll with another com-
13 munity-rated health plan; and

14 (2) notify the health plan that it shall imme-
15 diately cease enrollment activities until it has ob-
16 tained certifications from the appropriate certifying
17 entity or court that the violation has been corrected.

18 Such actions shall not be taken without providing the
19 health plan with a reasonable opportunity to correct such
20 violations, except where providing such an opportunity
21 would risk health or safety.

22 **SEC. 5238. DISCRIMINATION CLAIMS.**

23 (a) CIVIL ACTION BY AGGRIEVED PERSON.—

24 (1) IN GENERAL.—Any person who is aggrieved
25 by a violation of section 1914 may commence a civil

1 action against the party or parties committing such
2 violation in an appropriate State court or district
3 court of the United States.

4 (2) STANDARDS.—The standards used to deter-
5 mine whether a violation has occurred in a complaint
6 alleging discrimination on the basis of age or disabil-
7 ity under section 1914 shall be the standards ap-
8 plied under the Age Discrimination Act of 1975 (42
9 U.S.C. 6101 et seq.) and the Americans with Dis-
10 abilities Act of 1990 (42 U.S.C. 12101 et. seq.).

11 (3) RELIEF.—In any action under paragraph
12 (1), if the court finds a violation of section 1914, the
13 court may award such equitable and injunctive relief
14 as it deems appropriate, and may award to the ag-
15 grievied person any sums lost as a result of the viola-
16 tion. If the court finds that the party or parties
17 committing a violation engaged in intentional dis-
18 crimination in violation of section 1914, the ag-
19 grievied person may recover compensatory damages.
20 If the court finds that the party or parties commit-
21 ting such violation did so with malice or reckless in-
22 difference to the federally protected rights of the ag-
23 grievied person, the aggrieved person may recover
24 punitive damages under this section against a de-

1 fendant other than a government, government agen-
2 cy or political subdivision.

3 (4) ATTORNEYS' FEES.—In any action under
4 paragraph (1), the court, in its discretion, may allow
5 the prevailing party, other than the United States,
6 a reasonable attorney's fee (including expert fees
7 and other litigation expenses) as part of the costs,
8 and the United States shall be liable for costs the
9 same as a private person.

10 (b) ACTION BY SECRETARY.—Whenever the Sec-
11 retary of Health and Human Services finds that a party
12 has failed to comply with section 1914 or with an applica-
13 ble regulation issued under such section, the Secretary
14 shall notify the party. If within a reasonable period of time
15 the party fails or refuses to comply, the Secretary may—

16 (1) refer the matter to the Attorney General
17 with a recommendation that an appropriate civil ac-
18 tion be instituted;

19 (2) terminate or limit the participation of such
20 party in the programs authorized by this Act;

21 (3) withhold Federal financial assistance to the
22 party; or

23 (4) take such other action as may be provided
24 by law.

1 (c) ACTION BY ATTORNEY GENERAL.—When a mat-
2 ter is referred to the Attorney General under subsection
3 (b)(1), the Attorney General may bring a civil action in
4 a district court of the United States for such relief as may
5 be appropriate, including injunctive relief. In a civil action
6 under this section, the court—

7 (1) may grant any equitable relief that the
8 court considers to be appropriate;

9 (2) may award such other relief as the court
10 considers to be appropriate, including in cases of in-
11 tentional discrimination compensatory and punitive
12 damages; and

13 (3) may, to vindicate the public interest when
14 requested by the Attorney General, assess a civil
15 money penalty against the party in an amount—

16 (A) not exceeding \$50,000 for a first viola-
17 tion; and

18 (B) not exceeding \$100,000 for any subse-
19 quent violation.

20 **SEC. 5239. NONDISCRIMINATION IN FEDERALLY ASSISTED**
21 **PROGRAMS.**

22 Federal payments under subtitle C of title VI shall
23 be treated as Federal financial assistance for purposes of
24 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.
25 794), section 303 of the Age Discrimination Act of 1975

1 (42 U.S.C. 6102), and section 601 of the Civil Rights Act
2 of 1964 (42 U.S.C. 2000d).

3 **SEC. 5240. CIVIL AND ADMINISTRATION ACTION BY ESSEN-**
4 **TIAL COMMUNITY PROVIDER.**

5 (a) IN GENERAL.—An electing essential community
6 provider (as defined in section 1431(d)) who is aggrieved
7 by the failure of a health plan to fulfill a duty imposed
8 on the plan by section 1431 may commence a civil action
9 against the plan in an appropriate State court or district
10 court of the United States.

11 (b) RELIEF.—In an action under subsection (a), if
12 the court finds that the health plan has failed to fulfill
13 a duty imposed on the plan by section 1431, the electing
14 essential community provider may recover compensatory
15 damages and the court may order any other appropriate
16 relief.

17 (c) ATTORNEY'S FEES.—In any action under sub-
18 section (a), the court, in its discretion, may allow the pre-
19 vailing party, other than the United States, a reasonable
20 attorney's fee (including expert fees) as part of the costs,
21 and the United States shall be liable for costs the same
22 as a private person.

23 (d) STATE COMPLAINT SYSTEM REQUIRED.—Prior
24 to commencing an action under subsection (a), the ag-
25 grieved essential community provider may first elect to

1 utilize the administrative process provided under this sub-
2 section as follows:

3 (1) The Secretary shall prescribe regulations
4 governing administrative grievance actions by essen-
5 tial community providers that shall be consistent
6 with the requirements of section 5204 and that shall
7 provide for the consolidation of complaints (at the
8 election of the essential community providers) in
9 cases involving multiple complaints against a single
10 health plan.

11 (2) A State shall make available to each elect-
12 ing essential community provider that is aggrieved
13 by an action of a health plan under section 1431,
14 the opportunity to file a complaint in the complaint
15 review office established under section 5202. In the
16 case of essential community providers located in a
17 cooperative established in any State by the Sec-
18 retary, the Secretary shall assume all of the duties
19 and obligations of such State under this section.

20 **SEC. 5241. FACIAL CONSTITUTIONAL CHALLENGES.**

21 (a) JURISDICTION.—The United States District
22 Court for the District of Columbia shall have original and
23 exclusive jurisdiction of any civil action brought to invali-
24 date this Act or a provision of this Act on the ground of
25 its being repugnant to the Constitution of the United

1 States on its face and for every purpose. In any action
2 described in this subsection, the district court may not
3 grant any temporary order or preliminary injunction re-
4 straining the enforcement, operation, or execution of this
5 Act or any provision of this Act.

6 (b) CONVENING OF THREE-JUDGE COURT.—An ac-
7 tion described in subsection (a) shall be heard and deter-
8 mined by a district court of three judges in accordance
9 with section 2284 of title 28, United States Code.

10 (c) CONSOLIDATION.—When actions described in
11 subsection (a) involving a common question of law or fact
12 are pending before a district court, the court shall order
13 all the actions consolidated.

14 (d) DIRECT APPEAL TO SUPREME COURT.—In any
15 action described in subsection (a), an appeal may be taken
16 directly to the Supreme Court of the United States from
17 any final judgment, decree, or order in which the district
18 court—

19 (1) holds this Act or any provision of this Act
20 invalid; and

21 (2) makes a determination that its holding will
22 materially undermine the application of the Act as
23 whole.

24 (e) CONSTRUCTION.—This section does not limit—

25 (1) the right of any person—

1 (A) to a litigation concerning the Act or
2 any portion of the Act; or

3 (B) to petition the Supreme Court for re-
4 view of any holding of a district court by writ
5 of certiorari at any time before the rendition of
6 judgment in a court of appeals; or

7 (2) the authority of the Supreme Court to grant
8 a writ of certiorari for the review described in para-
9 graph (1)(B).

10 **SEC. 5242. TREATMENT OF PLANS AS PARTIES IN CIVIL AC-**
11 **TIONS.**

12 (a) IN GENERAL.—A health plan may sue or be sued
13 under this Act as an entity. Service of summons, sub-
14 poena, or other legal process of a court or hearing officer
15 upon a trustee or an administrator of any such plan in
16 his capacity as such shall constitute service upon the plan.
17 In a case where a plan has not designated in applicable
18 plan documents an individual as agent for the service of
19 legal process, service upon the Secretary of Health and
20 Human Services (in the case of a community-rated health
21 plan) or the Secretary of Labor (in the case of an experi-
22 enced-rated health plan) shall constitute such service. The
23 Secretary, not later than 15 days after receipt of service
24 under the preceding sentence, shall notify the adminis-
25 trator or any trustee of the plan of receipt of such service.

1 (b) OTHER PARTIES.—Any money judgment under
2 this Act against a plan referred to in subsection (a) shall
3 be enforceable only against the plan as an entity and shall
4 not be enforceable against any other person unless liability
5 against such person is established in his individual capac-
6 ity under this Act.

7 **SEC. 5243. WHISTLEBLOWER PROTECTIONS.**

8 (a) IN GENERAL.—A health care entity (as defined
9 in section 11101(7)) or a health plan may not discharge,
10 discriminate or otherwise take adverse action against any
11 employee with respect to compensation, terms, conditions
12 or privileges of employment because the employee (or any
13 person acting pursuant to the request of the employee)
14 provided information to any Federal, State or private su-
15 pervisory agency or entity regarding a possible violation
16 of any provision of this Act or any regulation issued under
17 this Act.

18 (b) CIVIL ACTION.—An employee or former employee
19 who believes that such employee has been discharged, dis-
20 criminated or otherwise subject to adverse action in viola-
21 tion of subsection (a) may file a civil action in the appro-
22 priate United States district court within 2 years of the
23 date of such discharge, discrimination or adverse action.

24 (c) DETERMINATION OF COURT.—If a court in an ac-
25 tion under subsection (b) determines that a violation of

1 subsection (a) has occurred, the court may order the
2 health care entity or plan that committed the violation—

3 (1) to reinstate the employee to his or her
4 former position;

5 (2) to pay compensatory damages to the em-
6 ployee;

7 (3) to pay reasonable costs and attorneys fees
8 incurred by the employee in bringing such action;
9 and

10 (4) to take such other appropriate actions to
11 remedy any past discrimination.

12 **SEC. 5244. GENERAL NONPREEMPTION OF RIGHTS AND**
13 **REMEDIES.**

14 Nothing in this title shall be construed to deny, im-
15 pair, or otherwise adversely affect a right or remedy avail-
16 able under law to any person, except to the extent the
17 right or remedy is inconsistent with this title.

18 **Subtitle D—Medical Malpractice**

19 **PART 1—LIABILITY REFORM**

20 **SEC. 5301. FEDERAL TORT REFORM.**

21 (a) APPLICABILITY.—

22 (1) IN GENERAL.—Except as provided in sec-
23 tion 5302, this part shall apply with respect to any
24 medical malpractice liability action brought in any
25 State or Federal court, except that this part shall

1 not apply to a claim or action for damages arising
2 from a vaccine-related injury or death to the extent
3 that title XXI of the Public Health Service Act ap-
4 plies to the claim or action.

5 (2) EFFECT ON SOVEREIGN IMMUNITY AND
6 CHOICE OF LAW OR VENUE.—Nothing in this part
7 shall be construed to—

8 (A) waive or affect any defense of sov-
9 ereign immunity asserted by any State under
10 any provision of law;

11 (B) waive or affect any defense of sov-
12 ereign immunity asserted by the United States;

13 (C) affect the applicability of any provision
14 of the Foreign Sovereign Immunities Act of
15 1976;

16 (D) preempt State choice-of-law rules with
17 respect to claims brought by a foreign nation or
18 a citizen of a foreign nation; or

19 (E) affect the right of any court to trans-
20 fer venue or to apply the law of a foreign nation
21 or to dismiss a claim of a foreign nation or of
22 a citizen of a foreign nation on the ground of
23 inconvenient forum.

24 (3) FEDERAL COURT JURISDICTION NOT ES-
25 TABLISHED ON FEDERAL QUESTION GROUNDS.—

1 Nothing in this part shall be construed to establish
2 any jurisdiction in the district courts of the United
3 States over medical malpractice liability actions on
4 the basis of section 1331 or 1337 of title 28, United
5 States Code.

6 (b) DEFINITIONS.—In this subtitle, the following
7 definitions apply:

8 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
9 TEM; ADR.—The term “alternative dispute resolu-
10 tion system” or “ADR” means a system that pro-
11 vides for the resolution of medical malpractice claims
12 in a manner other than through medical malpractice
13 liability actions.

14 (2) CLAIMANT.—The term “claimant” means
15 any person who alleges a medical malpractice claim,
16 and any person on whose behalf such a claim is al-
17 leged, including the decedent in the case of an action
18 brought through or on behalf of an estate.

19 (3) HEALTH CARE PROFESSIONAL.—The term
20 “health care professional” means any individual who
21 provides health care services in a State and who is
22 required by the laws or regulations of the State to
23 be licensed or certified by the State to provide such
24 services in the State.

1 (4) HEALTH CARE PROVIDER.—The term
2 “health care provider” means any organization or
3 institution that is engaged in the delivery of health
4 care services in a State and that is required by the
5 laws or regulations of the State to be licensed or cer-
6 tified by the State to engage in the delivery of such
7 services in the State.

8 (5) INJURY.—The term “injury” means any ill-
9 ness, disease, or other harm that is the subject of
10 a medical malpractice liability action or a medical
11 malpractice claim.

12 (6) MEDICAL MALPRACTICE LIABILITY AC-
13 TION.—The term “medical malpractice liability ac-
14 tion” means a cause of action brought in a State or
15 Federal court against a health care provider or
16 health care professional by which the plaintiff alleges
17 a medical malpractice claim.

18 (7) MEDICAL MALPRACTICE CLAIM.—The term
19 “medical malpractice claim” means a claim brought
20 against a health care provider or health care profes-
21 sional in which a claimant alleges that injury was
22 caused by the provision of (or the failure to provide)
23 health care services, except that such term does not
24 include—

1 (A) any claim based on an allegation of an
2 intentional tort;

3 (B) any claim based on an allegation that
4 a product is defective that is brought against
5 any individual or entity that is not a health
6 care professional or health care provider; or

7 (C) any claim brought pursuant to subtitle
8 C of this title.

9 **SEC. 5302. STATE-BASED ALTERNATIVE DISPUTE RESOLU-**
10 **TION MECHANISMS.**

11 (a) APPLICATION TO MALPRACTICE CLAIMS UNDER
12 PLANS.—Prior to or immediately following the commence-
13 ment of any medical malpractice action, the parties shall
14 participate in the alternative dispute resolution system ad-
15 ministered by the State under subsection (b). Such partici-
16 pation shall be in lieu of any other provision of Federal
17 or State law or any contractual agreement made by or on
18 behalf of the parties prior to the commencement of the
19 medical malpractice action.

20 (b) ADOPTION OF MECHANISM BY STATE.—Each
21 State shall—

22 (1) maintain or adopt at least one of the alter-
23 native dispute resolution methods satisfying the re-
24 quirements specified under subsection (c) and (d) for
25 the resolution of medical malpractice claims arising

1 from the provision of (or failure to provide) health
2 care services to individuals enrolled in a health plan;
3 and

4 (2) clearly disclose to enrollees (and potential
5 enrollees) the availability and procedures for
6 consumer grievances, including a description of the
7 alternative dispute resolution method or methods
8 adopted under this subsection.

9 (c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE
10 DISPUTE RESOLUTION METHODS.—

11 (1) IN GENERAL.—The Board shall, by regula-
12 tion, develop alternative dispute resolution methods
13 for the use by States in resolving medical mal-
14 practice claims under subsection (a). Such methods
15 shall include at least the following:

16 (A) ARBITRATION.—The use of arbitra-
17 tion, a nonjury adversarial dispute resolution
18 process which may, subject to subsection (d),
19 result in a final decision as to facts, law, liabil-
20 ity or damages.

21 (B) CLAIMANT-REQUESTED BINDING ARBI-
22 TRATION.—For claims involving a sum of
23 money that falls below a threshold amount set
24 by the Board, the use of arbitration not subject

1 to subsection (d). Such binding arbitration shall
2 be at the sole discretion of the claimant.

3 (C) MEDIATION.—The use of mediation, a
4 settlement process coordinated by a neutral
5 third party without the ultimate rendering of a
6 formal opinion as to factual or legal findings.

7 (D) EARLY NEUTRAL EVALUATION.—The
8 use of early neutral evaluation, in which the
9 parties make a presentation to a neutral attor-
10 ney or other neutral evaluator for an assess-
11 ment of the merits, to encourage settlement. If
12 the parties do not settle as a result of assess-
13 ment and proceed to trial, the neutral eval-
14 uator’s opinion shall be kept confidential.

15 (E) CERTIFICATE OF MERIT.—The re-
16 quirement that a medical malpractice plaintiff
17 submit to the court before trial a written report
18 by a qualified specialist that includes the spe-
19 cialist’s determination that, after a review of
20 the available medical record and other relevant
21 material, there is a reasonable and meritorious
22 cause for the filing of the action against the de-
23 fendant.

24 (2) STANDARDS FOR ESTABLISHING METH-
25 ODS.—In developing alternative dispute resolution

1 methods under paragraph (1), the Board shall as-
2 sure that the methods promote the resolution of
3 medical malpractice claims in a manner that—

4 (A) is affordable for the parties involved;

5 (B) provides for timely resolution of
6 claims;

7 (C) provides for the consistent and fair
8 resolution of claims; and

9 (D) provides for reasonably convenient ac-
10 cess to dispute resolution for individuals en-
11 rolled in plans.

12 (3) WAIVER AUTHORITY.—Upon application of
13 a State, the Board may grant the State the author-
14 ity to fulfill the requirement of subsection (b) by
15 adopting a mechanism other than a mechanism es-
16 tablished by the Board pursuant to this subsection,
17 except that such mechanism must meet the stand-
18 ards set forth in paragraph (2).

19 (d) FURTHER REDRESS.—Except with respect to the
20 claimant-requested binding arbitration method set forth in
21 subsection (c)(1)(B), and notwithstanding any other provi-
22 sion of a law or contractual agreement, a plan enrollee
23 dissatisfied with the determination reached as a result of
24 an alternative dispute resolution method applied under
25 this section may, after the final resolution of the enrollee's

1 claim under the method, bring a cause of action to seek
2 damages or other redress with respect to the claim to the
3 extent otherwise permitted under State law. The results
4 of any alternative dispute resolution procedure are inad-
5 missible at any subsequent trial, as are all statements, of-
6 fers, and other communications made during such proce-
7 dures, unless otherwise admissible under State law.

8 **SEC. 5303. LIMITATION ON AMOUNT OF ATTORNEY'S CON-**
9 **TINGENCY FEES.**

10 (a) IN GENERAL.—An attorney who represents, on
11 a contingency fee basis, a plaintiff in a medical mal-
12 practice liability action may not charge, demand, receive,
13 or collect for services rendered in connection with such ac-
14 tion (including the resolution of the claim that is the sub-
15 ject of the action under any alternative dispute resolution
16 system) in excess of—

17 (1) $33\frac{1}{3}$ percent of the first \$150,000 of the
18 total amount recovered by judgment or settlement in
19 such action; plus

20 (2) 25 percent of any amount recovered above
21 the amount described in paragraph (1);

22 unless otherwise determined under State law. Such
23 amount shall be computed after deductions are made for
24 all the expenses associated with the claim other than those

1 attributable to the normal operating expenses of the attor-
2 ney.

3 (b) CALCULATION OF PERIODIC PAYMENTS.—In the
4 event that a judgment or settlement includes periodic or
5 future payments of damages, the amount recovered for
6 purposes of computing the limitation on the contingency
7 fee under subsection (a) may, in the discretion of the
8 court, be based on the cost of the annuity or trust estab-
9 lished to make the payments. In any case in which an an-
10 nuity or trust is not established to make such payments,
11 such amount shall be based on the present value of the
12 payments.

13 (c) CONTINGENCY FEE DEFINED.—As used in this
14 section, the term “contingency fee” means any fee for pro-
15 fessional legal services which is, in whole or in part, con-
16 tingent upon the recovery of any amount of damages,
17 whether through judgment or settlement.

18 **SEC. 5304. REDUCTION OF AWARDS FOR RECOVERY FROM**
19 **COLLATERAL SOURCES.**

20 (a) REDUCTION OF AWARD.—The total amount of
21 damages recovered by a plaintiff in a medical malpractice
22 liability action shall be reduced by an amount that
23 equals—

24 (1) the amount of any payment which the plain-
25 tiff has received or to which the plaintiff is presently

1 entitled on account of the same injury for which the
2 damages are awarded, including payment under—

3 (A) Federal or State disability or sickness
4 programs;

5 (B) Federal, State, or private health insur-
6 ance programs;

7 (C) private disability insurance programs;

8 (D) employer wage continuation programs;
9 and

10 (E) any other program, if the payment is
11 intended to compensate the plaintiff for the
12 same injury for which damages are awarded;
13 less

14 (2) the amount of any premiums or any other
15 payments that the plaintiff has paid to be eligible to
16 receive the payment described in paragraph (1) and
17 any portion of the award subject to a subrogation
18 lien or claim.

19 (b) SUBROGATION.—The court may reduce a sub-
20 rogation lien or claim described in subsection (a)(2) by
21 an amount representing reasonable costs incurred in se-
22 curing the award subject to the lien or claim.

23 (c) INAPPLICABILITY OF SECTION.—This section
24 shall not apply to any case in which the court determines
25 that the reduction of damages pursuant to subsection (a)

1 would compound the effect of any State law limitation on
2 damages so as to render the plaintiff less than fully com-
3 pensated for his or her injuries.

4 **SEC. 5305. PERIODIC PAYMENT OF AWARDS.**

5 (a) IN GENERAL.—A party to a medical malpractice
6 liability action may petition the court to instruct the trier
7 of fact to award any future damages on an appropriate
8 periodic basis. If the court, in its discretion, so instructs
9 the trier of fact, and damages are awarded on a periodic
10 basis, the court may require the defendant to purchase
11 an annuity or other security instrument (typically based
12 on future damages discounted to present value) adequate
13 to assure payments of future damages.

14 (b) FAILURE OR INABILITY TO PAY.—With respect
15 to an award of damages described in subsection (a), if a
16 defendant fails to make payments in a timely fashion, or
17 if the defendant becomes or is at risk of becoming insol-
18 vent, upon such a showing the claimant may petition the
19 court for an order requiring that remaining balance be dis-
20 counted to present value and paid to the claimant in a
21 lump-sum.

22 (c) MODIFICATION OF PAYMENT SCHEDULE.—The
23 court shall retain authority to modify the payment sched-
24 ule based on changed circumstances.

1 (d) FUTURE DAMAGES DEFINED.—As used in this
2 section, the term “future damages” means any economic
3 or noneconomic loss other than that incurred or accrued
4 as of the time of judgment.

5 **SEC. 5306. CONSTRUCTION.**

6 Nothing in this subtitle shall be construed to preempt
7 any State law that sets a maximum limit on total dam-
8 ages.

9 **PART 2—OTHER PROVISIONS RELATING TO**
10 **MEDICAL MALPRACTICE LIABILITY**

11 **SEC. 5311. STATE MALPRACTICE REFORM DEMONSTRATION**
12 **PROJECTS.**

13 (a) ESTABLISHMENT.—The Secretary shall award
14 grants to States for the establishment of malpractice re-
15 form demonstration projects in accordance with this sec-
16 tion. Each such project shall be designed to assess the
17 fairness and effectiveness of one or more of the following
18 models:

- 19 (1) No-fault liability.
20 (2) Enterprise liability.
21 (3) Practice guidelines.

22 (b) DEFINITIONS.—For purposes of this section:

- 23 (1) MEDICAL ADVERSE EVENT.—The term
24 “medical adverse event” means an injury that is the
25 result of medical management as opposed to a dis-

1 ease process that creates disability lasting at least
2 one month after discharge, or that prolongs a hos-
3 pitalization for more than one month, and for which
4 compensation is available under a no-fault medical
5 liability system established under this section.

6 (2) NO-FAULT MEDICAL LIABILITY SYSTEM.—
7 The terms “no-fault medical liability system” and
8 “system” mean a system established by a State re-
9 ceiving a grant under this section which replaces the
10 common law tort liability system for medical injuries
11 with respect to certain qualified health care organi-
12 zations and qualified insurers and which meets the
13 requirements of this section.

14 (3) PROVIDER.—The term “provider” means
15 physician, physician assistant, or other individual
16 furnishing health care services in affiliation with a
17 qualified health care organization.

18 (4) QUALIFIED HEALTH CARE ORGANIZA-
19 TION.—The term “qualified health care organiza-
20 tion” means a hospital, a hospital system, a man-
21 aged care network, or other entity determined appro-
22 priate by the Secretary which elects in a State re-
23 ceiving a grant under this section to participate in
24 a no-fault medical liability system and which meets
25 the requirements of this section.

1 (5) QUALIFIED INSURER.—The term “qualified
2 insurer” means a health care malpractice insurer,
3 including a self-insured qualified health care organi-
4 zation, which elects in a State receiving a grant
5 under this section to participate in a no-fault medi-
6 cal liability system and which meets the require-
7 ments of this section.

8 (6) ENTERPRISE LIABILITY.—The term “enter-
9 prise liability” means a system in which State law
10 imposes malpractice liability on the health plan in
11 which a physician participates in place of personal li-
12 ability on the physician in order to achieve improved
13 quality of care, reductions in defensive medical prac-
14 tices, and better risk management.

15 (7) PRACTICE GUIDELINES.—The term “prac-
16 tice guidelines” means guidelines established by the
17 Agency for Health Care Policy and Research pursu-
18 ant to the Public Health Service Act or this Act.

19 (c) APPLICATIONS BY STATES.—

20 (1) IN GENERAL.—Each State desiring to es-
21 tablish a malpractice reform demonstration project
22 shall submit an application to the Secretary at such
23 time and in such manner as the Secretary shall re-
24 quire.

1 (2) CONTENTS OF APPLICATION.—An applica-
2 tion under paragraph (1) shall include—

3 (A) an identification of the State agency or
4 agencies that will administer the demonstration
5 project and be the grant recipient of funds for
6 the State;

7 (B) a description of the manner in which
8 funds granted to a State will be expended and
9 a description of fiscal control, accounting, and
10 audit procedures to ensure the proper dispersal
11 of and accounting for funds received under this
12 section; and

13 (C) such other information as the Sec-
14 retary determines appropriate.

15 (3) CONSIDERATION OF APPLICATIONS.—In re-
16 viewing all applications received from States desiring
17 to establish malpractice demonstration projects
18 under paragraph (1), the Secretary shall consider—

19 (A) data regarding medical malpractice
20 and malpractice litigation patterns in each
21 State;

22 (B) the contributions that any demonstra-
23 tion project will make toward reducing mal-
24 practice and costs associated with health care
25 injuries;

1 (C) diversity among the populations serv-
2 iced by the systems;

3 (D) geographic distribution; and

4 (E) such other criteria as the Secretary de-
5 termines appropriate.

6 (d) EVALUATION AND REPORTS.—

7 (1) BY THE STATES.—Each State receiving a
8 grant under this section shall conduct on-going eval-
9 uations of the effectiveness of any demonstration
10 project established in such State and shall submit an
11 annual report to the Secretary concerning the re-
12 sults of such evaluations at such times and in such
13 manner as the Secretary shall require.

14 (2) BY THE SECRETARY.—The Secretary shall
15 submit an annual report to Congress concerning the
16 fairness and effectiveness of the demonstration
17 projects conducted under this section. Such report
18 shall analyze the reports received by the Secretary
19 under paragraph (1).

20 (e) FUNDING.—

21 (1) IN GENERAL.—There are authorized to be
22 appropriated such sums as may be necessary to
23 carry out the purposes of this section.

24 (2) LIMITATIONS ON EXPENDITURES.—

1 (A) ADMINISTRATIVE EXPENSES.—Not
2 more than 10 percent of the amount of each
3 grant awarded to a State under this section
4 may be used for administrative expenses.

5 (B) WAIVER OF COST LIMITATIONS.—The
6 limitation under subparagraph (A) may be
7 waived as determined appropriate by the Sec-
8 retary.

9 (f) ELIGIBILITY FOR NO-FAULT DEMONSTRATION.—
10 A State is eligible to receive a no-fault liability demonstra-
11 tion grant if the application of the State under subsection
12 (c) includes—

13 (1) an identification of each qualified health
14 care organization selected by the State to participate
15 in the system, including—

16 (A) the location of each organization;

17 (B) the number of patients generally
18 served by each organization;

19 (C) the types of patients generally served
20 by each organization;

21 (D) an analysis of any characteristics of
22 each organization which makes such organiza-
23 tion appropriate for participation in the system;

24 (E) whether the organization is self-in-
25 sured for malpractice liability; and

1 (F) such other information as the Sec-
2 retary determines appropriate;

3 (2) an identification of each qualified insurer
4 selected by the State to participate in the system, in-
5 cluding—

6 (A) a schedule of the malpractice insur-
7 ance premiums generally charged by each in-
8 surer under the common law tort liability sys-
9 tem; and

10 (B) such other information as the Sec-
11 retary determines appropriate;

12 (3) a description of the procedure under which
13 qualified health care organizations and insurers elect
14 to participate in the system;

15 (4) a description of the system established by
16 the State to assure compliance with the require-
17 ments of this section by each qualified health care
18 organization and insurer; and

19 (5) a description of procedures for the prepara-
20 tion and submission to the State of an annual report
21 by each qualified health care organization and quali-
22 fied insurer participating in a system that shall in-
23 clude—

24 (A) a description of activities conducted
25 under the system during the year; and

1 (B) the extent to which the system ex-
2 ceeded or failed to meet relevant performance
3 standards including compensation for and de-
4 terrence of medical adverse events.

5 (g) ELIGIBILITY FOR ENTERPRISE LIABILITY DEM-
6 ONSTRATION.—A State is eligible to receive an enterprise
7 liability demonstration grant if the State—

8 (1) has entered into an agreement with a health
9 plan (other than a fee-for-service plan) operating in
10 the State under which the plan assumes legal liabil-
11 ity with respect to any medical malpractice claim
12 arising from the provision of (or failure to provide)
13 services under the plan by any physician participat-
14 ing in the plan; and

15 (2) has provided that, under the law of the
16 State, a physician participating in a plan that has
17 entered into an agreement with the State under
18 paragraph (1) may not be liable in damages or oth-
19 erwise for such a claim and the plan may not require
20 such physician to indemnify the plan for any such li-
21 ability.

22 (h) ELIGIBILITY FOR PRACTICE GUIDELINES DEM-
23 ONSTRATION.—A State is eligible to receive a practice
24 guidelines demonstration grant if the law of the State pro-
25 vides that in the resolution of any medical malpractice ac-

1 tion, compliance or non-compliance with an appropriate
2 practice guideline shall be admissible at trial as a rebutta-
3 ble presumption regarding medical negligence.

4 **Subtitle E—Expanded Efforts To**
5 **Combat Health Care Fraud and**
6 **Abuse**

7 **PART 1—IMPROVED ENFORCEMENT**

8 **SEC. 5401. ALL-PAYER HEALTH CARE FRAUD AND ABUSE**
9 **CONTROL PROGRAM.**

10 (a) IN GENERAL.—Not later than January 1, 1995,
11 the Secretary and the Attorney General of the United
12 States shall establish a joint program—

13 (1) to coordinate Federal, State, and local law
14 enforcement programs to control fraud and abuse
15 with respect to the delivery of and payment for
16 health care in the United States,

17 (2) to conduct investigations (including
18 consumer complaint investigations), audits, evalua-
19 tions, and inspections relating to the delivery of and
20 payment for health care in the United States, and

21 (3) to facilitate the enforcement of this subtitle
22 and other statutes applicable to health care fraud
23 and abuse.

24 (b) COORDINATION WITH LAW ENFORCEMENT
25 AGENCIES.—In carrying out the program under sub-

1 section (a), the Secretary and the Attorney General shall
2 consult with, and arrange for the sharing of data and re-
3 sources with Federal, State and local law enforcement
4 agencies, State Medicaid Fraud Control Units, and State
5 agencies responsible for the licensing and certification of
6 health care providers.

7 (c) COORDINATION WITH CONSUMER PURCHASING
8 COOPERATIVES AND HEALTH PLANS.—In carrying out
9 the program under subsection (a), the Secretary and the
10 Attorney General shall consult with, and arrange for the
11 sharing of data with representatives of consumer purchas-
12 ing cooperatives and health plans.

13 (d) AUTHORITIES OF ATTORNEY GENERAL AND SEC-
14 RETARY.—In carrying out duties under subsection (a), the
15 Attorney General and the Secretary are authorized—

16 (1) to conduct, supervise, and coordinate audits,
17 civil and criminal investigations, inspections, and
18 evaluations relating to the program established
19 under such subsection;

20 (2) to have access (including on-line access as
21 requested and available) to all records available to
22 consumer purchasing cooperatives and health plans
23 relating to the activities described in paragraph (1)
24 (subject to restrictions based on the confidentiality

1 of certain information under part 2 of subtitle B);
2 and

3 (3) to require the issuance of advisory opinions,
4 fraud alerts, and other appropriate educational ma-
5 terial to assist in compliance with the provisions of
6 this subtitle.

7 (e) QUALIFIED IMMUNITY FOR PROVIDING INFORMA-
8 TION.—The provisions of section 1157(a) of the Social Se-
9 curity Act (relating to limitation on liability) shall apply
10 to a person providing information or communications to
11 the Secretary or the Attorney General in conjunction with
12 their performance of duties under this section, in the same
13 manner as such section applies to information provided
14 to organizations with a contract under part B of title XI
15 of such Act.

16 (f) USE OF POWERS UNDER INSPECTOR GENERAL
17 ACT OF 1978.—In carrying out duties and responsibilities
18 under the program established under subsection (a), the
19 Inspector General is authorized to exercise all powers
20 granted under the Inspector General Act of 1978 to the
21 same manner and extent as provided in that Act.

22 (g) DEFINITIONS.—In this subtitle:

23 (1) HEALTH CARE.—The term “health care”
24 includes long-term care benefits under title II of this
25 Act.

1 (2) INSPECTOR GENERAL.—The term “Inspec-
2 tor General” means the Inspector General of the De-
3 partment of Health and Human Services.

4 **SEC. 5402. ESTABLISHMENT OF ALL-PAYER HEALTH CARE**
5 **FRAUD AND ABUSE CONTROL ACCOUNT.**

6 (a) ESTABLISHMENT.—

7 (1) IN GENERAL.—There is hereby established
8 an account to be known as the “All-Payer Health
9 Care Fraud and Abuse Control Account” (in this
10 section referred to as the “Anti-Fraud Account”).
11 The Anti-Fraud Account shall consist of such gifts
12 and bequests as may be made as provided in para-
13 graph (2) and such amounts as may be deposited in
14 such Anti-Fraud Account as provided in section
15 5411(d)(2). It shall also include the following:

16 (A) All criminal fines imposed in cases in-
17 volving a Federal health care offense (as de-
18 fined in subsection (d)).

19 (B) Penalties and damages imposed under
20 the False Claims Act (31 U.S.C. 3729 et seq.),
21 in cases involving claims related to the provision
22 of health care items and services (other than
23 funds awarded to a relator or for restitution).

1 (C) Administrative penalties and assess-
2 ments imposed under section 5411 (except as
3 otherwise provided by law).

4 (D) Amounts resulting from the forfeiture
5 of property by reason of a Federal health care
6 offense.

7 Any such funds received on or after the date of the
8 enactment of this Act shall be deposited in the Anti-
9 Fraud Account.

10 (2) AUTHORIZATION TO ACCEPT GIFTS.—The
11 Anti-Fraud Account is authorized to accept on be-
12 half of the United States money gifts and bequests
13 made unconditionally to the Anti-Fraud Account, for
14 the benefit of the Anti-Fraud Account or any activ-
15 ity financed through the Anti-Fraud Account.

16 (b) USE OF FUNDS.—

17 (1) IN GENERAL.—Amounts in the Anti-Fraud
18 Account shall be available without appropriation and
19 until expended as determined jointly by the Sec-
20 retary and the Attorney General of the United
21 States in carrying out the All-Payer Health Care
22 Fraud and Abuse Control Program established
23 under section 5401 (including the administration of
24 the Program), and may be used to cover costs in-

1 curred in operating the Program, including costs
2 of—

3 (A) prosecuting health care matters
4 (through criminal, civil and administrative pro-
5 ceedings);

6 (B) investigations (including equipment,
7 salaries, administratively uncontrollable work,
8 travel, and training of law enforcement person-
9 nel);

10 (C) financial and performance audits of
11 health care programs and operations;

12 (D) inspections and other evaluations;

13 (E) rewards paid under section 5404; and

14 (F) provider and consumer education (in-
15 cluding the provision of advisory opinions) re-
16 garding compliance with the provisions of this
17 subtitle.

18 Twenty percent of the amounts available in the Anti-
19 Fraud Account for any fiscal year shall be used for
20 costs described in subparagraph (F).

21 (2) FUNDS USED TO SUPPLEMENT AGENCY AP-
22 PROPRIATIONS.—It is intended that disbursements
23 made from the Anti-Fraud Account to any Federal
24 agency be used to increase and not supplant the re-
25 cipient agency's appropriated operating budget.

1 (c) ANNUAL REPORT.—The Secretary and the Attor-
2 ney General shall submit jointly an annual report to Con-
3 gress on the amount of revenue which is generated and
4 disbursed by the Anti-Fraud Account in each fiscal year.

5 (d) FEDERAL HEALTH CARE OFFENSE DEFINED.—
6 For purposes of subsection (a)(1)(A) and section 5404(a),
7 the term “Federal health care offense” means a violation
8 of, or a criminal conspiracy to violate—

9 (1) sections 226, 668, 1033, or 1347 of title
10 18, United States Code;

11 (2) section 1128B of the Social Security Act;

12 (3) sections 287, 371, 664, 666, 1001, 1027,
13 1341, 1343, or 1954 of title 18, United States Code,
14 if the violation or conspiracy relates to health care
15 fraud;

16 (4) sections 501 or 511 of the Employee Retire-
17 ment Income Security Act of 1974, if the violation
18 or conspiracy relates to health care fraud; or

19 (5) sections 301, 303(a)(2), or 303 (b) or (e)
20 of the Federal Food Drug and Cosmetic Act, if the
21 violation or conspiracy relates to health care fraud.

22 **SEC. 5403. USE OF FUNDS BY INSPECTOR GENERAL.**

23 (a) REIMBURSEMENTS FOR INVESTIGATIONS.—

24 (1) IN GENERAL.—The Inspector General is au-
25 thorized to receive and retain for current use reim-

1 bursement for the costs of conducting investigations,
2 when such restitution is ordered by a court, volun-
3 tarily agreed to by the payer, or otherwise.

4 (2) CREDITING.—Funds received by the Inspec-
5 tor General as reimbursement for costs of conduct-
6 ing investigations shall be deposited to the credit of
7 the appropriation from which initially paid, or to ap-
8 propriations for similar purposes currently available
9 at the time of deposit, and shall remain available for
10 obligation for 1 year from the date of their deposit.

11 (3) EXCEPTION FOR FORFEITURES.—This sub-
12 section does not apply to investigative costs paid to
13 the Inspector General from the Department of Jus-
14 tice Asset Forfeiture Fund, which monies shall be
15 deposited and expended in accordance with sub-
16 section (b).

17 (b) HHS OFFICE OF INSPECTOR GENERAL ASSET
18 FORFEITURE PROCEEDS FUND.—

19 (1) IN GENERAL.—There is hereby established
20 the “HHS Office of Inspector General Asset Forfeit-
21 ure Proceeds Fund,” to be administered by the In-
22 spector General, which shall be available to the In-
23 spector General without fiscal year limitation for ex-
24 penses relating to the investigation of matters within
25 the jurisdiction of the Inspector General.

1 (2) DEPOSITS.—There shall be deposited in the
2 Fund all proceeds from forfeitures that have been
3 transferred to the Inspector General from the De-
4 partment of Justice Asset Forfeiture Fund under
5 section 524 of title 28, United States Code.

6 **SEC. 5404. REWARDS FOR INFORMATION LEADING TO**
7 **PROSECUTION AND CONVICTION.**

8 (a) IN GENERAL.—In special circumstances, the Sec-
9 retary and the Attorney General of the United States may
10 jointly make a payment of up to \$10,000 to a person who
11 furnishes information unknown to the Government relat-
12 ing to a possible prosecution of a Federal health care of-
13 fense (as defined in section 5402(d)).

14 (b) INELIGIBLE PERSONS.—A person is not eligible
15 for a payment under subsection (a) if—

16 (1) the person is a current or former officer or
17 employee of a Federal or State government agency
18 or instrumentality who furnishes information discov-
19 ered or gathered in the course of government em-
20 ployment;

21 (2) the person knowingly participated in the of-
22 fense;

23 (3) the information furnished by the person
24 consists of allegations or transactions that have been
25 disclosed to the public—

1 (A) in a criminal, civil, or administrative
2 proceeding;

3 (B) in a congressional, administrative or
4 General Accounting Office report, hearing,
5 audit, or investigation; or

6 (C) by the news media, unless the person
7 is the original source of the information; or

8 (4) when, in the judgment of the Attorney Gen-
9 eral, it appears that a person whose illegal activities
10 are being prosecuted or investigated could benefit
11 from the award.

12 (c) DEFINITION.—For the purposes of subsection
13 (b)(3)(C), the term “original source” means a person who
14 has direct and independent knowledge of the information
15 that is furnished and has voluntarily provided the informa-
16 tion to the Government prior to disclosure by the news
17 media.

18 (d) NO JUDICIAL REVIEW.—Neither the failure of
19 the Secretary and the Attorney General to authorize a
20 payment under subsection (a) nor the amount authorized
21 shall be subject to judicial review.

1 retary under this subsection, in accordance with an
2 annual rate established by the Secretary under the
3 Federal Claims Collection Act. The rate of interest
4 charged shall be the rate in effect on the date the
5 determination becomes final and shall remain fixed
6 at that rate until the entire amount due is paid. In
7 addition, the Secretary is authorized to recover the
8 costs of collection in any case where such penalties
9 and assessments are not paid within 30 days after
10 the determination becomes final, or in the case of a
11 compromised amount, where payments are more
12 than 90 days past due. In lieu of actual costs, the
13 Secretary is authorized to impose a charge of up to
14 10 percent of the amount of such penalties and as-
15 sessments owed to cover the costs of collection.

16 (3) DETERMINATIONS TO EXCLUDE PER-
17 MITTED.—In addition to any civil monetary penalty
18 or assessment imposed under this subsection, the
19 Secretary may make a determination in the same
20 proceeding to exclude a provider from participation
21 in all applicable health plans for the delivery of or
22 payment for health care items or services (in accord-
23 ance with section 5414(c)).

24 (c) PROCEDURES FOR IMPOSITION OF PENALTIES.—

1 (1) APPLICABILITY OF PROCEDURES UNDER SO-
2 CIAL SECURITY ACT.—Except as otherwise provided
3 in paragraph (2), the provisions of section 1128A of
4 the Social Security Act (other than subsections (a)
5 and (b) and the second sentence of subsection (f))
6 shall apply to the imposition of a civil monetary pen-
7 alty, assessment, or exclusion under this section in
8 the same manner as such provisions apply with re-
9 spect to the imposition of a penalty, assessment, or
10 exclusion under section 1128A of such Act.

11 (2) AUTHORITY OF SECRETARY OF LABOR AND
12 STATES TO IMPOSE PENALTIES, ASSESSMENTS, AND
13 EXCLUSIONS.—

14 (A) IN GENERAL.—The Secretary of Labor
15 or a State may initiate an action to impose a
16 civil monetary penalty, assessment, or exclusion
17 under this section with respect to actions relat-
18 ing to a large group sponsor if authorized by
19 the Attorney General of the United States and
20 the Secretary pursuant to regulations promul-
21 gated by the Secretary in consultation with the
22 Attorney General.

23 (B) REQUIREMENTS DESCRIBED.—Under
24 the regulations promulgated under subpara-
25 graph (A), the Attorney General and the Sec-

1 retary shall review an action proposed by the
2 Secretary of Labor or a State, and not later
3 than 60 days after receiving notice of the pro-
4 posed action from the Secretary of Labor or the
5 State, shall—

6 (i) approve the proposed action to be
7 taken by the Secretary of Labor or the
8 State;

9 (ii) disapprove the proposed action; or

10 (iii) assume responsibility for initiat-
11 ing a criminal, civil, or administrative ac-
12 tion based on the information provided in
13 the notice.

14 (C) ACTION DEEMED APPROVED IF DEAD-
15 LINE MISSED.—If the Attorney General and the
16 Secretary fail to respond to a proposed action
17 by the Secretary of Labor or a State within the
18 period described in subparagraph (B), the At-
19 torney General and the Secretary shall be
20 deemed to have approved the proposed action to
21 be taken by the Secretary of Labor or the
22 State.

23 (d) TREATMENT OF AMOUNTS RECOVERED.—Any
24 amounts recovered under this section shall be paid to the
25 Secretary and disposed of as follows:

1 ject to a civil monetary penalty under section 5411 may,
2 in a civil action against the individual or entity in the
3 United States District Court, obtain treble damages and
4 costs including attorneys' fees against the individual or en-
5 tity and such equitable relief as is appropriate.

6 (b) REQUIREMENTS FOR BRINGING ACTION.—A per-
7 son may bring a civil action under this section only if—

8 (1) the person provides the Secretary with writ-
9 ten notice of—

10 (A) the person's intent to bring an action
11 under this section,

12 (B) the identities of the individuals or enti-
13 ties the person intends to name as defendants
14 to the action, and

15 (C) all information the person possesses
16 regarding the activity that is the subject of the
17 action that may materially affect the Sec-
18 retary's decision to initiate a proceeding to im-
19 pose a civil monetary penalty under section
20 5411 against the defendants, and

21 (2) one of the following conditions is met:

22 (A) During the 60-day period that begins
23 on the date the Secretary receives the written
24 notice described in paragraph (1), the Secretary
25 does not notify the person that the Secretary

1 intends to initiate an investigation to determine
2 whether to impose a civil monetary penalty
3 under section 5411 against the defendants.

4 (B) The Secretary notifies the person dur-
5 ing the 60-day period described in subpara-
6 graph (A) that the Secretary intends to initiate
7 an investigation to determine whether to impose
8 a civil monetary penalty under such section
9 against the defendants, and the Secretary sub-
10 sequently notifies the person that the Secretary
11 no longer intends to initiate an investigation or
12 proceeding to impose a civil monetary penalty
13 against the defendants.

14 (C) After the expiration of the 1-year pe-
15 riod that begins on the date written notice is
16 provided to the Secretary, the Secretary has not
17 initiated a proceeding to impose a civil mone-
18 tary penalty against the defendants.

19 (c) TREATMENT OF EXCESS AWARDS.—If a person
20 is awarded any amounts in an action brought under this
21 section that are in excess of the damages suffered by the
22 person as a result of the defendant's activities, 20 percent
23 of such amounts shall be withheld from the person for pay-
24 ment into the All-Payer Health Care Fraud and Abuse
25 Control Account established under section 5402(a).

1 (d) STATUTE OF LIMITATIONS.—No action may be
2 brought under this section more than 6 years after the
3 date of the activity with respect to which the action is
4 brought.

5 (e) NO LIMITATION ON OTHER ACTIONS.—Nothing
6 in this section shall limit the right of any person to pursue
7 any other right of action or remedy available under the
8 law.

9 (f) PENDENT JURISDICTION.—Nothing in this sec-
10 tion shall be construed, by reason of a claim arising under
11 this section, to confer on the Courts of the United States
12 jurisdiction over any State law claim.

13 **SEC. 5413. EXCLUSION FROM PROGRAM PARTICIPATION.**

14 (a) MANDATORY EXCLUSION.—

15 (1) IN GENERAL.—Except as provided in para-
16 graph (2), the Secretary shall exclude an individual
17 or entity from participation in any applicable health
18 plan if the individual or entity—

19 (A) is excluded from participation in a
20 public program under, or is otherwise described
21 in, section 1128(a) of the Social Security Act
22 (relating to individuals and entities convicted of
23 health care-related crimes or patient abuse);

24 (B) has been convicted after the date of
25 the enactment of this section, under Federal or

1 State law, in connection with the delivery of a
2 health care item or service of a criminal offense
3 consisting of a felony relating to fraud, theft,
4 embezzlement, breach of fiduciary responsibil-
5 ity, or other financial misconduct; or

6 (C) has been convicted after such date,
7 under Federal or State law, of a criminal of-
8 fense consisting of a felony relating to the un-
9 lawful manufacture, distribution, prescription,
10 or dispensing of a controlled substance.

11 (2) WAIVER PERMITTED.—

12 (A) IN GENERAL.—When, in the opinion of
13 the Secretary, mandatory exclusion of an indi-
14 vidual or entity would significantly harm the
15 public health or pose a significant risk to the
16 public health, the Secretary may waive such ex-
17 clusion and shall apply such other appropriate
18 penalties as authorized under this subtitle.

19 (B) APPLICATION FOR WAIVER OF EXCLU-
20 SION.—

21 (i) IN GENERAL.—An individual or
22 entity subject to mandatory exclusion
23 under this subsection may apply to the
24 Secretary, in a manner specified by the

1 Secretary in regulations, for waiver of the
2 exclusion.

3 (ii) SECRETARIAL RESPONSE.—The
4 Secretary may waive the exclusion for the
5 reasons described in subparagraph (A).

6 (C) NOTIFICATION OF TERMINATION.—
7 The Secretary shall promptly notify each spon-
8 sor of an applicable health plan and each entity
9 that administers a State health care program
10 described in section 1128(h) of the Social Secu-
11 rity Act of each termination of exclusion made
12 under this paragraph.

13 (b) PERMISSIVE EXCLUSION.—The Secretary may
14 exclude an individual or entity from participation in any
15 applicable health plan if the individual or entity—

16 (1) is excluded from participation in a public
17 program under, or is otherwise described in, section
18 1128(b) of the Social Security Act (other than para-
19 graphs (3), (6)(A), (6)(C), (6)(D), (10), or (13) of
20 such section);

21 (2) has been convicted after the date of the en-
22 actment of this section, under Federal or State law,
23 in connection with the delivery of a health care item
24 or service of a criminal offense consisting of a mis-
25 demeanor relating to fraud, theft, embezzlement,

1 breach of fiduciary responsibility, or other financial
2 misconduct; or

3 (3) has been convicted after the date of the en-
4 actment of this section, under Federal or State law,
5 of a criminal offense consisting of a misdemeanor re-
6 lating to the unlawful manufacture, distribution,
7 prescription, or dispensing of a controlled substance.

8 (c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EX-
9 CLUSION.—

10 (1) NOTICE OF EXCLUSION.—An exclusion
11 under this section or section 5411(b)(3) shall be ef-
12 fective at such time and upon such reasonable notice
13 to the public and to the individual or entity excluded
14 as may be specified in regulations consistent with
15 paragraph (2).

16 (2) EFFECTIVE DATE OF EXCLUSION.—Such an
17 exclusion shall be effective with respect to services
18 furnished to an individual on or after the effective
19 date of the exclusion.

20 (3) PERIOD OF EXCLUSION.—

21 (A) IN GENERAL.—The Secretary shall
22 specify, in the notice of exclusion under para-
23 graph (1) and the notice under section 5411(e),
24 the minimum period (or, in the case of an ex-
25 clusion of an individual excluded from participa-

1 tion in a public program under, or is otherwise
2 described in, section 1128(b)(12) of the Social
3 Security Act, the period) of the exclusion.

4 (B) MINIMUM PERIOD FOR MANDATORY
5 EXCLUSIONS.—In the case of a mandatory ex-
6 clusion under subsection (a), the minimum pe-
7 riod of exclusion shall be not less than 2 years.

8 (C) MINIMUM PERIOD FOR CERTAIN PER-
9 MISSIVE EXCLUSIONS.—

10 (i) FRAUD, OBSTRUCTION OF INVES-
11 TIGATION, AND CONTROLLED SUBSTANCE
12 CONVICTION.—In the case of an exclusion
13 of an individual excluded from participa-
14 tion in a public program under, or is other-
15 wise described in, paragraph (1) or (2) of
16 section 1128(b) of the Social Security Act
17 or paragraph (2) or (3) of subsection (b)
18 of this section, the period of exclusion shall
19 be a minimum of 1 year, unless the Sec-
20 retary determines that a longer period is
21 necessary because of aggravating cir-
22 cumstances.

23 (ii) SUSPENSIONS.—In the case of an
24 exclusion of an individual or entity ex-
25 cluded from participation in a public pro-

1 gram under, or is otherwise described in,
2 paragraph (4), (5)(A), or (5)(B) of section
3 1128(b) of the Social Security Act, the pe-
4 riod of the exclusion shall not be less than
5 the period during which the individual's or
6 entity's license to provide health care is re-
7 voked, suspended or surrendered, or the in-
8 dividual or the entity is excluded or sus-
9 pended from a Federal or State health
10 care program.

11 (iii) UNNECESSARY SERVICES.—In the
12 case of an exclusion of an individual or en-
13 tity described in paragraph (6)(B) of sec-
14 tion 1128(b) of the Social Security Act,
15 the period of the exclusion shall be not less
16 than 1 year.

17 (iv) DENIAL OF IMMEDIATE AC-
18 CESS.—In the case of an exclusion of an
19 individual described in paragraph (12) of
20 section 1128(b) of the Social Security Act,
21 the period of the exclusion shall be equal
22 to the sum of—

23 (I) the length of the period in
24 which the individual failed to grant

1 the immediate access described in that
2 paragraph, and

3 (II) an additional period, not to
4 exceed 90 days, set by the Secretary.

5 (d) NOTICE TO ENTITIES ADMINISTERING PUBLIC
6 PROGRAMS FOR THE DELIVERY OF OR PAYMENT FOR
7 HEALTH CARE ITEMS OR SERVICES.—

8 (1) IN GENERAL.—The Secretary shall exercise
9 the authority under this section in a manner that re-
10 sults in an individual's or entity's exclusion from all
11 applicable health plans for the delivery of or pay-
12 ment for health care items or services.

13 (2) NOTIFICATION REQUIREMENTS.—The Sec-
14 retary shall promptly notify each sponsor of an ap-
15 plicable health plan and each entity that administers
16 a State health care program described in section
17 1128(h) of the Social Security Act of the fact and
18 circumstances of each exclusion (together with the
19 period thereof) effected against an individual or en-
20 tity under this section or under section 5411(b)(3).

21 (e) NOTICE TO STATE LICENSING AGENCIES.—The
22 provisions of section 1128(e) of the Social Security Act
23 shall apply to this section in the same manner as such
24 provisions apply to sections 1128 and 1128A of such Act.

25 (f) NOTICE, HEARING, AND JUDICIAL REVIEW.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 any individual or entity that is excluded (or directed
3 to be excluded) from participation under this section
4 is entitled to reasonable notice and opportunity for
5 a hearing thereon by the Secretary to the same ex-
6 tent as is provided in section 205(b) of the Social
7 Security Act, and to judicial review of the Sec-
8 retary’s final decision after such hearing as is pro-
9 vided in section 205(g) of such Act, except that such
10 action shall be brought in the Court of Appeals of
11 the United States for the judicial circuit in which
12 the individual or entity resides, or has a principal
13 place of business, or, if the individual or entity does
14 not reside or have a principal place of business with-
15 in any such judicial circuit, in the United States
16 Court of Appeals for the District of Columbia Cir-
17 cuit.

18 (2) ADMINISTRATIVE HEARING.—Unless the
19 Secretary determines that the health or safety of in-
20 dividuals receiving services warrants the exclusion
21 taking effect earlier, any individual or entity that is
22 the subject of an adverse determination based on
23 paragraphs (6)(B), (7), (8), (9), (11), (12), (14), or
24 (15) of section 1128(b) of the Social Security Act,
25 shall be entitled to a hearing by an administrative

1 law judge (as provided under section 205(b) of the
2 Social Security Act) on the determination before any
3 exclusion based upon the determination takes effect.
4 If a hearing is requested, the exclusion shall be ef-
5 fective upon the issuance of an order by the adminis-
6 trative law judge upholding the determination of the
7 Secretary to exclude.

8 (3) SPECIAL RULES.—The provisions of section
9 205(h) of the Social Security Act shall apply with
10 respect to this section or section 5411(b)(3) to the
11 same extent as such provisions apply with respect to
12 title II of such Act.

13 (g) APPLICATION FOR TERMINATION OF EXCLU-
14 SION.—

15 (1) IN GENERAL.—An individual or entity ex-
16 cluded (or directed to be excluded) from participa-
17 tion under this section or section 5411(b)(3) may
18 apply to the Secretary, in a manner specified by the
19 Secretary in regulations and at the end of the mini-
20 mum period of exclusion (or, in the case of an indi-
21 vidual or entity described in section 1128(b)(12), the
22 period of exclusion) provided under this section or
23 section 5411(b)(3) and at such other times as the
24 Secretary may provide, for termination of the exclu-
25 sion.

1 (2) SECRETARIAL RESPONSE.—The Secretary
2 may terminate the exclusion if the Secretary deter-
3 mines, on the basis of the conduct of the applicant
4 which occurred after the date of the notice of exclu-
5 sion or which was unknown to the Secretary at the
6 time of the exclusion, that—

7 (A) there is no basis under this section or
8 section 5411(b)(3) for a continuation of the ex-
9 clusion, and

10 (B) there are reasonable assurances that
11 the types of actions which formed the basis for
12 the original exclusion have not recurred and will
13 not recur.

14 (3) NOTIFICATION OF TERMINATION.—The Sec-
15 retary shall promptly notify each sponsor of an ap-
16 plicable health plan and each entity that administers
17 a State health care program described in section
18 1128(h) of the Social Security Act of each termi-
19 nation of exclusion made under this subsection.

20 (h) CONVICTED DEFINED.—In this section, the term
21 “convicted” has the meaning given such term in section
22 1128(i) of the Social Security Act.

23 (i) REQUEST FOR EXCLUSION.—The sponsor of any
24 applicable health plan (including a State in the case of
25 a consumer purchasing cooperative and the Secretary of

1 Labor in the case of a large group sponsor) may request
2 that the Secretary of Health and Human Services exclude
3 an individual or entity with respect to actions under such
4 a plan in accordance with this section.

5 (j) EFFECT OF EXCLUSION.—Notwithstanding any
6 other provision of this Act, no payment may be made
7 under a health plan for the delivery of or payment for any
8 item or service (other than an emergency item or service,
9 not including items or services furnished in an emergency
10 room of a hospital) furnished—

11 (1) by an individual or entity during the period
12 when such individual or entity is excluded pursuant
13 to this section or section 5411(b)(3) from participa-
14 tion in a health plan; or

15 (2) at the medical direction or on the prescrip-
16 tion of a physician during the period when the physi-
17 cian is excluded pursuant to this section or section
18 5411(b)(3) from participation in a health plan and
19 the person furnishing the item or service knew or
20 had reason to know of the exclusion (after a reason-
21 able time period after reasonable notice has been
22 furnished to the person).

1 **PART 3—AMENDMENTS TO CRIMINAL LAW**

2 **SEC. 5421. HEALTH CARE FRAUD.**

3 (a) IN GENERAL.—Chapter 63 of title 18, United
4 States Code, is amended by adding at the end the follow-
5 ing:

6 **“§ 1347. Health care fraud**

7 “(a) Whoever knowingly executes, or attempts to exe-
8 cute, a scheme or artifice—

9 “(1) to defraud any consumer purchasing coop-
10 erative, health plan, or other person, in connection
11 with the delivery of or payment for health care bene-
12 fits, items, or services; or

13 “(2) to obtain, by means of false or fraudulent
14 pretenses, representations, or promises, any of the
15 money or property owned by, or under the custody
16 or control of, any consumer purchasing cooperative,
17 health plan, or person in connection with the deliv-
18 ery of or payment for health care benefits, items, or
19 services;

20 shall be fined under this title or imprisoned not more than
21 10 years, or both. If the violation results in serious bodily
22 injury (as defined in section 1365 of this title) such person
23 shall be imprisoned for life or any term of years.

24 “(b) As used in this section—

1 (b) CLERICAL AMENDMENT.—The table of sections
2 at the beginning of chapter 31 of title 18, United States
3 Code, is amended by adding at the end the following:

“668. Theft or embezzlement in connection with health care.”.

4 **SEC. 5423. FALSE STATEMENTS.**

5 (a) IN GENERAL.—Chapter 47 of title 18, United
6 States Code, is amended by adding at the end the follow-
7 ing:

8 **“§ 1033. False statements relating to health care mat-
9 ters**

10 “(a) Whoever, in any matter involving a consumer
11 purchasing cooperative or health plan, knowingly and will-
12 fully falsifies, conceals, or covers up by any trick, scheme,
13 or device a material fact, or makes any false, fictitious,
14 or fraudulent statements or representations, or makes or
15 uses any false writing or document knowing the same to
16 contain any false, fictitious, or fraudulent statement or
17 entry, shall be fined under this title or imprisoned not
18 more than 5 years, or both.

19 “(b) As used in this section, the terms ‘consumer pur-
20 chasing cooperative’ and ‘health plan’ have the meanings
21 given those terms under title I of the Health Security
22 Act.”.

23 (b) CLERICAL AMENDMENT.—The table of sections
24 at the beginning of chapter 47 of title 18, United States
25 Code, is amended by adding at the end the following:

“1033. False statements relating to health care matters.”.

1 **SEC. 5424. BRIBERY AND GRAFT.**

2 (a) IN GENERAL.—Chapter 11 of title 18, United
3 States Code, is amended by adding at the end the follow-
4 ing:

5 **“§ 226. Bribery and graft in connection with health**
6 **care**

7 “(a) Whoever—

8 “(1) directly or indirectly, corruptly gives, of-
9 fers, or promises anything of value to a health care
10 official, or offers or promises a health care official
11 to give anything of value to any other person, with
12 intent—

13 “(A) to influence any of the health care of-
14 ficial’s actions, decisions, or duties relating to a
15 consumer purchasing cooperative or health
16 plan;

17 “(B) to influence such an official to com-
18 mit or aid in the committing, or collude in or
19 allow, any fraud, or make opportunity for the
20 commission of any fraud, on a consumer pur-
21 chasing cooperative or health plan; or

22 “(C) to induce such an official to engage
23 in any conduct in violation of the lawful duty of
24 such official; or

1 “(2) being a health care official, directly or in-
2 directly, corruptly demands, seeks, receives, accepts,
3 or agrees to accept anything of value personally or
4 for any other person or entity, the giving of which
5 violates paragraph (1) of this subsection;

6 shall be fined under this title or imprisoned not more than
7 15 years, or both.

8 “(b) Whoever, otherwise than as provided by law for
9 the proper discharge of any duty, directly or indirectly
10 gives, offers, or promises anything of value to a health
11 care official, for or because of any of the health care offi-
12 cial’s actions, decisions, or duties relating to a consumer
13 purchasing cooperative or health plan, shall be fined under
14 this title or imprisoned not more than two years, or both.

15 “(c) As used in this section—

16 “(1) the term ‘health care official’ means—

17 “(A) an administrator, officer, trustee, fi-
18 duciary, custodian, counsel, agent, or employee
19 of any consumer purchasing cooperative or
20 health plan;

21 “(B) an officer, counsel, agent, or em-
22 ployee, of an organization that provides services
23 under contract to any consumer purchasing co-
24 operative or health plan;

1 (1) by striking “or” at the end of subparagraph
2 (A);

3 (2) by inserting “or” at the end of subpara-
4 graph (B); and

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

6 “(C) committing or about to commit a Federal
7 health care offense (as defined in section 5402(d) of
8 the Health Security Act);”.

9 **SEC. 5426. GRAND JURY DISCLOSURE.**

10 Section 3322 of title 18, United States Code, is
11 amended—

12 (1) by redesignating subsections (c) and (d) as
13 subsections (d) and (e), respectively; and

14 (2) by inserting after subsection (b) the follow-
15 ing:

16 “(c) A person who is privy to grand jury information
17 concerning a health law violation—

18 “(1) received in the course of duty as an attor-
19 ney for the Government; or

20 “(2) disclosed under rule 6(e)(3)(A)(ii) of the
21 Federal Rules of Criminal Procedure;

22 may disclose that information to an attorney for the Gov-
23 ernment to use in any civil proceeding related to a Federal
24 health care offense (as defined in section 5402(d) of the
25 Health Security Act).”.

1 **SEC. 5427. FORFEITURES FOR VIOLATIONS OF FRAUD STAT-**
2 **UTES.**

3 Section 982(a) of title 18, United States Code, is
4 amended by inserting after paragraph (5) the following:

5 “(6) The court, in imposing sentence on a person con-
6 victed of a Federal health care offense (as defined in sec-
7 tion 5402(d) of the Health Security Act), shall order such
8 person to forfeit to the United States any property, real
9 or personal, constituting or traceable to the gross proceeds
10 obtained, directly or indirectly, as a result of the commis-
11 sion of the offense.”.

12 **PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS**
13 **ACT**

14 **SEC. 5431. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

15 Section 3729 of title 31, United States Code, is
16 amended—

17 (1) in subsection (a)(7), by inserting “or to a
18 health plan” after “property to the Government”;

19 (2) in the matter following subsection (a)(7), by
20 inserting “or health plan” before “sustains because
21 of the act of that person,”;

22 (3) at the end of the first sentence of sub-
23 section (a), by inserting “or health plan” before
24 “sustains because of the act of the person.”;

25 (4) in subsection (c)—

1 (A) by inserting “the term” after “sec-
2 tion,”; and

3 (B) by adding at the end the following:
4 “The term also includes any request or demand,
5 whether under contract or otherwise, for money
6 or property which is made or presented to a
7 health plan.”; and

8 (5) by adding at the end the following:

9 “(f) HEALTH PLAN DEFINED.—For purposes of this
10 section, the term ‘health plan’ has the meaning given such
11 term under section 1400 of the Health Security Act.”.

12 **PART 5—EFFECTIVE DATE**

13 **SEC. 5441. EFFECTIVE DATE.**

14 Except as otherwise provided in this subtitle, the pro-
15 visions of, and amendments made by, this subtitle shall
16 be effective on and after January 1, 1995.

17 **Subtitle F—Repeal of Exemption**

18 **SEC. 5501. REPEAL OF EXEMPTION FOR HEALTH INSUR-**

19 **ANCE.**

20 (a) IN GENERAL.—Section 3 of the Act of March 9,
21 1945 (15 U.S.C. 1013), known as the McCarran-Ferguson
22 Act, is amended by adding at the end the following:

23 “(c) Notwithstanding that the business of insurance
24 is regulated by State law, nothing in this Act shall limit
25 the applicability of the following Acts to the business of

1 insurance to the extent that such business relates to the
2 provision of health benefits:

3 “(1) The Sherman Act (15 U.S.C. 1 et seq.).

4 “(2) The Clayton Act (15 U.S.C. 12 et seq.).

5 “(3) Federal Trade Commission Act (15 U.S.C.
6 41 et seq.).

7 “(4) The Act of June 19, 1936 (49 Stat. 1526;
8 15 U.S.C. 21a et seq.), known as the Robinson-Pat-
9 man Antidiscrimination Act.”.

10 (b) EFFECTIVE DATE.—The amendment made by
11 subsection (a) shall take effect on the first day of the sixth
12 month beginning after the date of the enactment of this
13 Act.

14 **TITLE VI—PREMIUM CAPS; PRE-**
15 **MIUM-BASED FINANCING;**
16 **AND PLAN PAYMENTS**

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1 **SEC. 6000. GENERAL DEFINITIONS.**

2 (a) DEFINITIONS RELATING TO PER CAPITA PRE-
 3 MIUM RATES.—In this title:

4 (1) FILED PER CAPITA COMMUNITY BID.—The
 5 term “filed per capita community bid” means the
 6 per capita premium bid that is filed with a State for
 7 a community-rated plan offered in a health care cov-
 8 erage area under subpart A of part 1 and is avail-
 9 able to all community rate eligible individuals enroll-
 10 ing directly with a health plan.

1 (2) ACCEPTED PER CAPITA COOPERATIVE
2 BID.—The term “accepted per capita cooperative
3 bid” means the per capita premium rate agreed
4 upon by a cooperative and a plan taking into ac-
5 count any discount to such bid negotiated under sec-
6 tion 1302(c)(2).

7 (3) FINAL COMMUNITY RATE.—The term “final
8 community rate” means the filed per capita commu-
9 nity bid, taking into account any voluntary reduction
10 in such bid made under section 6004(e).

11 (4) FINAL COOPERATIVE RATE.—The term
12 “final cooperative bid” means the accepted per cap-
13 ita cooperative bid, taking into account any vol-
14 untary reductions in such bid made under section
15 6004(e).

16 (b) DEFINITIONS RELATED TO WEIGHTED AVERAGE
17 PER CAPITA PREMIUM RATES.—In this title:

18 (1) WEIGHTED AVERAGE ACCEPTED BID.—The
19 term “weighted average accepted bid” means, for a
20 health care coverage area for a year, the average
21 across all plans of—

22 (A) the filed per capita community bid for
23 each community-rated health plan offered in a
24 health care coverage area weighted to reflect
25 the relative enrollment (net of any enrollment

1 through a cooperative) of community rate eligi-
2 ble individuals among such plans; and

3 (B) the accepted per capita cooperative bid
4 for each community-rated health plan offered in
5 a health care coverage area weighted to reflect
6 the relative enrollment of community rate eligi-
7 ble individuals through a cooperative among
8 such plans.

9 (2) WEIGHTED AVERAGE DISCOUNT RATE.—
10 The term “weighted average discount rate” means,
11 for a health care coverage area for a year, the lesser
12 of—

13 (A) the per capita premium target for the
14 health care coverage area (as defined in section
15 6003) for the year; or

16 (B) the average across all plans of the less-
17 er of—

18 (i) the final community rate; or

19 (ii) the final cooperative rate, (appli-
20 cable only for plans offered through the co-
21 operative);

22 for each community-rated health plan, weighted
23 to reflect the total enrollment of community
24 rate eligible individuals among such plans.

1 (3) **WEIGHTED AVERAGE PREMIUM.**—The term
2 “weighted average premium” means, for a class of
3 enrollment and with respect to a health care cov-
4 erage area for the year, the product of—

5 (A) the weighted average discount rate (as
6 defined in paragraph (2));

7 (B) the uniform per capita conversion fac-
8 tor (established under section 6211 for the
9 area; and

10 (C) the premium class factor established
11 by the Board for that class under section 1631.

12 (d) **INCORPORATION OF OTHER DEFINITIONS.**—Ex-
13 cept as otherwise provided in this title, the definitions of
14 terms in subtitle J of title I of this Act shall apply to
15 this title.

16 **Subtitle A—Premium Caps**

17 **PART 1—HEALTH EXPENDITURES OF HEALTH** 18 **CARE COVERAGE AREAS**

19 **Subpart A—Computation of Targets and Accepted** 20 **Bids**

21 **SEC. 6001. COMPUTATION OF HEALTH CARE COVERAGE** 22 **AREA INFLATION FACTORS.**

23 (a) **COMPUTATION.**—

24 (1) **IN GENERAL.**—This section provides for the
25 computation of factors that limit the growth of pre-

1 miums for the comprehensive benefit package in
2 community-rated health plans. The Board shall com-
3 pute and publish, not later than March 1 of each
4 year (beginning with 1995) the health care coverage
5 area inflation factor (as defined in paragraph (2))
6 for each health care coverage area for the following
7 year.

8 (2) HEALTH CARE COVERAGE AREAS INFLA-
9 TION FACTOR.—In this part, the term “health care
10 coverage area inflation factor” means, for a year for
11 a health care coverage area—

12 (A) the general health care inflation factor
13 for the year (as defined in paragraph (3));

14 (B) adjusted under subsection (c) (to take
15 into account material changes in the demo-
16 graphic and socio-economic characteristics of
17 the population of community rate eligible indi-
18 viduals);

19 (C) decreased by the percentage adjust-
20 ment (if any) provided with respect to the
21 health care coverage area under subsection (d)
22 (relating to adjustment for previous excess ex-
23 penditures); and

24 (D) in the case of the year 2001, increased
25 by a factor that the Board determines to reflect

1 the ratio of (i) the actuarial value of the in-
2 crease in benefits provided in that year under
3 the comprehensive benefit package to (ii) the
4 actuarial value of the benefits that would have
5 been in such package in the year without regard
6 to the increase.

7 For purposes of subparagraph (D)(i), the actuarial
8 value of the increase with respect to mental illness
9 and substance abuse services (included within the
10 comprehensive benefit package) shall not exceed an
11 actuarial value based on the amount of the total ex-
12 penditures that would have been made in 2001 by
13 States and subdivisions of States for mental illness
14 and substance abuse services (included in such pack-
15 age as of 2001) if this Act had not been enacted.

16 (3) GENERAL HEALTH CARE INFLATION FAC-
17 TOR.—

18 (A) 1996 THROUGH 2000.—In this part,
19 the term “general health care inflation factor”,
20 for a year, means the percentage increase in the
21 CPI (as specified under subsection (b)) for the
22 year plus the following:

- 23 (i) For 1996, 1.5 percentage points.
24 (ii) For 1997, 1.0 percentage points.
25 (iii) For 1998, 0.5 percentage points.

1 (iv) For 1999 and for 2000, 0 per-
2 centage points.

3 (B) YEARS AFTER 2000.—

4 (i) RECOMMENDATION TO CON-
5 GRESS.—In 1999, the Board shall submit
6 to Congress recommendations, after con-
7 sultation with the Federal Reserve Board,
8 on what the general health care inflation
9 factor should be for years beginning with
10 2001.

11 (ii) FAILURE OF CONGRESS TO ACT.—
12 If the Congress fails to enact a law specify-
13 ing the general health care inflation factor
14 for a year after 2000, the Board, in Janu-
15 ary of the year before the year involved,
16 shall compute such factor for the year in-
17 volved. Such factor shall be the product of
18 the factors described in subparagraph (C)
19 for that fiscal year, minus 1.

20 (iii) STUDY BY FEDERAL RESERVE
21 BOARD.—Not later than January 1, 1999,
22 the Federal Reserve Board shall conduct a
23 study, and report to the National Health
24 Board, concerning what the general health
25 care inflation factor should be for years be-

1 ginning with 2001. Such study shall con-
2 sider whether continued indexing with re-
3 spect to such factor is advisable and
4 whether the consumer price index should
5 be used (in whole or in part, modified or
6 unmodified) with respect to premium caps
7 for future years. The recommendations of
8 the Federal Reserve Board under such
9 study shall be considered in the rec-
10 ommendations submitted under clause (i).

11 (C) FACTORS.—The factors described in
12 this subparagraph for a year are the following:

13 (i) CPI.—1 plus the percentage
14 change in the CPI for the year, determined
15 based upon the percentage change in the
16 average of the CPI for the 12-month pe-
17 riod ending with August 31 of the previous
18 fiscal year over such average for the pre-
19 ceding 12-month period.

20 (ii) REAL GDP PER CAPITA.—1 plus
21 the average annual percentage change in
22 the real, per capita gross domestic product
23 of the United States during the 3-year pe-
24 riod ending in the preceding calendar year,

1 determined by the Board based on data
2 supplied by the Department of Commerce.

3 (b) PROJECTION OF INCREASE IN CPI.—

4 (1) IN GENERAL.—For purposes of this section,
5 the Board shall specify, as of the time of publica-
6 tion, the annual percentage increase in the CPI (as
7 defined in section 1902(9)) for the following year.

8 (2) DATA TO BE USED.—Such increase shall be
9 the projection of the CPI contained in the budget of
10 the United States transmitted by the President to
11 the Congress in the year.

12 (c) SPECIAL ADJUSTMENT FOR MATERIAL CHANGES
13 IN DEMOGRAPHIC CHARACTERISTICS OF POPULATION.—

14 (1) ADJUSTMENT FOR LARGE GROUP PUR-
15 CHASER OPT-IN.—

16 (A) IN GENERAL.—The Board shall de-
17 velop a method for adjusting the health care
18 coverage area inflation factor for each health
19 care coverage area in order to reflect material
20 changes in the demographic characteristics of
21 community rate eligible individuals residing in
22 the coverage area (in comparison with such
23 characteristics for the previous year) as a result
24 of the termination of an election of one or more
25 large group purchasers under section 1406.

1 (B) BASIS FOR ADJUSTMENTS.—Adjust-
2 ments under this paragraph (whether an in-
3 crease or decrease) shall be based on the char-
4 acteristics and factors used for making adjust-
5 ments in payments under section 6124.

6 (2) ADJUSTMENT FOR AREA TREND COMPARED
7 TO NATIONAL TREND.—

8 (A) IN GENERAL.—The Board shall de-
9 velop a method for adjusting the health care
10 coverage area inflator factor for each health
11 care coverage area in order to reflect material
12 changes in the demographic characteristics (in-
13 cluding at least age, gender, and socio-economic
14 status) and health status of community rate eli-
15 gible individuals residing in the coverage area
16 in comparison with the average change in such
17 characteristics for such individuals residing in
18 the United States. The adjustment under this
19 paragraph shall be for changes not taken into
20 account in the adjustment under paragraph (1).

21 (B) NEUTRAL ADJUSTMENT.—Such meth-
22 od (and any annual adjustment under this
23 paragraph) shall be designed to result in the
24 adjustment effected under this paragraph for a

1 year not changing the weighted average of the
2 health care coverage area inflation factors.

3 (3) APPLICATION.—The Board shall provide, on
4 an annual basis, for an adjustment of health care
5 coverage area inflation factors under this subsection
6 using such methods.

7 (d) CONSULTATION PROCESS.—The Board shall have
8 a process for consulting with representatives of States be-
9 fore establishing the health care coverage area inflation
10 factors for each year under this section.

11 **SEC. 6002. BOARD DETERMINATION OF NATIONAL PER CAP-**
12 **ITA BASELINE PREMIUM TARGET.**

13 (a) IN GENERAL.—Not later than January 1, 1995,
14 the Board shall determine a national per capita baseline
15 premium target. Such target is equal to—

16 (1) the national average per capita current cov-
17 erage health expenditures (determined under sub-
18 section (b)),

19 (2) updated under subsection (c).

20 (b) DETERMINATION OF NATIONAL AVERAGE PER
21 CAPITA CURRENT COVERAGE HEALTH EXPENDITURES.—

22 (1) IN GENERAL.—The Board shall determine
23 the national average per capita current coverage
24 health expenditures equal to—

1 (A) total covered current health care ex-
2 penditures (described in paragraph (2)), divided
3 by

4 (B) the estimated population in the United
5 States of community rate eligible individuals (as
6 determined by the Board as of 1993 under
7 paragraph (4)) for whom such expenditures
8 were determined.

9 The population under subparagraph (B) shall not in-
10 clude SSI recipients or AFDC recipients.

11 (2) CURRENT HEALTH CARE EXPENDITURES.—
12 For purposes of paragraph (1)(A), the Board shall
13 determine current health care expenditures as fol-
14 lows:

15 (A) DETERMINATION OF TOTAL EXPENDI-
16 TURES.—The Board shall first determine the
17 amount of total payments made for items and
18 services included in the comprehensive benefit
19 package (determined without regard to cost
20 sharing) in the United States in 1993.

21 (B) REMOVAL OF CERTAIN EXPENDITURES
22 NOT TO BE COVERED IN THE COMPREHENSIVE
23 BENEFIT PACKAGE.—The amount so deter-
24 mined shall be decreased by the proportion of

1 such amount that is attributable to any of the
2 following:

3 (i) Medicare beneficiaries (other than
4 such beneficiaries who are community rate
5 eligible individuals).

6 (ii) AFDC recipients or SSI recipi-
7 ents.

8 (iii) Expenditures which are paid for
9 through workers' compensation or auto-
10 mobile or other liability insurance.

11 (iv) Expenditures by parties (includ-
12 ing the Federal Government) that the
13 Board determines will not be payable by
14 community-rated plans for coverage of the
15 comprehensive benefit package under this
16 Act (as defined in section 1101).

17 (C) ADDITION OF PROJECTED EXPENDI-
18 TURES FOR UNINSURED AND UNDERINSURED
19 INDIVIDUALS.—The amount so determined and
20 adjusted shall be increased to take into account
21 increased utilization of, and expenditures for,
22 items and services covered under the com-
23 prehensive benefit package likely to occur, as a
24 result of coverage under a community-rated
25 health plan of individuals who, as of 1993 were

1 uninsured or underinsured with respect to the
2 comprehensive benefit package. In making such
3 determination, such expenditures shall be based
4 on the estimated average cost for such services
5 in 1993 (and not on private payment rates es-
6 tablished for such services). In making such de-
7 termination, the estimated amount of uncom-
8 pensated care in 1993 shall be removed and will
9 not include adjustments to offset payments
10 below costs by public programs.

11 (D) ADDITION OF COSTS OF ADMINISTRA-
12 TION.—The amount so determined and ad-
13 justed shall be increased by an estimated per-
14 centage (determined by the Board, but no more
15 than 15 percent) that reflects the proportion of
16 premiums that are required for health plan ad-
17 ministration for State administration (including
18 costs for administration of income-related pre-
19 mium discounts and cost sharing reductions)
20 and for State premium taxes (which taxes shall
21 be limited to such amounts in 1993 as are at-
22 tributable to the health benefits to be included
23 in the comprehensive benefit package). Such ad-
24 justments shall not include any marketing fees

1 (described in section 1511) or cooperative fees
2 (described in section 1305).

3 (E) DECREASE FOR COST SHARING.—The
4 amount so determined and adjusted shall be de-
5 creased by a percentage that reflects (i) the es-
6 timated average percentage of total amounts
7 payable for items and services covered under
8 the comprehensive benefit package that will be
9 payments in the form of cost sharing under a
10 higher cost sharing plan, and (ii) the percent-
11 age reduction in utilization estimated to result
12 from the application of high cost sharing.

13 (3) SPECIAL RULES.—

14 (A) BENEFITS USED.—The determinations
15 under this section shall be based on the com-
16 prehensive benefit package as in effect in 1996.

17 (B) ASSUMING NO CHANGE IN EXPENDI-
18 TURE PATTERN.—The determination under
19 paragraph (2) shall be made without regard to
20 any change in the pattern of expenditures that
21 may result from the enrollment of AFDC recipi-
22 ents and SSI recipients in community-rated
23 health plans.

24 (4) ELIGIBLE INDIVIDUALS.—In this sub-
25 section, the determination of who are community

1 rate eligible individuals under this subsection shall
2 be made as though this Act was fully in effect in
3 each State as of 1993.

4 (c) UPDATING.—

5 (1) IN GENERAL.—Subject to paragraph (3),
6 the Board shall update the amount determined
7 under subsection (b)(1) for each of 1994 and 1995
8 by the appropriate update factor described in para-
9 graph (2) for the year.

10 (2) APPROPRIATE UPDATE FACTOR.—In para-
11 graph (1), the appropriate update factor for a year
12 is 1 plus the annual percentage increase for the year
13 (as determined by the Secretary, based on actual or
14 projected information) in private sector health care
15 spending for items and services included in the com-
16 prehensive benefit package (as of 1996).

17 (3) LIMIT.—The total, cumulative update under
18 this subsection shall not exceed 15 percent.

19 **SEC. 6003. DETERMINATION OF AREA PER CAPITA PRE-**
20 **MIUM TARGETS.**

21 (a) INITIAL DETERMINATION.—Not later than Janu-
22 ary 1, 1995, the Board shall determine, for each health
23 care coverage area for 1996, a health care coverage area
24 per capita premium target. Such target shall equal—

1 (1) the national per capita baseline premium
2 target (determined by the Board under section
3 6002),

4 (2) updated by the health care coverage area in-
5 flation factor (as determined under section
6 6001(a)(2)) for 1996, and

7 (3) adjusted by the adjustment factor for the
8 health care coverage area (determined under sub-
9 section (c)).

10 (b) SUBSEQUENT DETERMINATIONS.—

11 (1) DETERMINATION.—Not later than March 1
12 of each year (beginning with 1996) the Board shall
13 determine, for each health care coverage area for the
14 succeeding year a health care coverage area per cap-
15 ita premium target.

16 (2) GENERAL RULE.—Subject to subsection (e),
17 such target shall equal—

18 (A) the health care coverage area per cap-
19 ita target determined under this section (with-
20 out regard to subsection (e)) for the health care
21 coverage area for the previous year,

22 (B) updated by the health care coverage
23 area inflation factor (as determined in section
24 6001(a)) for the year.

1 (3) ADJUSTMENT FOR PREVIOUS EXCESS RATE
2 OF INCREASE IN EXPENDITURES.—Such target for a
3 year is subject to a decrease under section 6001(d).

4 (c) ADJUSTMENT FACTORS FOR HEALTH CARE COV-
5 ERAGE AREAS FOR INITIAL DETERMINATION.—

6 (1) IN GENERAL.—The Board shall establish an
7 adjustment factor for each health care coverage area
8 in a manner consistent with this subsection.

9 (2) CONSIDERATIONS.—In establishing the fac-
10 tor for each health care coverage area, the Board
11 shall consider, using information of the type de-
12 scribed in paragraph (3), the difference between the
13 national average of the factors taken into account in
14 determining the national per capita baseline pre-
15 mium target and such factors for the health care
16 coverage area, including variations in health care ex-
17 penditures and in rates of uninsurance and
18 underinsurance in the different areas and including
19 variations in the proportion of expenditures for serv-
20 ices provided by academic health centers in the dif-
21 ferent areas.

22 (3) TYPE OF INFORMATION.—The type of infor-
23 mation described in this paragraph is—

24 (A) information on variations in premiums
25 across States and across health care coverage

1 areas within a State (based on surveys and
2 other data);

3 (B) information on variations in per capita
4 health spending by State, as measured by the
5 Secretary;

6 (C) information on variations across States
7 in per capita spending under the medicare pro-
8 gram and in such spending among health care
9 coverage areas within a State under such pro-
10 gram;

11 (D) area rating factors commonly used by
12 actuaries;

13 (E) information on variations in the extent
14 to which States and health care coverage areas
15 need additional investment because they have
16 successfully controlled health care costs; and

17 (F) information on variations among
18 States and health care coverage areas due to
19 underutilization of health care services resulting
20 from geographic barriers and lack of access to
21 health care services, particularly in underserved
22 rural and urban areas.

23 (4) APPLICATION OF FACTORS IN NEUTRAL
24 MANNER.—The application of the adjustment factors
25 under this subsection for 1996 shall be done in a

1 manner so that the weighted average of the health
2 care coverage area per capita premium targets for
3 1996 is equal to the national per capita baseline pre-
4 mium target determined under section 6002. Such
5 weighted average shall be based on the Board's esti-
6 mate of the expected distribution of community rate
7 eligible individuals (taken into account under section
8 6002) among the health care coverage areas.

9 (5) CONSULTATION PROCESS.—The Board shall
10 have a process for consulting with representatives of
11 States and purchasing cooperative before establish-
12 ing the adjustment for health care coverage areas
13 under this subsection.

14 (d) TREATMENT OF CERTAIN STATES.—

15 (1) NON-PARTICIPATING.—In the case of a
16 State that is not a participating State or otherwise
17 has not established health care coverage areas, the
18 entire State shall be treated under the provisions of
19 this part as composing a single health care coverage
20 area.

21 (2) CHANGES IN AREA BOUNDARIES.—In the
22 case of a State that changes the boundaries of its
23 health care coverage areas (including the establish-
24 ment of such areas after 1996), the Board shall pro-
25 vide a method for computing a health care coverage

1 area per capita premium target for each health care
2 coverage area affected by such change in a manner
3 that—

4 (A) reflects the factors taken into account
5 in establishing the adjustment factors for health
6 care coverage areas under subsection (c), and

7 (B) results in the weighted average of the
8 newly computed regional targets for the health
9 care coverage areas affected by the change
10 equal to the weighted average of the regional
11 targets for the health care coverage areas as
12 previously established.

13 (e) ADJUSTMENT FOR PREVIOUS EXCESS RATE OF
14 INCREASE IN EXPENDITURES.—

15 (1) IN GENERAL.—If the actual weighted aver-
16 age accepted bid for a health care coverage area for
17 a year (as determined by the Board based on actual
18 enrollment in the first month of the year) exceeds
19 the health care coverage area per capita premium
20 target (determined under this section) for the year,
21 then the health care coverage area per capita pre-
22 mium target shall be reduced, by $\frac{1}{2}$ of the excess
23 percentage (described in paragraph (2)) for the year,
24 for each of the 2 succeeding years.

1 (2) EXCESS PERCENTAGE.—The excess percent-
2 age described in this paragraph for a year is the per-
3 centage by which—

4 (A) the actual weighted average accepted
5 bid (referred to in paragraph (1)) for a health
6 care coverage area for the year, exceeds

7 (B) the health care coverage area per cap-
8 ita premium target (determined under this sec-
9 tion) for the year.

10 **SEC. 6004. INITIAL RATE FILING AND BID NEGOTIATION**
11 **PROCESS.**

12 (a) FILING AND BIDDING PROCESS.—

13 (1) FILING COMMUNITY BIDS.—

14 (A) IN GENERAL.—Not later than July 1
15 before the first year, and not later than August
16 1 of each succeeding year, each plan seeking to
17 participate as a community-rated health plan,
18 with respect to the health care coverage area, in
19 the following year shall file a per capita commu-
20 nity bid in the manner specified under sub-
21 section (c).

22 (B) SUBMISSION OF BIDS TO COOPERA-
23 TIVES.—Each plan filing a per capita commu-
24 nity bid with respect to a health care coverage
25 area under subparagraph (A) shall also submit

1 to the cooperative of such health care coverage
2 area a per capita premium bid (not to exceed
3 the rate filed under subparagraph (A) for such
4 plan) for coverage of the comprehensive benefit
5 package as specified in section 1101 in the
6 manner described under subsection (c).

7 (C) ESTABLISHMENT OF RULES AND PRO-
8 CEDURES FOR FILING PREMIUM BIDS.—In ac-
9 cordance with section 1660, each participating
10 State shall establish rules and procedures for
11 the filing of premium rates and submission of
12 premium bids by plans.

13 (D) DISCLOSURE.—In conjunction with
14 the filing of per capita community bids, the
15 State may determine to disclose (or not to dis-
16 close) the health care coverage area per capita
17 premium target for the health care coverage
18 area (determined under section 6003) for the
19 year involved.

20 (E) CONDITION.—Each community bid
21 filed and cooperative bid submitted under this
22 subsection with respect to a community-rated
23 health plan shall be conditioned upon the plan's
24 agreement to accept any payment reduction
25 that may be imposed under section 6011.

1 (2) NEGOTIATION PROCESS.—Following the
2 bidding process under paragraph (1), a cooperative
3 may conduct negotiations with health plans relating
4 to the premiums to be charged for such community-
5 rated health plans within a cooperative. Such nego-
6 tiations may result in the resubmission of bids to the
7 cooperative, but in no case shall a health plan resub-
8 mit a bid that exceeds its prior bid.

9 (3) LEGALLY BINDING BIDS.—All rates filed
10 and bids submitted under this subsection must be le-
11 gally binding with respect to the plans involved.

12 (4) ACCEPTANCE.—

13 (A) PER CAPITA COMMUNITY BID.—The
14 final community rate for a community-rated
15 health plan under this subsection shall be con-
16 sidered to be the accepted bid for such plan, ex-
17 cept as provided in subsection (e).

18 (B) PER CAPITA COOPERATIVE BID.—The
19 final cooperative bid submitted to a cooperative
20 for a community-rated health plan under this
21 subsection shall be considered to be the accept-
22 ed bid for such plan, except as provided in sub-
23 section (e).

24 (5) ASSISTANCE.—The Board shall provide
25 States and cooperatives with such information and

1 technical assistance as may assist such States and
2 cooperatives in carrying out the provisions of this
3 subsection.

4 (b) SUBMISSION OF INFORMATION TO BOARD.—By
5 not later than September 1 of each year for which commu-
6 nity per capita bids are filed under subsection (a), each
7 State shall submit to the Board a report that discloses
8 for each community-rating area—

9 (1) information regarding the per capita com-
10 munity bid filed and accepted cooperative bids nego-
11 tiated under subsection (a) by the different plans;

12 (2)(A) for the first year, any information the
13 Board may request concerning an estimation of
14 the—

15 (i) enrollment likely in each such plan of
16 community rate eligible individuals through co-
17 operatives; and

18 (ii) the enrollment likely in each such plan
19 of community rate eligible individuals by enroll-
20 ment mechanisms other than cooperatives in ac-
21 cordance with section 1660, or

22 (B) for a succeeding year—

23 (i) the actual distribution of enrollment of
24 community rate eligible individuals in commu-

1 nity-rated health plans through cooperatives;
2 and

3 (ii) the actual distribution of enrollment of
4 community rate eligible individuals in commu-
5 nity-rated health plans through enrollment
6 mechanisms other than cooperatives, in accord-
7 ance with section 1660;

8 in the year in which the report is transmitted; and

9 (3) limitations on capacity of community-rated
10 health plans.

11 (c) COMPUTATION OF WEIGHTED AVERAGE ACCEPT-
12 ED BID.—

13 (1) IN GENERAL.—For each health care cov-
14 erage area the Board shall determine a weighted av-
15 erage accepted bid for each year for which rates are
16 filed with the State under subsection (a). Such de-
17 termination shall be based on information on accept-
18 ed bids for the year, submitted under subsection
19 (b)(1), and shall take into account, subject to para-
20 graph (2), the information on enrollment distribu-
21 tion submitted under subsection (b)(2).

22 (2) ENROLLMENT DISTRIBUTION RULES.—In
23 making the determination under paragraph (1) for a
24 health care coverage area, the Board shall establish

1 rules respecting the treatment of enrollment in plans
2 that are discontinued or are newly offered.

3 (3) EXCLUSION OF WORKSITE HEALTH PRO-
4 MOTION DISCOUNTS.—For purposes of calculating
5 the weighted average accepted bid and enforcing the
6 per capita premium targets in a health care coverage
7 area in a State, the Board shall consider the accept-
8 ed bids for the year, without consideration or inclu-
9 sion of any worksite health promotion discount.

10 (d) NOTICE TO CERTAIN STATES.—

11 (1) IN GENERAL.—By not later than October 1
12 of each year for which rates are filed with a State,
13 the Board shall notify a State—

14 (A) if the weighted average accepted bid
15 (determined under subsection (c)) for the health
16 care coverage area is greater than the health
17 care coverage area per capita premium target
18 for such area (determined under section 6003)
19 for the year, and

20 (B) of the weighted average discount rate
21 for the health care coverage area.

22 (2) NOTICE OF PREMIUM REDUCTIONS.—If no-
23 tice is provided to a State under paragraph (1), the
24 Board shall notify the State and each noncomplying
25 plan of any plan payment reduction computed under

1 section 6011 for such a plan and the opportunity to
2 voluntarily reduce the accepted bid under subsection
3 (e) in order to avoid such a reduction.

4 (e) VOLUNTARY REDUCTION OF ACCEPTED BIDS.—
5 After the Board has determined under subsection (c) the
6 weighted average accepted bid for a health care coverage
7 area and the Board has determined plan payment reduc-
8 tions, before such date as the Board may specify (in order
9 to provide for an open enrollment period), a noncomplying
10 plan has the opportunity to voluntarily reduce its filed
11 community bid (and if applicable, its accepted cooperative
12 bid) by the amount of the plan payment reduction that
13 would otherwise apply to the plan. Such reduction shall
14 not affect the amount of the plan payment reduction for
15 any other plan for that year.

16 **SEC. 6005. STATE FINANCIAL INCENTIVES.**

17 (a) ELECTION.—Any participating State may elect to
18 assume responsibility for containment of health care ex-
19 penditures in the State consistent with this part. Such re-
20 sponsibility shall include submitting annual reports to the
21 Board on any activities undertaken by the State to contain
22 such expenditures. A participating State may regulate the
23 rates charged by providers furnishing health care items
24 and services to all private payers. Such regulation of rates
25 may not cause an experienced-rated health plan to be

1 charged, directly or indirectly, rates different from those
2 charged other community-rated health plans for the same
3 items and services or otherwise discriminate against expe-
4 rience-rated health plans.

5 (b) FINANCIAL INCENTIVE.—In the case of a State
6 that has made an election under subsection (a), if the
7 Board determines for a particular year (beginning with
8 the first year) that the statewide weighted average of the
9 weighted average discount rates (based on actual average
10 enrollment for the year), for health care coverage areas
11 in the State, is less than the statewide weighted average
12 of the health care coverage area per capita premium tar-
13 gets (based upon such enrollment) for such areas for the
14 year, then the amount of the State maintenance-of-effort
15 payment under section 9001(b), for the following year,
16 shall be reduced by $\frac{1}{2}$ of the product of—

17 (1) the amount by which the amount of such
18 statewide average target exceeds the amount of such
19 statewide average accepted bid, divided by the
20 amount of such target; and

21 (2) the total of the amount of the Federal pay-
22 ments made in that particular year to the State
23 under subtitle B of title IX.

24 (c) ALTERNATIVE STATE PROVIDER PAYMENT SYS-
25 TEMS.—Notwithstanding any other provision of law, in the

1 case of an alternative State provider payment system that
2 has been approved by the Secretary and in continuous op-
3 eration since July 1, 1977, the payment rates and meth-
4 odologies required under the State system for services pro-
5 vided in that State shall apply to all purchasers and
6 payors, including those under employee welfare benefit
7 plans authorized under the Employee Retirement Income
8 Security Act of 1974, workers' compensation programs
9 under State law, the Federal Employees' Compensation
10 Act under chapter 81 of title 5, United States Code, and
11 Federal employee health benefit plans under chapter 89
12 of title 5, United States Code.

13 **SEC. 6006. RECOMMENDATIONS TO ELIMINATE REGIONAL**
14 **VARIATIONS IN AREA TARGETS DUE TO VARI-**
15 **ATION IN PRACTICE PATTERNS; CONGRES-**
16 **SIONAL CONSIDERATION.**

17 (a) ESTABLISHMENT OF ADVISORY COMMISSION ON
18 REGIONAL VARIATIONS IN HEALTH EXPENDITURES.—
19 The chair of the Board shall establish, by not later than
20 60 days after the date of appointment of the first chair,
21 an advisory commission on regional variations in health
22 expenditures.

23 (b) COMPOSITION.—The advisory commission shall
24 be composed of consumers, employers, providers, rep-
25 resentatives of health plans, States, individuals with exper-

1 tise in the financing of health care, individuals with exper-
2 tise in the economics of health care, and representatives
3 of diverse geographic areas.

4 (c) ELIMINATION OF REGIONAL VARIATION IN PRE-
5 MIUMS DUE TO PRACTICE PATTERN.—

6 (1) COMMISSION STUDY.—The advisory com-
7 mission shall examine methods of reducing or elimi-
8 nating variation in health care coverage area per
9 capita premium targets that are clearly due to vari-
10 ation in practice patterns not justified by differences
11 in need for health care services, presence of aca-
12 demic health centers or other facilities meeting re-
13 search, training, or care needs broader than those of
14 the population in the area, or other factors (such as
15 health care input prices and demographic factors),
16 by 2002.

17 (2) COMMISSION REPORT.—The advisory com-
18 mission shall submit to the Board a report that
19 specifies one or more methods for reducing or elimi-
20 nating the variation described in paragraph (1).

21 (3) BOARD RECOMMENDATIONS.—The Board,
22 after reviewing the report and such other studies as
23 it deems appropriate and after consulting with the
24 Prospective Payment Assessment Commission, the
25 Physician Payment Review Commission and such

1 other experts as it deems appropriate, shall submit
2 to Congress, by not later October 1, 1996, detailed
3 recommendations respecting the specific method to
4 be used to reduce or eliminate the variation de-
5 scribed in paragraph (1) by 2006. Such rec-
6 ommendations shall not propose the reduction or
7 elimination of differences in per capita premium tar-
8 gets that are not the result of inappropriate dif-
9 ferences in practice patterns and shall be designed
10 to avoid unnecessary disruption in the health care
11 systems and economies of affected regions.

12 (d) CONGRESSIONAL CONSIDERATION.—

13 (1) IN GENERAL.—Detailed recommendations
14 submitted under subsection (c)(3) shall apply under
15 this subtitle unless a joint resolution (described in
16 paragraph (2)) disapproving such recommendations
17 is enacted, in accordance with the provisions of
18 paragraph (3), before the end of the 60-day period
19 beginning on the date on which such recommenda-
20 tions were submitted. For purposes of applying the
21 preceding sentence and paragraphs (2) and (3), the
22 days on which either House of Congress is not in
23 session because of an adjournment of more than
24 three days to a day certain shall be excluded in the
25 computation of a period.

1 (2) JOINT RESOLUTION OF DISAPPROVAL.—A
2 joint resolution described in this paragraph means
3 only a joint resolution which is introduced within the
4 10-day period beginning on the date on which the
5 Board submits recommendations under subsection
6 (e)(3) and—

7 (A) which does not have a preamble;

8 (B) the matter after the resolving clause of
9 which is as follows: “That Congress disapproves
10 the recommendations of the National Health
11 Board concerning elimination of regional vari-
12 ation in health care coverage area premiums, as
13 submitted by the Board on _____.”,
14 the blank space being filled in with the appro-
15 priate date; and

16 (C) the title of which is as follows: “Joint
17 resolution disapproving recommendations of the
18 National Health Board concerning elimination
19 of regional variation in health care coverage
20 area premiums, as submitted by the Board on
21 _____.”, the blank space being filled
22 in with the appropriate date.

23 (3) PROCEDURES FOR CONSIDERATION OF RES-
24 OLUTION OF DISAPPROVAL.—Subject to paragraph
25 (4), the provisions of section 2908 (other than sub-

1 section (a)) of the Defense Base Closure and Re-
2 alignment Act of 1990 shall apply to the consider-
3 ation of a joint resolution described in paragraph (2)
4 in the same manner as such provisions apply to a
5 joint resolution described in section 2908(a) of such
6 Act.

7 (4) SPECIAL RULES.—For purposes of applying
8 paragraph (3) with respect to such provisions—

9 (A) any reference to the Committee on
10 Armed Services of the House of Representatives
11 shall be deemed a reference to an appropriate
12 Committee of the House of Representatives
13 (specified by the Speaker of the House of Rep-
14 resentatives at the time of submission of rec-
15 ommendations under subsection (c)(3)) and any
16 reference to the Committee on Armed Services
17 of the Senate shall be deemed a reference to an
18 appropriate Committee of the Senate (specified
19 by the Majority Leader of the Senate at the
20 time of submission of recommendations under
21 subsection (c)(3)); and

22 (B) any reference to the date on which the
23 President transmits a report shall be deemed a
24 reference to the date on which the Board sub-
25 mits a recommendation under subsection (c)(3).

1 (e) ELIMINATION OF REGIONAL VARIATION STATE
2 PAYMENT AMOUNTS.—

3 (1) COMMISSION STUDY.—The advisory com-
4 mission shall examine methods of reducing inappro-
5 priate variation among States in the level of pay-
6 ments required under subtitle A of title IX by 2002.

7 (2) COMMISSION REPORT.—The advisory com-
8 mission shall submit to the Board a report that
9 specifies one or more methods for reducing the vari-
10 ation described in paragraph (1).

11 (3) BOARD RECOMMENDATIONS.—The Board
12 shall submit to Congress, by not later than July 1,
13 1995, detailed recommendations respecting the spe-
14 cific method to be used to reduce the variation de-
15 scribed in paragraph (1) by 2002 in a budget neu-
16 tral manner with respect to total government pay-
17 ments and payments by the Federal Government. In
18 submitting recommendations under this paragraph,
19 the Board shall consider the fiscal capacity of the
20 States.

21 (4) CONGRESSIONAL CONSIDERATION.—

22 (A) IN GENERAL.—Subject to the succeed-
23 ing provisions of this paragraph, the provisions
24 of subsection (d) shall apply to recommenda-
25 tions under paragraph (3) in the same manner

1 as they apply to recommendations under sub-
2 section (c)(3).

3 (B) SPECIAL RULES.—In applying sub-
4 paragraph (A)—

5 (i) the following shall be substituted
6 for the matter after the resolving clause
7 described in subsection (d)(2)(B): “That
8 Congress disapproves the recommendations
9 of the National Health Board concerning
10 reduction of regional variation in State
11 payments, as submitted by the Board on
12 _____.”; and

13 (ii) the following shall be substituted
14 for the title described in subsection
15 (d)(2)(C): “Joint resolution disapproving
16 recommendations of the National Health
17 Board concerning reducing regional vari-
18 ation in State payments, as submitted by
19 the Board on _____.”.

20 (f) INFORMATION.—The advisory commission shall
21 provide the Board, States, and community-rated health
22 plans with information about regional differences in health
23 care costs and practice patterns.

1 **SEC. 6007. REFERENCE TO LIMITATION ON ADMINISTRA-**
2 **TIVE AND JUDICIAL REVIEW OF CERTAIN DE-**
3 **TERMINATIONS.**

4 For limitation on administrative and judicial review
5 of certain determinations under this part, see section
6 5232.

7 **SEC. 6008. APPLICATION OF MARKETING AND COOPERA-**
8 **TIVE FEES.**

9 Cooperative fees (as described in section 1305) and
10 health plan marketing fees (as described in section
11 1511(b)) shall not be incorporated into the calculation of
12 plan and health care coverage areas' compliance with the
13 premium targets established in this part or in the deter-
14 mination of eligibility for discounts under subtitle B of
15 this title.

16 **Subpart B—Plan and Provider Payment Reductions**
17 **to Maintain Expenditures within Targets**

18 **SEC. 6011. PLAN PAYMENT REDUCTION.**

19 (a) PLAN PAYMENT REDUCTION.—In order to assure
20 that premium-related payments to community-rated
21 health plans offered in a health care coverage area are
22 consistent with the applicable area per capita target for
23 the health care coverage area (computed under this sub-
24 title), payment to a noncomplying plan (as defined in sub-
25 section (b)(2)) for a year is subject to a reduction in plan

1 payment by the amount equal to plan payment reduction
2 specified in subsection (c) for the year.

3 (b) NONCOMPLYING HEALTH CARE COVERAGE AREA
4 AND NONCOMPLYING PLAN DEFINED.—In this part:

5 (1) NONCOMPLYING HEALTH CARE COVERAGE
6 AREA.—The term “noncomplying health care cov-
7 erage area” means, for a year, a health care cov-
8 erage area for which the weighted average accepted
9 bid (computed under section 6004(c)) exceeds the
10 health care coverage area per capita premium target
11 for the year.

12 (2) NONCOMPLYING PLAN.—The term “non-
13 complying plan” means, for a year, a community
14 rated health plan offered in a noncomplying health
15 care coverage area if the applicable premium rate for
16 the year exceeds the maximum complying bid (as de-
17 fined in subsection (d)) for the year. No plan shall
18 be a noncomplying plan for a year before the first
19 year in which the plan is offered as a community
20 rated health plan under this Act.

21 (c) AMOUNT OF PLAN PAYMENT REDUCTION.—

22 (1) IN GENERAL.—The amount of the plan pay-
23 ment reduction, for a noncomplying plan offered in
24 a health care coverage area, is the area-wide reduc-
25 tion percentage (as defined in paragraph (2)) of the

1 excess bid amount (as defined in paragraph (3)) for
2 the plan.

3 (2) AREA-WIDE REDUCTION PERCENTAGE.—

4 (A) IN GENERAL.—In paragraph (1), the
5 term “area-wide reduction percentage” means,
6 for a noncomplying plan offered in a health
7 care coverage area for a year—

8 (i) the amount by which—

9 (I) the weighted average accepted
10 bid (computed under section
11 6004(c)(1)) for the health care cov-
12 erage area for the year, exceeds (II)
13 the health care coverage area per cap-
14 ita target for the area for the year; di-
15 vided by

16 (ii) the sum, for noncomplying
17 plans offered in the health care cov-
18 erage area, of the plan proportions of
19 area excess bid amounts (described in
20 subparagraph (B)(i)) for the year.

21 (B) PLAN PROPORTION OF HEALTH CARE
22 COVERAGE AREA EXCESS BID AMOUNT DE-
23 SCRIBED.—

24 (i) IN GENERAL.—The “plan propor-
25 tion of area excess bid amount” described

1 in this clause, for a noncomplying plan, is
2 the product of—

3 (I) the excess bid amount (as de-
4 fined in paragraph (3)) for the plan,
5 and

6 (II) the plan enrollment propor-
7 tion (as defined in clause (ii)) for the
8 plan.

9 (ii) PLAN ENROLLMENT PROPOR-
10 TION.—In clause (i)(II), the term “plan
11 enrollment proportion” means, with respect
12 to a health plan offered in a health care
13 coverage area, the total enrollment of com-
14 munity-rate eligible individuals enrolled in
15 such plan expressed as a percentage of the
16 total enrollment of community-rate eligible
17 individuals in all community-rated plans
18 offered in the health care coverage area.
19 Such proportion shall be computed based
20 on the information used in computing the
21 weighted average accepted bid for the area
22 under section 6004(c)(1).

23 (3) EXCESS BID AMOUNT.—In this subsection,
24 the “excess bid amount”, with respect to a non-
25 complying plan for a year, is the amount by which—

1 (A) the accepted bid for the year (not tak-
2 ing into account any voluntary reduction under
3 section 6004(e)), exceeds

4 (B) the maximum complying bid (as de-
5 fined in subsection (d)) for the plan for the
6 year.

7 (d) COMMUNITY-RATED HEALTH PLANS WITH AN
8 ACCEPTED COOPERATIVE BID NOT EQUAL TO THE FINAL
9 COMMUNITY RATE FOR SUCH PLAN.—

10 (1) IN GENERAL.—For the purposes of this sec-
11 tion (relating to determining plan compliance and
12 plan payment reduction), if a community-rated
13 health plan has more than one applicable premium
14 rate, such health plan shall be treated as a separate
15 health plan with respect to each applicable premium
16 rate and the enrollment in each such health plan
17 shall be considered to be the number of community-
18 rated individuals enrolled in the community-rated
19 plan at the applicable premium rate.

20 (2) The applicable final premium rate with re-
21 spect to a community rated health plan shall be—

22 (A) for a community-rated plan offered
23 through the state-designated enrollment process
24 (or through any other manner of enrollment

1 other than through a cooperative), the final
2 community rate; or

3 (B) for a community rated health plan of-
4 fered through a cooperative, the final coopera-
5 tive rate for such cooperative.

6 (e) MAXIMUM COMPLYING BID.—

7 (1) IN GENERAL.—In this part for the first
8 year and for subsequent years, the “maximum com-
9 plying bid” for each community-rated health plan, is
10 the health care coverage area per capita premium
11 target for the area (determined under section 6003)
12 for the year.

13 (2) SPECIAL RULES FOR NEW PLANS.—

14 (A) IN GENERAL.—Subject to subpara-
15 graph (B), in the case of a community rated
16 health plan that is first offered in a health care
17 coverage area in a year after the first year the
18 maximum complying bid shall be the health
19 care coverage area per capita premium target
20 for the year.

21 (B) AUTHORITY.—The Board or a State
22 may establish rules to modify the application of
23 subparagraph (A) for community-rated health
24 plans in the State in order—

1 (i) to prevent abusive premium prac-
2 tices by entities previously offering plans,
3 or

4 (ii) to encourage the availability of all
5 types of plans in the State and to permit
6 establishment of new plans.

7 **SEC. 6012. PROVIDER PAYMENT REDUCTION.**

8 (a) PARTICIPATING PROVIDERS.—

9 (1) IN GENERAL.—Each community-rated
10 health plan in the health care coverage area, as part
11 of its contract or agreement with any participating
12 provider or group of participating providers shall—

13 (A) include a provision that provides that
14 if the plan is a noncomplying plan for a year,
15 payments to the provider (or group) shall be re-
16 duced by the applicable network reduction per-
17 centage (described in paragraph (2)) for the
18 year; and

19 (B) not include any provision which the
20 State determines otherwise varies the payments
21 to such providers (or group) because of, or in
22 relation to, a plan payment reduction under sec-
23 tion 6011 or otherwise is intended to nullify the
24 effect of subparagraph (A).

1 For purposes of this section, a plan described in sec-
2 tion 6011(d) shall be treated as a single plan with
3 the total enrollment of such plan equal to the sum
4 of the amounts described in section 6011(d)(1). The
5 Board may issue regulations relating to the require-
6 ments of this paragraph.

7 (2) APPLICABLE NETWORK REDUCTION PER-
8 CENTAGE.—

9 (A) IN GENERAL.—Subject to subpara-
10 graph (B), the “applicable network reduction
11 percentage”, with respect to participating pro-
12 viders of a noncomplying plan for a year
13 equals—

14 (i) the plan payment reduction
15 amount for the plan for the year (as deter-
16 mined under section 6011(c)), divided by

17 (ii) the final accepted bid for the plan
18 for the year, adjusted under subparagraph
19 (B).

20 (B) INDUCED VOLUME OFFSET.—The
21 Board shall provide for an appropriate increase
22 of the percentage reduction computed under
23 subparagraph (A) to take into account any esti-
24 mated increase in volume of services provided
25 that may reasonably be anticipated as a con-

1 sequence of applying a reduction in payment
2 under this subsection. The Board may compute
3 and apply such increase differently for different
4 classes of providers or services or different
5 types of health plans (as the Board may de-
6 fine).

7 (b) OTHER PROVIDERS.—

8 (1) IN GENERAL.—Each community rated
9 health plan that is a noncomplying plan in a year
10 shall provide for a reduction in the amount of pay-
11 ments to providers (or groups of providers) that are
12 not participating providers under the applicable fee
13 schedule under section 1523 by the applicable non-
14 network reduction percentage (described in para-
15 graph (2)) for the year.

16 (2) APPLICABLE NONNETWORK REDUCTION
17 PERCENTAGE.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the “applicable nonnetwork reduc-
20 tion percentage”, with respect to
21 nonparticipating providers of a noncomplying
22 plan for a year is—

23 (i) the plan payment reduction
24 amount for the plan for the year (as deter-
25 mined under section 6011(c)), divided by

1 (ii) the final accepted bid for the plan
2 for the year, adjusted under subparagraph
3 (B).

4 (B) INDUCED VOLUME OFFSET.—The
5 Board shall provide for an appropriate increase
6 of the percentage reduction computed under
7 subparagraph (A) to take into account any esti-
8 mated increase in volume of services provided
9 that may reasonably be anticipated as a con-
10 sequence of applying a reduction in payment
11 under this subsection. The Board may compute
12 and apply such increase differently for different
13 classes of providers or services or different
14 types of health plans (as the Board may de-
15 fine).

16 (c) APPLICATION TO COST SHARING AND TO BAL-
17 ANCE BILLING RESTRICTIONS.—For purposes of applying
18 section 1523 (relating to balance billing limitations) and
19 part 2 of subtitle B of title I (relating to computation of
20 cost sharing), the payment basis otherwise used for com-
21 puting any limitation on billing or cost sharing shall be
22 such payment basis as adjusted by any reductions effected
23 under this section.

1 **PART 2—HEALTH EXPENDITURES OF LARGE**

2 **GROUP PURCHASERS**

3 **SEC. 6021. CALCULATION OF PREMIUM EQUIVALENTS.**

4 (a) IN GENERAL.—By January 1, 1998, the Board
5 shall develop a methodology for calculating an annual per
6 capita expenditure equivalent for amounts paid for cov-
7 erage for the comprehensive benefit package within a large
8 group purchaser.

9 (b) ADJUSTMENT PERMITTED.—Such methodology
10 shall permit a large group purchaser to petition the Sec-
11 retary of Labor for an adjustment of the inflation adjust-
12 ment that would otherwise apply to compensate for mate-
13 rial changes in the demographic characteristics of the ex-
14 perience rate eligible individuals receiving coverage
15 through plans offered in a health care coverage area.

16 (c) REPORTING.—In 2001 and each subsequent year,
17 each large group purchaser shall report to the Secretary
18 of Labor, in a form and manner specified by the Secretary,
19 the average of the annual per capita expenditure equiva-
20 lent for the previous 3-year period.

21 **SEC. 6022. SANCTIONS FOR LARGE GROUP PURCHASER**
22 **FOR EXCESS INCREASE IN EXPENDITURES.**

23 (a) SANCTION.—

24 (1) ACTIONS AGAINST LARGE EMPLOYERS.—If
25 a large group purchaser that is a large employer has
26 two excess years (as defined in subsection (b)) in a

1 3-year-period, then, effective beginning with the sec-
2 ond year following the second excess year in such pe-
3 riod, the Secretary of Labor shall take action under
4 section 1402.

5 (2) TERMINATION OF SPONSORSHIP FOR OTHER
6 LARGE GROUP PURCHASERS.—If a large group pur-
7 chaser that is not a large employer has two excess
8 years (as defined in subsection (b)) in a 3-year-pe-
9 riod, then, effective beginning with the second year
10 following the second excess year in such period—

11 (A) the Secretary of Labor shall terminate
12 the election of the large group purchaser under
13 section 1402; and

14 (B) an employer that was an experience-
15 rated employer with respect to such purchaser
16 shall become a community-rated employer (un-
17 less the employer has become an experience-
18 rated employer of another such large group
19 purchaser).

20 (3) INITIAL 3-YEAR PERIOD.—Paragraph (1)
21 shall apply to the 3-year period beginning on Janu-
22 ary 1, 1998.

23 (b) EXCESS YEAR.—

24 (1) IN GENERAL.—In subsection (a), the term
25 “excess year” means, for a large group purchaser, a

1 year (after 2000) for which the rate of increase for
2 the large group purchaser (specified in paragraph
3 (2)) for the year, exceeds the national corporate in-
4 flation factor (specified in paragraph (3)) for the
5 year.

6 (2) RATE OF INCREASE FOR LARGE GROUP
7 PURCHASER.—The rate of increase for a large group
8 purchaser for a year, specified in this paragraph, is
9 the percentage by which the average of the annual
10 per capita expenditure equivalent for the large group
11 purchaser (reported under section 6021 (c)) for the
12 3-year period ending with such year, exceeds the av-
13 erage of the annual per capita expenditure equiva-
14 lent for the large group purchaser (reported under
15 such subsection) for the 3-year period ending with
16 the previous year.

17 (3) NATIONAL CORPORATE INFLATION FAC-
18 TOR.—The national corporate inflation factor for a
19 year, specified in this paragraph, is the average of
20 the general health care inflation factors (as defined
21 in section 6001(a)(3)) for each of the 3 years ending
22 with such year.

1 PART 3—TREATMENT OF SINGLE-PAYER STATES**2 SEC. 6031. SPECIAL RULES FOR SINGLE-PAYER STATES.**

3 In the case of a Statewide single-payer State, for pur-
4 poses of section 1222(6), the Board shall compute a State-
5 wide per capita premium target for each year in the same
6 manner as the health care coverage area per capita pre-
7 mium target is determined under section 6003.

8 PART 4—TRANSITION PROVISIONS**9 SEC. 6041. MONITORING PRICES AND EXPENDITURES.**

10 (a) IN GENERAL.—The Secretary shall establish a
11 program to monitor prices and expenditures in the health
12 care system in the United States.

13 (b) REPORTS.—The Secretary shall periodically re-
14 port to the President on—

15 (1) the rate of increase in expenditures in each
16 sector of the health care system, and

17 (2) how such rates compare with rate of overall
18 increase in health care spending and rate of increase
19 in the consumer price index.

20 (c) ACCESS TO INFORMATION.—

21 (1) IN GENERAL.—The Secretary may obtain,
22 through surveys or otherwise, information on prices
23 and expenditures for health care services. The Sec-
24 retary may compel health care providers and third
25 party payers to disclose such information as is nec-
26 essary to carry out the program under this section.

1 (2) CONFIDENTIALITY.—Non-public informa-
2 tion obtained under this subsection with respect to
3 individual patients is confidential.

4 (d) PERIODIC REPORTS.—The Secretary shall peri-
5 odically issue public reports on the matters described in
6 subsection (b).

7 **SEC. 6042. HEALTH CARE UTILIZATION RESEARCH PRO-**
8 **GRAM.**

9 To assist health plans in determining the appropriate
10 cost of services to populations not previously covered by
11 private health insurance, the Secretary of Health and
12 Human Services shall conduct a program of research on
13 the characteristics and health care utilization patterns of
14 such populations, including Medicaid eligible individuals,
15 unemployed individuals, and out-of-labor force individuals.
16 Not later than 6 months after the date of enactment of
17 this Act, such program shall be completed and a report
18 concerning such program shall be submitted by the Sec-
19 retary to health plans in such form as the Secretary deter-
20 mines is the most useful to such plans

1 **Subtitle B—Premium-Related**
2 **Financings**

3 **PART 1—FAMILY PREMIUM PAYMENTS**

4 **Subpart A—Family Share**

5 **SEC. 6101. FAMILY SHARE OF PREMIUM.**

6 (a) REQUIREMENT.—Each family enrolled in a com-
7 munity-rated health plan or in a, experienced-rated health
8 plan in a class of family enrollment is responsible for pay-
9 ment of the family share of premium payable respecting
10 such enrollment. Such premium may be paid by an em-
11 ployer or other person on behalf of such a family.

12 (b) FAMILY SHARE OF PREMIUM DEFINED.—

13 (1) IN GENERAL.—In this subtitle, the term
14 “family share of premium” means, with respect to
15 enrollment of a family—

16 (A) in a community-rated health plan, the
17 amount specified in paragraph (2) for the class,
18 or

19 (B) in an experienced-rated health plan,
20 the amount specified in paragraph (3) for the
21 class.

22 (2) COMMUNITY-RATED PLANS.—

23 (A) IN GENERAL.—The amount specified
24 in this paragraph for a health plan based on a
25 class of family enrollment is the sum of the

1 base amounts described in subparagraph (B)
2 reduced (but not below zero) by the sum of the
3 amounts described in subparagraph (C).

4 (B) BASE.—The base amounts described
5 in this subparagraph (for a plan for a class of
6 enrollment) are as follows:

7 (i) PLAN PREMIUM.—The applicable
8 premium specified in section 6102(a) with
9 respect to such class of enrollment.

10 (ii) FAMILY COLLECTION SHORT-
11 FALL.—20 percent of the family collection
12 shortfall add-on (computed under section
13 6107 for such class).

14 (iii) MARKETING FEE.—Any applica-
15 ble marketing fee as described in section
16 1511(b).

17 (C) CREDITS AND DISCOUNTS.—The
18 amounts described in this subparagraph (for a
19 plan for a class of enrollment) are as follows:

20 (i) FAMILY CREDIT.—The amount of
21 the family credit under section 6103(a).

22 (ii) INCOME RELATED DISCOUNT.—
23 The amount of any income-related discount
24 provided under section 6104(a)(1).

1 (iii) EXCESS PREMIUM CREDIT.—The
2 amount of any excess premium credit pro-
3 vided under section 6105.

4 (iv) LARGE GROUP SPONSOR OPT-IN
5 CREDIT.—The amount of any large group
6 sponsor opt-in credit provided under sec-
7 tion 6106.

8 (v) ADDITIONAL CREDIT FOR SSI AND
9 AFDC RECIPIENTS.—In the case of an SSI
10 or AFDC family or for whom the amount
11 described in clause (ii) is equal to the
12 amount described in section 6104(b)(1)(A),
13 the amount described in subparagraph
14 (B)(ii).

15 (D) LIMIT ON MISCELLANEOUS CRED-
16 ITS.—In no case shall the family share, due to
17 credits under subparagraph (C), be less than
18 zero.

19 (E) LIMITATION.—In no case shall the
20 family share for a particular plan be greater
21 than the premium otherwise payable under sec-
22 tion 6101 due to the application of the worksite
23 health promotion discount under section
24 6102(a)(1) and the worksite health promotion
25 adjustment to the credit under section 6103.

1 (3) EXPERIENCE-RATED PLANS.—

2 (A) IN GENERAL.—The amount specified
3 in this paragraph for an experience-rated health
4 plan based on a class of family enrollment is
5 the premium described in subparagraph (B) re-
6 duced (but not below zero) by the sum of the
7 amounts described in subparagraph (C).

8 (B) PREMIUM.—The premium described in
9 this subparagraph (for a plan for a class of en-
10 rollment) is the premium specified under sec-
11 tion 1404 with respect to the plan and class of
12 enrollment involved.

13 (C) CREDITS AND DISCOUNTS.—The
14 amounts described in this subparagraph (for a
15 plan for a class of enrollment) are as follows:

16 (i) FAMILY CREDIT.—The amount of
17 the family credit under section 6103(b).

18 (ii) INCOME RELATED DISCOUNT.—
19 The amount of any income-related discount
20 provided under section 6104(a)(2).

21 **SEC. 6102. AMOUNT OF PREMIUM.**

22 (a) COMMUNITY-RATED PLANS.—The amount of the
23 applicable premium charged by a community-rated health
24 plan for all families in a class of family enrollment under

1 a community-rated health plan offered in the health care
2 coverage area—

3 (1) with respect to a family enrolled through a
4 mechanism other than a cooperative, equal to the
5 product of—

6 (A) the final community rate for the plan
7 (as defined in section 6000(a)(3)),

8 (B) the uniform per capita conversion fac-
9 tor (as specified in section 6211) for the health
10 care coverage area, and

11 (C) the premium class factor established
12 by the Board for that class under section 1631;
13 increased for any applicable marketing fees (de-
14 scribed in section 1511); or

15 (2) with respect to a family enrolled through a
16 cooperative, equal to the product of—

17 (A) the final cooperative rate for the plan
18 (as defined in section 6000(a)(4));

19 (B) the uniform per capita conversion fac-
20 tor (described under section 6211) for the
21 health care coverage area;

22 (C) the premium class factor established
23 by Board for that class under section 1631.

24 (b) REFERENCE TO OTHER PREMIUMS.—The
25 amount of the premium charged by a large group pur-

1 chaser for all families in a class of family enrollment under
2 an experience-rated health plan offered by the purchaser
3 is specified under section 1404.

4 (c) SPECIAL RULES FOR DIVIDED FAMILIES.—In the
5 case of an individual who is a qualifying employee of an
6 employer, if the individual has a spouse or child who is
7 not treated as part of the individual's family because of
8 section 1012—

9 (1) the combined premium for both families
10 under this section shall be computed as though such
11 section had not applied if such combined premium is
12 less than the total of the premiums otherwise appli-
13 cable (without regard to this subsection),

14 (2) the large group purchaser and the entity de-
15 scribed in section 1252 shall divide such combined
16 premium between the families proportionally (con-
17 sistent with rules established by the Board), and

18 (3) in such case, credits and other amounts
19 shall be pro-rated in a manner consistent with rules
20 established by the Board.

21 **SEC. 6103. FAMILY CREDIT.**

22 (a) COMMUNITY-RATED PLANS.—The credit pro-
23 vided under this section for a family enrolled in a commu-
24 nity-rated plan for a class of family enrollment is equal
25 to 80 percent of the weighted average premium (as defined

1 in section 6000(b)) for community-rated plans offered in
2 the health care coverage area for the class.

3 (b) EXPERIENCE-RATED PLANS.—The credit pro-
4 vided under this section for a family enrolled in an experi-
5 ence-rated health plan for a class of family enrollment is
6 equal to the minimum employer premium payment re-
7 quired under section 6131 with respect to the family.

8 **SEC. 6104. PREMIUM DISCOUNT BASED ON INCOME.**

9 (a) IN GENERAL.—

10 (1) ENROLLEES IN COMMUNITY-RATED
11 PLANS.—Subject to paragraph (2), each family en-
12 rolled with a community-rated or experience-rated
13 plan is entitled to a premium discount under this
14 section, in the amount specified in subsection (b)(1)
15 if the family—

16 (A) is an AFDC or SSI family;

17 (B) is determined, under subtitle C of title
18 I, to have family adjusted income below 150
19 percent of the applicable poverty level; or

20 (C) is a family described in subsection
21 (c)(3) for which the family obligation amount
22 under subsection (c) for the year would other-
23 wise exceed a specified percent of family ad-
24 justed income described in such subsection.

1 (2) NO LIABILITY FOR INDIANS AND CERTAIN
2 VETERANS AND MILITARY PERSONNEL.—

3 (A) IN GENERAL.—In the case of an indi-
4 vidual described in subparagraph (B), because
5 the applicable health plan does not impose any
6 premium for such an individual, the individual
7 is not eligible for any premium discount under
8 this section.

9 (B) INDIVIDUALS DESCRIBED.—An indi-
10 vidual described in this subparagraph is—

11 (i) an electing veteran (as defined in
12 section 1012(d)(1)) who is enrolled under
13 a health plan of the Department of Veter-
14 ans Affairs and who, under the laws and
15 rules as in effect as of December 31, 1994,
16 has a service-connected disability or who is
17 unable to defray the expenses of necessary
18 care as determined under section 1722(a)
19 of title 38, United States Code;

20 (ii) active duty military personnel (as
21 defined in section 1012(d)(2)); and

22 (iii) an electing Indian (as defined in
23 section 1012(d)(3)).

24 (3) MONTHLY APPLICATION TO AFDC AND SSI
25 FAMILIES.—Paragraph (1)(A) (and the family obli-

1 gation amount under subsection (c) insofar as it re-
2 lates to an AFDC or SSI family) shall be applied to
3 the premium or family obligation amount only for
4 months in which the family is such an AFDC or SSI
5 family.

6 (b) AMOUNT OF PREMIUM DISCOUNT.—

7 (1) IN GENERAL.—Subject to the succeeding
8 paragraphs of this subsection, the amount of the
9 premium discount under this subsection for a family
10 under a class of family enrollment is equal to—

11 (A) 20 percent of—

12 (i) for a family enrolled in a commu-
13 nity-rated plan offered in a community-rat-
14 ing area, the weighted average premium
15 for community-rated plans offered in the
16 community-rating area, increased by any
17 amount provided under paragraph (2); or

18 (ii) for a family enrolled in an experi-
19 ence-rated plan offered in a premium area,
20 the weighted average premium for experi-
21 ence-rated plans offered in the premium
22 area (as determined under section
23 6131(b)(1)(A)) or, if less, the amount de-
24 termined under clause (i) for the commu-

1 nity-rating area in which the family re-
2 sides;

3 reduced (but not below zero) by—

4 (B) the sum of—

5 (i) the family obligation amount de-
6 scribed in subsection (c); and

7 (ii) the amount of any employer pay-
8 ment (not required under part 2) towards
9 the family share of premiums for covered
10 members of the family.

11 (2) INCREASE FOR COMMUNITY-RATED FAMI-
12 LIES TO ASSURE ENROLLMENT IN AT-OR-BELOW-AV-
13 ERAGE-COST PLAN.—In the case of a family enrolled
14 in a community-rated plan, if a State determines
15 that a family eligible for a discount under this sec-
16 tion is unable to enroll in an at-or-below-average-
17 cost plan (as defined in paragraph (3)) that serves
18 the area in which the family resides, the amount of
19 the premium discount under this subsection is in-
20 creased to the extent that such amount will permit
21 the family to enroll in a community-rated plan with-
22 out the need to pay a family share of premium
23 under this part in excess of the sum described in
24 paragraph (1)(B).

1 (3) AT-OR-BELOW-AVERAGE-COST PLAN DE-
2 FINED.—In this section, the term “at-or-below-aver-
3 age-cost plan” means a community-rated plan the
4 premium for which does not exceed, for the class of
5 family enrollment involved, the weighted average
6 premium for the community-rating area.

7 (c) FAMILY OBLIGATION AMOUNT.—

8 (1) DETERMINATION.—Subject to paragraphs
9 (2) and (3), the family obligation amount under this
10 subsection is determined as follows:

11 (A) NO OBLIGATION IF INCOME BELOW IN-
12 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
13 FAMILY.—If the family adjusted income (as de-
14 fined in section 1282(d)) of the family is less
15 than the income threshold amount (specified in
16 paragraph (4)) or if the family is an AFDC or
17 SSI family, the family obligation amount is
18 zero.

19 (B) INCOME ABOVE INCOME THRESHOLD
20 AMOUNT.—If such income is at least such in-
21 come threshold amount and the family is not an
22 AFDC or SSI family, the family obligation
23 amount is the sum of the following:

24 (i) FOR INCOME (ABOVE INCOME
25 THRESHOLD AMOUNT) UP TO THE POV-

1 ERTY LEVEL.—The product of the initial
2 marginal rate (specified in paragraph (2))
3 and the amount by which—

4 (I) the family adjusted income
5 (not including any portion that ex-
6 ceeds the applicable poverty level for
7 the class of family involved), exceeds;

8 (II) such income threshold
9 amount.

10 (ii) GRADUATED PHASE OUT OF DIS-
11 COUNT UP TO 150 PERCENT OF POVERTY
12 LEVEL.—The product of the final marginal
13 rate (specified in paragraph (2)) and the
14 amount by which the family adjusted in-
15 come exceeds 100 percent (but is less than
16 150 percent) of the applicable poverty
17 level.

18 (2) MARGINAL RATES.—In paragraph (1), for a
19 year:

20 (A) INITIAL MARGINAL RATE.—The initial
21 marginal rate is the ratio of—

22 (i) 3 percent of the applicable poverty
23 level for the class of enrollment involved
24 for the year; to

1 (ii) the amount by which such poverty
2 level exceeds such income threshold
3 amount.

4 (B) FINAL MARGINAL RATE.—The final
5 marginal rate is 5.7 percent.

6 (3) LIMITATION TO 3.9 PERCENT FOR ALL FAM-
7 ILIES.—

8 (A) IN GENERAL.—In no case shall the
9 family obligation amount under this subsection
10 for the year exceed 3.9 percent.

11 (B) INDEXING OF PERCENTAGE.—

12 (i) IN GENERAL.—The percentage
13 specified in subparagraph (A) shall be ad-
14 justed for any year after 1994 so that the
15 percentage for the year bears the same
16 ratio to the percentage so specified as the
17 ratio of—

18 (I) 1 plus the general health care
19 inflation factor (as defined in section
20 6001(a)(3)) for the year, bears to

21 (II) 1 plus the percentage speci-
22 fied in section 1135 (relating to index-
23 ing of dollar amounts related to cost
24 sharing) for the year.

1 (ii) ROUNDING.—Any adjustment
2 under clause (i) for a year shall be round-
3 ed to the nearest multiple of 1/10 of 1 per-
4 centage point.

5 (4) INCOME THRESHOLD AMOUNT.—

6 (A) IN GENERAL.—For purposes of this
7 subtitle, the income threshold amount specified
8 in this paragraph is \$1,000 (adjusted under
9 subparagraph (B)).

10 (B) INDEXING.—For the 1-year period be-
11 ginning on January 1, 1995, the income thresh-
12 old amount specified in subparagraph (A) shall
13 be increased or decreased by the same percent-
14 age as the percentage increase or decrease by
15 which the average CPI (described in section
16 1902(12)) for the 12-month-period ending with
17 August 31 of the preceding year exceeds such
18 average for the 12-month period ending with
19 August 31, 1993.

20 (C) ROUNDING.—Any increase or decrease
21 under subparagraph (B) for a year shall be
22 rounded to the nearest multiple of \$10.

23 **SEC. 6105. EXCESS PREMIUM CREDIT.**

24 (a) IN GENERAL.—If plan payment reductions are
25 made for one or more community-rated health plans of-

1 fered in a health care coverage area for plan payments
2 in a year under section 6021, all families enrolling in com-
3 munity-rated health plans shall receive a credit under this
4 section, in the amount described in subsection (b), in the
5 case of each family enrolled in a community-rated health
6 plan offered in the health care coverage area for premiums
7 in the year.

8 (b) AMOUNT OF CREDIT.—

9 (1) IN GENERAL.—Subject to paragraph (2),
10 the amount of the credit under this subsection, for
11 a family enrolled in a class of family enrollment in
12 a health care coverage area for a year, is the amount
13 that would be the weighted average premium for
14 such area, class, and year, if the per capita excess
15 premium amount (determined under subsection (c))
16 for the area for the year were substituted for the
17 weighted average discount rate for the health care
18 coverage area for the year.

19 (2) ADJUSTMENT TO ACCOUNT FOR USE OF ES-
20 TIMATES.—Subject to section 9201, if the total pay-
21 ments made to all community-rated health plans in
22 a year under section 6203 exceeds (or is less than)
23 the total of such payments estimated by the State
24 (based on the weighted average discount rate under
25 subsection (c)(1)), because of a difference between—

1 (A) the State's estimate of the distribution
2 of enrolled families between excess premium
3 plans and other plans, and

4 (B) the actual distribution of such enrolled
5 families among such plans,
6 the amount of the credit under this section in the
7 second succeeding year shall be reduced (or in-
8 creased, respectively) by the amount of such excess
9 (or deficit) in the total of such payments made to all
10 such plans.

11 (c) PER CAPITA EXCESS PREMIUM AMOUNT.—The
12 per capita excess premium amount, for a health care cov-
13 erage area for a year, is the amount by which—

14 (1) the weighted average discount rate (as de-
15 fined in section 6000(a)(2)) for the area for the
16 year, exceeds

17 (2) the health care coverage area per capita
18 premium target for the area for the year.

19 **SEC. 6106. LARGE GROUP PURCHASER OPT-IN CREDIT.**

20 (a) IN GENERAL.—If community-rated individuals
21 are owed a payment adjustment under section 6124 for
22 a year, then the State shall provide for a credit under this
23 section equal to 20 percent of the amount described in
24 subsection (b), in the case of each family enrolled in a

1 community-rated plan offered in the health care coverage
2 area.

3 (b) AMOUNT OF CREDIT.—The amount described in
4 this subsection, for a family enrolled in a class of family
5 enrollment for a health care coverage area for a year, is
6 the amount that would be the weighted average premium
7 for such area, class, and year, if the per capita large group
8 purchaser opt-in amount (determined under subsection
9 (c)) for the area for the year were substituted for the
10 weighted average discount rate for the area for the year.

11 (c) PER CAPITA LARGE GROUP PURCHASER OPT-IN
12 AMOUNT.—The per capita large group purchaser opt-in
13 amount, for a health care coverage area for a year, is—

14 (1) the total amount of the payment adjust-
15 ments owed for the year under section 6124, divided
16 by

17 (2) the estimated average number of community
18 rate eligible individuals in the health care coverage
19 area during the year (reduced by the average num-
20 ber of such individuals whose family share of pre-
21 miums, determined without regard to this section
22 and section 6107, is zero).

23 **SEC. 6107. FAMILY COLLECTION SHORTFALL ADD-ON.**

24 (a) IN GENERAL.—The family collection shortfall
25 add-on, for a health care coverage area for a class of en-

1 rollment for a year, is the amount that would be the
2 weighted average premium for such area, class, and year,
3 if the per capita collection shortfall amount (determined
4 under subsection (b)) for the area for the year were sub-
5 stituted for the weighted average discount rate for the
6 health care coverage area for the year.

7 (b) COMPUTATION OF PER CAPITA ADJUSTMENT
8 FOR COLLECTION SHORTFALLS.—

9 (1) PER CAPITA COLLECTION SHORTFALL
10 AMOUNT.—The per capita collection shortfall
11 amount, for a health care coverage area for a year,
12 under this subsection is equal to—

13 (A) the amount estimated under paragraph

14 (2)(A) for the year, divided by

15 (B) the estimated average number of com-
16 munity rate eligible individuals in the health
17 care coverage area during the year (reduced by
18 the average number of such individuals whose
19 family share of premiums, determined without
20 regard to this section and section 6106, is
21 zero).

22 (2) AGGREGATE COLLECTION SHORTFALL.—

23 (A) IN GENERAL.—Each State shall esti-
24 mate, for each year (beginning with the first
25 year) the total amount of payments which the

1 State can reasonably identify as owed to com-
2 munity-rated health plans under this Act (tak-
3 ing into account any premium reduction or dis-
4 count under this subtitle and including amounts
5 owed under subpart B and not taking into ac-
6 count any penalties) for the year and not likely
7 to be collected (after making collection efforts
8 described in section 6209) during a period spec-
9 ified by the Secretary beginning on the first day
10 of the year.

11 (B) EXCLUSION OF GOVERNMENT
12 DEBTS.—The amount under subparagraph (A)
13 shall not include any payments owed to a com-
14 munity-rated health plan by the Federal, State,
15 or local governments.

16 (C) ADJUSTMENT FOR PREVIOUS SHORT-
17 FALL ESTIMATION DISCREPANCY.—Subject to
18 section 9201, the amount estimated under this
19 paragraph for a year shall be adjusted to reflect
20 over (or under) estimations in the amounts so
21 computed under this paragraph for previous
22 years (based on actual collections), taking into
23 account interest payable based upon borrowings
24 (or savings) attributable to such over or under
25 estimations.

1 (c) APPORTIONMENT OF ADJUSTMENT.—The Board
 2 shall implement a method for the distribution of the aggre-
 3 gate collection shortfall amount for each health care cov-
 4 erage area (as described in (b)(2)) across premiums in the
 5 area. Such method shall reflect a blend of each plan’s
 6 share of the area’s aggregate shortfall and the unadjusted
 7 per-capita collection shortfall amount.

8 **SEC. 6108. NO LOSS OF COVERAGE.**

9 In no case shall the failure to pay amounts owed
 10 under this Act result in an individual’s or family’s loss
 11 of coverage.

12 **SEC. 6109. APPLICATION OF ADJUSTMENTS.**

13 Per-capita adjustments described in sections 6105,
 14 6106, 6107 and 6125 shall be converted into adjustments
 15 applicable to each class of premium under a methodology
 16 to be established by the Board.

17 **Subpart B—Repayment of Family Credit by Certain**
 18 **Families**

19 **SEC. 6110. REPAYMENT OF FAMILY CREDIT BY CERTAIN**
 20 **FAMILIES.**

21 (a) IN GENERAL.—Subject to the succeeding provi-
 22 sions of this subpart, each family which is provided a fam-
 23 ily credit under section 6103(a) for a class of enrollment
 24 is liable for repayment of an amount equal to the base

1 employment monthly premium (applicable to such class)
2 for the month under section 6122.

3 (b) REDUCTION FOR SELF-EMPLOYMENT PAY-
4 MENTS.—The liability of a family under this section for
5 a year shall be reduced (but not below zero) by the amount
6 of any employer payments made in the year under section
7 6126 based on the net earnings from self-employment of
8 a family member.

9 **SEC. 6111. NO LIABILITY FOR FAMILIES EMPLOYED FULL-**
10 **TIME; REDUCTION IN LIABILITY FOR PART-**
11 **TIME EMPLOYMENT.**

12 (a) IN GENERAL.—The amount of any liability under
13 section 6110 shall be reduced, in accordance with rules
14 established by the National Health Board consistent with
15 this section, based on employer premiums payable under
16 section 6121 with respect to the employment of a family
17 member who is a qualifying employee or with respect to
18 a family member. In no case shall the reduction under this
19 section result in any payment owing to a family.

20 (b) CREDIT FOR FULL-TIME AND PART-TIME EM-
21 PLOYMENT.—

22 (1) IN GENERAL.—Under rules of the Board, in
23 the case of a family enrolled under a class of family
24 enrollment, if a family member is a qualifying em-
25 ployee for a month and (except in the case described

1 in section 6114(a)) the employer is liable for pay-
2 ment under section 6121 based on such employ-
3 ment—

4 (A) FULL-TIME EMPLOYMENT CREDIT.—If
5 the employment is on a full-time basis (as de-
6 fined in section 1901(b)(2)(A)) the liability
7 under section 6110 shall be reduced by the
8 credit amount described in subparagraph (C).

9 (B) PART-TIME EMPLOYMENT CREDIT.—If
10 the employment is on a part-time basis (as de-
11 fined in section 1901(b)(2)(A)) the liability
12 under section 6110 shall be reduced by the em-
13 ployment ratio (as defined in section
14 1901(b)(2)(B)) of the credit amount described
15 in subparagraph (C).

16 (C) FULL-TIME MONTHLY CREDIT.—The
17 amount of the credit under this subparagraph,
18 with respect to employment by an employer in
19 a month, is $\frac{1}{12}$ (or, if applicable, the fraction
20 described in paragraph (2)) of the amount owed
21 under section 6110, based on the class of en-
22 rollment, for the year.

23 (2) COVERAGE DURING ONLY PART OF A
24 YEAR.—In the case of a family that is not enrolled
25 in a community-rated health plan for all the months

1 in a year, the fraction described in this paragraph
2 is 1 divided by the number of months in the year in
3 which the family was enrolled in such a plan.

4 (3) AGGREGATION OF CREDITS.—For purposes
5 of paragraph (1)—

6 (A) INDIVIDUALS.—In the case of an indi-
7 vidual who is a qualifying employee of more
8 than one employer in a month, the credit for
9 the month shall equal the sum of the credits
10 earned with respect to employment by each em-
11 ployer. Such sum may exceed the credit amount
12 described in paragraph (1)(C).

13 (B) COUPLES.—In the case of a couple
14 each spouse of which is a qualifying employee
15 in a month, the credit for the month shall equal
16 the sum of the credits earned with respect to
17 employment by each spouse. Such sum may ex-
18 ceed the credit amount described in paragraph
19 (1)(C).

20 (c) TREATMENT OF CHANGE OF ENROLLMENT STA-
21 TUS.—In the case of a family for which the class of family
22 enrollment changes during a year, the Board shall estab-
23 lish rules for appropriate conversion and allocation of the
24 credit amounts under the previous provisions of this sec-
25 tion in a manner that reflects the relative values of the

1 base employment monthly premiums (as determined under
2 section 6122) among the different classes of family enroll-
3 ment.

4 **SEC. 6112. LIMITATION OF LIABILITY BASED ON INCOME.**

5 (a) IN GENERAL.—In the case of an eligible family
6 described in subsection (b), the repayment amount re-
7 quired under this subpart (after taking into account any
8 work credit earned under section 6111) with respect to
9 a year shall not exceed the amount of liability described
10 in subsection (c) for the year.

11 (b) ELIGIBLE FAMILY DESCRIBED.—An eligible fam-
12 ily described in this subsection is a family which is deter-
13 mined, under section 1282 by the State for the health care
14 coverage area in which the family resides, to have wage-
15 adjusted income (as defined in subsection (d)) below 300
16 percent of the applicable poverty level.

17 (c) AMOUNT OF LIABILITY.—

18 (1) DETERMINATION.—Subject to subsection
19 (f), in the case of a family enrolled in a class of en-
20 rollment with wage-adjusted income (as defined in
21 subsection (d)), the amount of liability under this
22 subsection is determined as follows:

23 (A) NO OBLIGATION IF INCOME BELOW IN-
24 COME THRESHOLD AMOUNT OR IF AFDC OR SSI
25 FAMILY.—If such income is than the income

1 threshold amount (specified in section
2 6104(c)(4)) or if the family is an AFDC or SSI
3 family, the amount of liability is zero.

4 (B) INCOME ABOVE INCOME THRESHOLD
5 AMOUNT.—If such income is at least such in-
6 come threshold amount and the family is not an
7 AFDC or SSI family, the amount of liability is
8 the sum of the following:

9 (i) FOUR PERCENT OF INCOME
10 (ABOVE INCOME THRESHOLD AMOUNT) UP
11 TO THE POVERTY LEVEL.—The initial
12 marginal rate (specified in paragraph
13 (2)(A)) of the amount by which—

14 (I) the wage-adjusted income
15 (not including any portion that ex-
16 ceeds the applicable poverty level for
17 the class of family involved), exceeds

18 (II) such income threshold
19 amount.

20 (ii) SECOND MARGINAL RATE.—The
21 second marginal rate (specified in para-
22 graph (2)(B)) of the amount by which—

23 (I) the wage adjusted income
24 (not including any portion that ex-
25 ceeds twice the applicable poverty

1 level for the class of family involved),
2 exceeds

3 (II) the applicable poverty level
4 for the class of family enrollment.

5 (iii) FINAL MARGINAL RATE.—Where
6 wage-adjusted income exceeds 200 percent
7 of the applicable poverty level, the final
8 marginal rate (specified in paragraph
9 (2)(C)) of the amount by which the wage-
10 adjusted income exceeds 100 percent of the
11 applicable poverty level.

12 (2) MARGINAL RATES.—In paragraph (1)—

13 (A) INITIAL MARGINAL RATE.—The initial
14 marginal rate, for a year for a class of enroll-
15 ment, is the ratio of—

16 (i) 4 percent of the applicable poverty
17 level for the class of enrollment for the
18 year, to

19 (ii) the amount by which such poverty
20 level exceeds such income threshold
21 amount.

22 (B) SECOND MARGINAL RATE.—The sec-
23 ond marginal rate, for a year for the class of
24 enrollment, is 7.6 percent.

1 (C) FINAL MARGINAL RATE.—The final
2 marginal rate, for a year for a class of enroll-
3 ment, is the ratio of—

4 (i) the amount by which (I) the
5 amount of the repayment amount de-
6 scribed in section 6111(a) exceeds (II) 5.8
7 percent of twice the applicable poverty level
8 (for the class and year); to

9 (ii) 200 percent of such poverty level.

10 (3) SECOND MARGINAL RATE.—

11 (A) IN GENERAL.—If, for a class of enroll-
12 ment for a health care coverage area in a State,
13 the second marginal rate exceeds the final mar-
14 ginal rate, the State may adjust such marginal
15 rates as provided in subparagraph (B).

16 (B) SAME RATE APPLICABLE.—Under an
17 adjustment made by a State under subpara-
18 graph (A), the second marginal rate and the
19 final marginal rate shall be the same and shall
20 be the ratio of—

21 (i) the amount by which (I) the
22 amount of the repayment amount de-
23 scribed in section 6111(a) exceeds (II) 4
24 percent of the applicable poverty level (for
25 the class and year); to

1 (ii) 200 percent of such poverty level.

2 (4) MONTHLY APPLICATION TO AFDC AND SSI
3 FAMILIES.—Paragraph (1) insofar as it relates to an
4 AFDC or SSI family shall be applied so as to reduce
5 to zero the liability amount only for months in which
6 the family is such an AFDC or SSI family.

7 (d) WAGE-ADJUSTED INCOME DEFINED.—In this
8 subtitle, the term “wage-adjusted income” means, for a
9 family, family adjusted income of the family (as defined
10 in section 1282), reduced by the sum of the following:

11 (1)(A) Subject to subparagraph (B), the
12 amount of any wages included in such family’s in-
13 come that is received for employment which is taken
14 into account in the computation of the amount of
15 employer premiums under section 6121 (without
16 consideration of section 6126).

17 (B) The reduction under subparagraph (A)
18 shall not exceed for a year \$5,000 (adjusted under
19 section 6104(c)(3)(B)) multiplied by the number of
20 months (including portions of months) of employ-
21 ment with respect to which employer premiums were
22 payable under section 6121 (determined in a manner
23 consistent with section 1901(b)(3)).

1 (2) The amount of net earnings from self em-
2 ployment of the family taken into account under sec-
3 tion 6126.

4 (3) The amount of unemployment compensation
5 included in income under section 85 of the Internal
6 Revenue Code of 1986.

7 (e) DETERMINATIONS.—A family’s wage-adjusted in-
8 come and the amount of liability under subsection (c) shall
9 be determined by the applicable health care coverage area
10 upon application by a family under subpart B of part 3
11 of subtitle D of title I.

12 (f) NO LIABILITY FOR INDIANS AND CERTAIN VET-
13 ERANS AND MILITARY PERSONNEL.—The provisions of
14 paragraph (3) of section 6104(a) shall apply to the reduc-
15 tion in liability under this section in the same manner as
16 such paragraph applies to the premium discount under
17 section 6104.

18 **SEC. 6113. PAYMENTS BY NONQUALIFYING EMPLOYEES.**

19 (a) IN GENERAL.—In the case of an eligible family
20 described in paragraph (b), the net liability of the family
21 under this section shall be the amount described in sub-
22 section (c), limited by the amount described in subsection
23 (d) plus the amount described in subsection (e).

24 (b) ELIGIBLE FAMILY DESCRIBED.—The family de-
25 scribed in this paragraph is a family that has one or more

1 nonqualifying employees and has no full-time qualifying
2 employees. The Board shall develop rules for applying this
3 section to families whose employment status with respect
4 to exempt employers changes during the year.

5 (c) AMOUNT.—The amount described in this sub-
6 section is the sum of—

7 (1) the family share as defined in section 6101
8 (including any discounts under 6104); and

9 (2) the family credit repayment amount de-
10 scribed in subpart B of title VI (including any re-
11 ductions under section 6113); reduced by—

12 (3) the amount (if any) by which that the pre-
13 mium specified in 6102(a) with respect to such fam-
14 ily exceeds the weighted average premium (applica-
15 ble to the family).

16 (d) LIMIT.—The limit described in this subsection is
17 the following:

18 (1) for a family with family adjusted income of
19 less than 150 percent of the applicable poverty level,
20 4 percent of family adjusted income;

21 (2) for a family with family adjusted income of
22 at least 150 percent but less than 175 percent of the
23 applicable poverty level, 4.5 percent of family ad-
24 justed income;

1 (3) for a family with family adjusted income of
2 at least 175 percent but less than 225 percent of the
3 applicable poverty level, 5 percent of family adjusted
4 income; and

5 (4) for a family with family adjusted income of
6 at least 225 percent but less than 400 percent of the
7 applicable poverty level, 6 percent of family adjusted
8 income.

9 (e) The amount described in this subsection is the
10 amount in subsection (c)(3).

11 (f) INDEXING OF PERCENTAGES.—

12 (1) IN GENERAL.—The percentage of family ad-
13 justed income specified in paragraphs (1) through
14 (4) of subsection (d) shall be adjusted for any year
15 after 1994 so that the percentage for the year bears
16 the same ratio to the percentage so specified as the
17 ratio of—

18 (A) 1 plus the general health care inflation
19 factor (as defined in section 6001(a)(3)) for the
20 year, bears to

21 (B) 1 plus the percentage specified in sec-
22 tion 1135 (relating to indexing of dollar
23 amounts related to cost sharing) for the year.

1 individual were 65 years of age based only on the
2 employment of the individual, or has completed 40
3 quarters of employment through a State or local
4 government, or has completed 40 quarters of em-
5 ployment through a State or local government, and

6 (4) is not a medicare-eligible individual.

7 (c) QUALIFIED SPOUSE OR CHILD DEFINED.—In
8 subsection (a), the term “qualified spouse or child” means,
9 in relation to an eligible retiree for a month, an individual
10 who establishes to the satisfaction of the community-rated
11 health plan (for the health care coverage area in which
12 the individual resides) under rules of the Secretary that
13 the requirements in one of the following paragraphs is met
14 with respect to the individual:

15 (1) The individual (A) is under 65 years of age
16 and is (and has been for a period of at least one
17 year) married to an eligible retiree or (B) is a child
18 of the eligible retiree.

19 (2) In the case of a person who was an eligible
20 retiree at the time of the person’s death—

21 (A) the individual was (and had for a pe-
22 riod of at least one year been) married to the
23 retiree at the time of the person’s death,

24 (B) the individual is under 65 years of age,

1 (C) the individual is not employed on a
2 full-time basis (as defined in section
3 1901(b)(2)(A)),

4 (D) the individual is not remarried, and

5 (E) the deceased spouse would still be an
6 eligible retiree in the month if such spouse had
7 not died.

8 (3) The individual is a child of an individual de-
9 scribed in paragraph (2).

10 (d) APPLICATION.—An individual may not be deter-
11 mined to be an eligible retiree or qualified spouse or child
12 unless an application has been filed with the State. Such
13 application shall contain such information as the Secretary
14 may require to establish such status and verify informa-
15 tion in the application. Any material misrepresentation in
16 the application is subject to a penalty in the same manner
17 as a misrepresentation described in section 1282.

18 **SEC. 6115. SPECIAL TREATMENT OF CERTAIN MEDICARE**
19 **BENEFICIARIES.**

20 In the case of an individual who would be a medicare-
21 eligible individual in a month but for the application of
22 section 1012(a) on the basis of employment (in the month
23 or a previous month) of the individual or the individual's
24 spouse or parent, the individual (or spouse or parent, as
25 the case may be) so employed is considered, for purposes

1 of section 6112, to be a full-time employee described in
2 such section in such month.

3 **PART 2—EMPLOYER PREMIUM PAYMENTS**

4 **Subpart A—Employers Exempt From Coverage**

5 **Obligations**

6 **SEC. 6116. EXEMPTION FROM COVERAGE OBLIGATIONS.**

7 An exempt employer as defined section 6117 shall be
8 exempt from requirements described in this part, except
9 the requirement described in section 6120, unless the em-
10 ployer elects under section 6118 to be treated as a commu-
11 nity-rated employer.

12 **SEC. 6117. EXEMPT EMPLOYER DEFINED.**

13 (a) IN GENERAL.—In this section—

14 (1) the term “exempt employer” means an em-
15 ployer that does not employ, on average, more than
16 10 full-time equivalent employees;

17 (2) and is an employer with average annual
18 wages per full-time equivalent employee of less than
19 \$24,000; and

20 (3) the average number of full-time equivalent
21 employees shall be determined by averaging the
22 number of full-time equivalent employees employed
23 by the employer in each countable month during the
24 year.

1 (b) COUNTABLE MONTH.—In paragraph (1), the
2 term “countable month” means, for an employer, a month
3 in which the employer employs any qualifying employee.

4 (c) DETERMINATIONS.—The number of full-time
5 equivalent employees shall be determined using the rules
6 under section 1901(b)(2).

7 (d) EXEMPT EMPLOYER.—The term “exempt em-
8 ployer” shall not include an individual described in section
9 6126(c)(2).

10 **SEC. 6118. ELECTION.**

11 A exempt employer may elect to be treated as a com-
12 munity-rated employer under the procedures described in
13 section.

14 **SEC. 6119. TREATMENT OF EXEMPT EMPLOYERS.**

15 (a) IN GENERAL.—

16 (1) COMMUNITY RATED EMPLOYER.—An ex-
17 empt employer shall be treated as a community
18 rated employer as of the first date of the first year
19 following an election made under section 6118.

20 (2) ELIGIBILITY FOR DISCOUNTS.—An exempt
21 employer making an election under section 6118
22 shall be eligible for discounts under 6123.

1 **SEC. 6120. NONELECTING EXEMPT EMPLOYER.**

2 (a) IN GENERAL.—The term “nonelecting exempt
3 employer” means an exempt employer that has not made
4 an election under section 6118.

5 (b) ASSESSMENT IN LIEU OF PARTICIPATION.—Each
6 State shall establish a mechanism to collect an assessment
7 of payroll from each non-electing employer to be used to
8 defray the cost of subsidies to the employees of such em-
9 ployer.

10 (c) AMOUNT OF ASSESSMENT.—For purposes of sub-
11 section (b)—

12 (1) with respect to employers with 5 or fewer
13 full-time equivalent employees, the assessment of
14 payroll under such subsection shall be 1 percent; and

15 (2) with respect to employers with more than 6
16 but less than 11 full-time equivalent employees, the
17 assessment of payroll under such subsection shall be
18 2 percent.

19 **Subpart B—Community-Rated Employers**

20 **SEC. 6121. EMPLOYER PREMIUM PAYMENT REQUIRED.**

21 (a) REQUIREMENT.—

22 (1) IN GENERAL.—Each community-rated em-
23 ployer described in paragraph (2) for a month shall
24 pay at least an amount equal to the sum across all
25 qualifying employees of the amount specified in sub-
26 section (b) for each such qualifying employee of the

1 employer. Such payments shall be made in accord-
2 ance with section 1345(c).

3 (2) EMPLOYER DESCRIBED.—An employer de-
4 scribed in this paragraph for a month is an employer
5 that—

6 (A) in a month employs one or more quali-
7 fying employees (as defined in section
8 1901(b)(1)); and

9 (B) is not exempt under section 3127 of
10 the Internal Revenue Code of 1986 from the
11 taxes imposed in section 3111 of such code.

12 (3) TREATMENT OF CERTAIN EMPLOYMENT BY
13 EXPERIENCE-RATED EMPLOYERS.—An experience-
14 rated employer shall be deemed, for purposes of this
15 subpart, to be a community-rated employer with re-
16 spect to qualifying employees who are not experience
17 rate eligible individuals.

18 (b) PREMIUM PAYMENT AMOUNT.—

19 (1) IN GENERAL.—Except as provided in sec-
20 tion 6123 (relating to a discount for certain employ-
21 ers), section 6124 (relating to large employers elect-
22 ing coverage through community-rated health plans),
23 section 6125 (relating to the employer collection
24 shortfall add-on), and section 6127 (relating to
25 qualified worksite health promotion programs, the

1 amount of the employer premium payment, for a
2 month for each qualifying employee of the employer
3 who is residing in a health care coverage area, is the
4 payment amount computed under paragraph (2)
5 with respect to such employee in such area.

6 (2) PAYMENT AMOUNT FOR EACH EMPLOYEE IN
7 A CLASS OF FAMILY ENROLLMENT.—Subject to
8 paragraph (4), the payment amount under this para-
9 graph, for an employer for each qualifying employee
10 residing in a health care coverage area, is the prod-
11 uct of—

12 (A) the base employment monthly premium
13 determined under section 6122 for the applica-
14 ble class of family enrollment (as defined in
15 paragraph (3)) for the previous month for the
16 health care coverage area, and

17 (B) the full-time employment ratio (as de-
18 fined in section 1901 for the previous month.

19 (3) APPLICABLE CLASS OF FAMILY ENROLL-
20 MENT.—The applicable class of family enrollment
21 described in this paragraph is the class of family en-
22 rollment selected by the qualifying employee.

23 (4) TREATMENT OF CERTAIN EMPLOYEES.—In
24 applying this subpart in the case of a qualifying em-

1 ployee (other than a medicare-eligible individual)
2 who is not enrolled in any health plan—

3 (A) the employee is deemed enrolled in a
4 community-rated health plan (for the health
5 care coverage area in which the individual re-
6 sides) in the dual parent class of enrollment,
7 and

8 (B) if the employee's residence is not
9 known, the employee is deemed to reside in the
10 health care coverage area in which the employee
11 principally is employed for the employer.

12 (5) TRANSITIONAL RULES FOR FIRST MONTH IN
13 FIRST YEAR FOR A STATE.—In the case of an em-
14 ployer for a State in the first month of the State's
15 first year—

16 (A) the premium amount for each qualify-
17 ing employee for such month shall be computed
18 by substituting “month” for “previous month”
19 in paragraph (2);

20 (B) payment for such month shall be made
21 on the first of the month based on an estimate
22 of the payment for such month;

23 (C) an adjustment shall be made to the
24 payment in the following month to reflect the
25 difference between the payment in the first

1 month and the payment in the following month
2 (calculated without regard to the adjustment
3 under this subparagraph); and

4 (D) the reconciliation of premiums for
5 such first month under section 1602(c) shall be
6 included in the reconciliation of premiums for
7 the following 12 months.

8 (6) SPECIAL RULES FOR DIVIDED FAMILIES.—
9 In the case of an individual who is a qualifying em-
10 ployee of an employer, if the individual has a spouse
11 or child who is not treated as part of the individual's
12 family because of section 1012—

13 (A) the employer premium payment under
14 this section shall be computed as though such
15 section had not applied, and

16 (B) the State shall provide for proportional
17 payments (consistent with rules established by
18 the Secretary) to the health plans (if different)
19 of the qualifying employee and of the employ-
20 ee's spouse and children.

21 (7) SPECIAL RULES FOR CERTAIN EMPLOYEES
22 RESIDING ABROAD.—The Office of Personnel Man-
23 agement shall determine the appropriate (voluntary)
24 employer premium amount with respect to each em-

1 ployee described in section 1707 electing to purchase
2 coverage through the FEHBP.

3 (c) APPLICATION DURING TRANSITION PERIOD.—

4 (1) IN GENERAL.—For purposes of applying
5 this subpart in the case of an employer described in
6 paragraph (3), there shall only be taken into account
7 qualifying employees (and wages of such employees)
8 who reside in a participating State.

9 (2) EXCEPTION.—Paragraph (1) shall not
10 apply in determining the average number of full-time
11 equivalent employees or whether an employer is a
12 medium employer.

13 (3) EMPLOYER DESCRIBED.—An employer de-
14 scribed in this paragraph is an employer that em-
15 ploys one or more qualifying employees in a partici-
16 pating State and one or more qualifying employees
17 in a State that is not a participating State.

18 (d) EXEMPTION FROM PREMIUM PAYMENTS.—An
19 employer shall be exempt from the payment of health care
20 premiums for exempt individuals defined in section
21 1902(19).

22 **SEC. 6122. COMPUTATION OF BASE EMPLOYMENT MONTH-**
23 **LY PREMIUM.**

24 (a) IN GENERAL.—Each State shall provide for the
25 computation for each year (beginning with the first year)

1 of a base employment monthly premium for each class of
2 family enrollment as follows:

3 (1) INDIVIDUAL ENROLLMENT.—The base em-
4 ployment monthly premium for the individual class
5 of enrollment is equal to $\frac{1}{12}$ of 80 percent of the
6 credit-adjusted weighted average premium (as de-
7 fined in paragraph (4)) for the health care coverage
8 area for the individual class of enrollment.

9 (2) COUPLE-ONLY ENROLLMENT.—

10 (A) IN GENERAL.—The base employment
11 monthly premium for the couple-only class of
12 enrollment is equal to $\frac{1}{12}$ of 80 percent of the
13 product described in subparagraph (B), divided
14 by the sum described in subparagraph (C).

15 (B) TOTAL PREMIUMS FOR COUPLE-ONLY
16 ENROLLMENTS.—The product described in this
17 subparagraph is—

18 (i) the credit-adjusted weighted aver-
19 age premium for such health care coverage
20 area for the couple-only class of enroll-
21 ment, multiplied by

22 (ii) the sum, for all the months in the
23 year, of the number of covered families re-
24 ceiving coverage through community-rated

1 health plans within such class of enroll-
2 ment in each such month.

3 (C) NUMBER OF WORKERS AND EXTRA
4 WORKERS.—The sum described in this subpara-
5 graph is—

6 (i) the sum specified in subparagraph
7 (B)(ii), plus

8 (ii) the number of additional workers
9 (determined under subsection (b)(1)), for
10 families receiving coverage within such
11 class from community-rated health plans
12 offered for the health care coverage area.

13 (3) SINGLE AND DUAL PARENT ENROLL-
14 MENTS.—

15 (A) IN GENERAL.—The base employment
16 monthly premium for the single parent and
17 dual parent classes of enrollment is equal to $\frac{1}{12}$
18 of 80 percent of the sum described in subpara-
19 graph (B), divided by the sum described in sub-
20 paragraph (C).

21 (B) TOTAL PREMIUMS FOR SINGLE AND
22 DUAL PARENT ENROLLMENTS.—The sum de-
23 scribed in this subparagraph is the sum of the
24 products described in the following clauses:

